

Volunteer continuing education

Statewide Health Insurance Benefits Advisors (SHIBA)

Medicare Advantage: How it works and what to do if you don't have access to it

- Understanding Medicare enrollment periods
- Module 11: Medicare Advantage plans and other Medicare health plans
- Advising tools and resources
- Counties without Medicare Advantage plans
- Health Home Program

January 2019

For volunteer training only – not for distribution

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Learning aids and handouts for November training

1. Understanding Medicare Part C & Part D enrollment periods, CMS Product No. 11219 Tip Sheet – included in this packet, 12 pages..... p. 11
2. CMS Module 11 – included in this packet, 50 pages..... p. 25
3. Decision Tree: Traditional Medicare or Medicare Advantage – separate handout, 1 page..... Handout
4. Comparing Medicare Supplement (Medigap) and Medicare Advantage Plans – included in this packet, 3 pages p. 77
5. Medicare Minute Script: Original Medicare and Medicare Advantage providers – included in this packet, 2 pages..... p. 83

NOTE: Some of the images may be difficult to read in the printed version of this packet. All materials are available on My SHIBA for your reference, review, and if you need to print a larger copy. Contact Diana at dianas@oic.wa.gov if you need assistance.

Acronyms

Acronyms in this list include terms in this training packet and CMS Module 11.

AIC	Amount in Controversy
AIDS	Acquired Immunodeficiency Syndrome
ALJ	Administrative Law Judge
ANOC	Annual Notice of Change
C-SNP	Chronic Condition Special Needs Plan
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CN	Categorically Needy (Medicaid)
CNP	Categorically Needy Program (Medicaid)
COLA	Cost-of-Living Adjustment
CY	Calendar Year
D-SNP	Dual Eligible Special Needs Plan
DSHS	Department of Social & Health Services
EOC	Evidence of Coverage
EP	Enrollment period
ESRD	End-Stage Renal Disease
FEHB	Federal Employees Health Benefits
FPL	Federal Poverty Level
GEP	General Enrollment Period
HAP	Health Action Plan
HCA	Health Care Authority
HIPAA	Health Insurance Portability and Accountability Act
HIS	Hospice Item Set
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HMOPOS	Health Maintenance Organization Point-of-Service
IEP	Initial Enrollment Period
IRE	Independent Review Entity

I-SNP	Institutional Special Needs Plan
LI NET	Limited Income NET Program
LIS	Low-income Subsidy
MA	Medicare Advantage
MA	Medicare Advantage
MA-PD	Medicare Advantage with Part D drug coverage
MAC	Medicare Appeals Council
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAO	Medicare Advantage Organizations
MA-PD	Medicare Advantage with Prescription Drug Coverage
MIPPA	Medicare Improvements for Patients & Providers Act
MMG	Medicare Marketing Guidelines
MSA	Medicare Savings Account
MSP	Medicare Savings Program
MSP	Medicare Secondary Payer
NCOA	National Council on Aging
NTP	National Training Program
OEP	Open Enrollment Period
OM	Original Medicare
OMHA	Office of Medicare Hearings and Appeals
OPM	Office of Personnel Management
PACE	Programs of All-Inclusive Care for the Elderly
PDP	Prescription Drug Plan
PEBB	Public Employees Benefits Board
PFFS	Private Fee-for-Service
POS	Point-of-Service
PPO	Preferred Provider Organization
PRISM	Predictive Risk Intelligence System
QRC	Quick Reference Card
RPEC	Retired Public Employees Council
RRB	Railroad Retirement Board

RTC	Regional Training Consultant
SEP	Special Enrollment Period
SHIBA	Statewide Health Insurance Benefits Advisors
SHIP	State Health Insurance Assistance Program
SMP	Senior Medicare Patrol
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SPAP	State Pharmaceutical Assistance Program
SSI	Supplemental Security Income
STARS	SHIP Tracking and Reporting System
TTY	Teletypewriter
UMP	Uniform Medical Plan
U.S.	United States
VA	Veterans Affairs (U.S. Department of)
VC	Volunteer Coordinator
VH	Volunteer Handbook
VRPM	Volunteer Risk Program Management
WA	Washington
WSHIP	Washington State High Risk Pool

Troubleshooting and sharing time

Welcome back! We hope you had a nice holiday season. Share with your group any questions or information:

- November topics
 - Discussed new Medicare Open Enrollment period: Jan. through March
 - Reviewed changes to Special Enrollment Period (SEP) for people with Extra Help
 - Reviewed 2018 training
 - Discussed 2019 counseling information and discussion topics
 - Looked at using Part D or Medicare Advantage drug coverage early in 2019
 - Talked about what to do when a drug is NOT covered in 2019
 - Reviewed SHIBA and PEBB – ways we can assist
 - Provided Unique ID and LI NET handouts
- Anything new to share from over the break?
- Review open enrollment successes, challenges, tips/hints, and lessons learned
- STARS updates
- Local topics
- Welcome to January! Think about cleaning out your binder. Let's catch up from being gone for December. We'll also spend a little time on this in March.

Volunteer learning objectives

Topic: Medicare Advantage: How it works. And what to do if clients don't have access to it.

- Define Medicare Advantage (MA) plans
- Describe how MA plans work
- Explain eligibility requirements and enrollment
- Recognize types of MA plans
- Explain Medicare Advantage rights, protections and appeals
- Summarize Medicare's marketing guidelines. Know the rules for gifts, rewards and incentives, educational and promotional activities, and agents and brokers.
- Explain the difference between Original Medicare (OM) and MA
- Describe different ways to supplement OM
- Describe Health Home benefits

Medicare and enrollment periods

Take a few minutes to discuss the following with your Regional Training Consultant (RTC):

- I. How do we explain the difference between Original Medicare and Medicare Advantage?
 - a. *Medicare & You*, pages 6-7
 - b. Medicare Minute Script on pages 81-84 of this packet.

- II. Enrollment periods early in 2019
 - a. MA OEP in January through March. We covered this in November 2018.
 - i. See *Medicare & You 2019* page 65
 - b. Medicare General Enrollment Period – GEP
 - i. January through March
 - ii. Coverage begins July 1
 - iii. Associated SEP for Part D or Part C is April through June
 - iv. All coverage begins July 1

Understanding Medicare Enrollment Periods, CMS Product No. 11219

Enrolling in Medicare is limited to certain times. This publication has information about enrolling in Medicare Advantage plans (Part C) and Medicare Prescription Drug Plans (Part D), including:

- Who can sign up
- When to sign up
- How the timing, including signing up late, can affect client costs.

Note: The handout starting on page 11 may be useful for you to add to your binder. You may remove the pages from this packet or you may print them out from [My SHIBA](#). This handout is posted under the January 2019 training.

Sources:

www.medicare.gov/Pubs/pdf/11219-Understanding-Medicare-Part-C-D.pdf

www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Publications-for-Partners-Items/CMS1215649.html

Notes



Revised October 2018

Understanding Medicare Part C & Part D Enrollment Periods

Enrollment in Medicare is limited to certain times. This publication has information about enrolling in Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D), including who can sign up, when to sign up, and how the timing, including signing up late, can affect your costs.

Note: For information about signing up for Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), visit [Medicare.gov/publications](https://www.Medicare.gov/publications) to view the booklet “Enrolling in Medicare Part A & Part B.”

Medicare Part C & D
Enrollment Periods

When can I sign up?

There are specific times when you can sign up for a Medicare Advantage Plan (like an HMO or PPO) or Medicare prescription drug coverage, or make changes to coverage you already have:

- During your Initial Enrollment Period when you first become eligible for Medicare or when you turn 65. See page 3.
- During certain enrollment periods that happen each year. See page 5.
- Under certain circumstances that qualify you for a Special Enrollment Period (SEP), like:
 - You move.
 - You're eligible for Medicaid.
 - You qualify for Extra Help with Medicare prescription drug costs.
 - You're getting care in an institution, like a skilled nursing facility or long-term care hospital.
 - You want to switch to a plan with a 5-star overall quality rating. Quality ratings are available on Medicare.gov.

See the charts beginning on page 7 for a list of different SEPs, including rules about how to qualify.

Note about joining a Medicare Advantage Plan

You must have Medicare Part A and Part B to join a Medicare Advantage Plan. In most cases, if you have End-Stage Renal Disease (ESRD), you can't join a Medicare Advantage Plan.

Initial Enrollment Periods

If this describes you...	You can...	At this time...
<p>You're newly eligible for Medicare because you turn 65.</p>	<p>Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.</p>	<p>During the 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.</p> <p>If you sign up for a Medicare Advantage Plan during this time, you can drop that plan at any time during the next 12 months and go back to Original Medicare.</p>
<p>You're newly eligible for Medicare because you have a disability and you're under 65.</p>	<p>Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan.</p>	<p>Starting 21 months after you get Social Security or Railroad Retirement Board (RRB) disability benefits. Your Medicare coverage begins 24 months after you get Social Security or RRB benefits. Your chance to sign up lasts through the 28th month after you get Social Security or RRB benefits.</p>
<p>You're already eligible for Medicare because of a disability, and you turn 65.</p>	<ul style="list-style-type: none"> ▪ Sign up for a Medicare Advantage Plan (with or without prescription drug coverage) or a Medicare Prescription Drug Plan. ▪ Switch from your current Medicare Advantage or Medicare Prescription Drug Plan to another plan. ▪ Drop a Medicare Advantage or Medicare Prescription Drug Plan completely. 	<p>During the 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.</p>
<p>You have Medicare Part A coverage, and you get Part B for the first time by enrolling during the Part B General Enrollment Period (January 1–March 31).</p>	<p>Sign up for a Medicare Advantage Plan (with or without prescription drug coverage).</p>	<p>Between April 1–June 30.</p>

Medicare Part C & D Enrollment Periods



Part D late enrollment penalty

The late enrollment penalty is an amount that's added to your Part D premium. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. If you have a penalty, you may have to pay it each month for as long as you have Medicare drug coverage. For more information about the late enrollment penalty, visit [Medicare.gov](https://www.Medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Enrollment periods that happen each year

Each year, you can make changes to your Medicare Advantage or Medicare prescription drug coverage for the following year. There are 2 separate enrollment periods each year. See the chart below for specific dates.

During this enrollment period...	You can...
<p>October 15–December 7 (Changes will take effect on January 1.)</p>	<ul style="list-style-type: none"> ▪ Change from Original Medicare to a Medicare Advantage Plan. ▪ Change from a Medicare Advantage Plan back to Original Medicare. ▪ Switch from one Medicare Advantage Plan to another Medicare Advantage Plan. ▪ Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage. ▪ Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage. ▪ Join a Medicare Prescription Drug Plan. ▪ Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan. ▪ Drop your Medicare prescription drug coverage completely.
<p>January 1–March 31 Medicare Advantage Open Enrollment Period (You can only make one change during this period. Changes will take effect the first of the month after the plan gets your request.)</p>	<ul style="list-style-type: none"> ▪ If you're in a Medicare Advantage Plan (with or without drug coverage), switch to another Medicare Advantage Plan (with or without drug coverage). ▪ Disenroll from your Medicare Advantage Plan and return to Original Medicare. If you choose to do so, you'll be able to join a Medicare Prescription Drug Plan. ▪ If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare. <p>You can't...</p> <ul style="list-style-type: none"> ▪ Switch from Original Medicare to a Medicare Advantage Plan. ▪ Join a Medicare Prescription Drug Plan if you're in Original Medicare. ▪ Switch from one Medicare Prescription Drug Plan to another if you're in Original Medicare.

**Medicare Part C & D
Enrollment Periods**



Special Enrollment Periods

You can make changes to your Medicare health and Medicare prescription drug coverage when certain events happen in your life, like if you move or you lose other insurance coverage. These chances to make changes are called Special Enrollment Periods (SEPs) and are in addition to the regular enrollment periods that happen each year. Rules about when you can make changes and the type of changes you can make are different for each SEP.

The SEPs listed on the next pages are examples. **This list doesn't include every situation.** For more information about SEPs, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Changes in where you live

If this describes you...	You can...	At this time...
<p>You move to a new address that isn't in your plan's service area.*</p>	<p>Switch to a new Medicare Advantage or Medicare Prescription Drug Plan.</p>	<p>If you tell your plan before you move, your chance to switch plans begins the month before the month you move and continues for 2 full months after you move.</p>
<p>You move to a new address that's still in your plan's service area, but you have new plan options in your new location.</p>	<p>* Note: If you're in a Medicare Advantage Plan and you move outside your plan's service area, you can also choose to return to Original Medicare. If you don't enroll in a new Medicare Advantage Plan during this SEP, you'll be enrolled in Original Medicare when you're disenrolled from your old Medicare Advantage Plan.</p>	<p>If you tell your plan after you move, your chance to switch plans begins the month you tell your plan, plus 2 more full months.</p>
<p>You move back to the U.S. after living outside the country.</p>	<p>Join a Medicare Advantage or Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you move back to the U.S.</p>
<p>You just moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital).</p>	<ul style="list-style-type: none"> ▪ Join a Medicare Advantage or Medicare Prescription Drug Plan. ▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan. ▪ Drop your Medicare Advantage Plan and return to Original Medicare. ▪ Drop your Medicare prescription drug coverage. 	<p>Your chance to join, switch, or drop coverage lasts as long as you live in the institution and for 2 full months after the month you move out of the institution.</p>
<p>You're released from jail.</p>	<p>Join a Medicare Advantage or Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you're released from jail.</p>

**Medicare Part C & D
Enrollment Periods**

Changes that cause you to lose your current coverage

If this describes you...	You can...	At this time...
You're no longer eligible for Medicaid.	<ul style="list-style-type: none"> ▪ Join a Medicare Advantage or Medicare Prescription Drug Plan. ▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan. ▪ Drop your Medicare Advantage Plan and return to Original Medicare. ▪ Drop your Medicare prescription drug coverage. 	(New for 2019) Your chance to change lasts for 3 full months from either the date you're no longer eligible or notified, whichever is later.
You find out that you won't be eligible for Extra Help for the following year.	<ul style="list-style-type: none"> ▪ Join a Medicare Advantage or Medicare Prescription Drug Plan. ▪ Switch from your current plan to another Medicare Advantage or Medicare Prescription Drug Plan. ▪ Drop your Medicare Advantage Plan and return to Original Medicare. ▪ Drop your Medicare prescription drug coverage. 	(New for 2019) Your chance to change lasts for 3 full months from either the date you're no longer eligible or notified, whichever is later.
You leave coverage from your employer or union.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month your coverage ends.
You involuntarily lose other drug coverage that's as good as Medicare drug coverage (creditable coverage), or your other coverage changes and is no longer creditable.	Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you lose your creditable coverage or are notified of the loss of creditable coverage, whichever is later.
You have drug coverage through a Medicare Cost Plan and you leave the plan.	Join a Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you drop your Medicare Cost Plan.
You drop your coverage in a Program of All-inclusive Care for the Elderly (PACE) Plan.	Join a Medicare Advantage or Medicare Prescription Drug Plan.	Your chance to join lasts for 2 full months after the month you drop your PACE plan.

Medicare Part C & D Enrollment Periods

You have a chance to get other coverage

If this describes you...	You can...	At this time...
You have a chance to enroll in other coverage offered by your employer or union.	Drop your current Medicare Advantage or Medicare Prescription Drug Plan to enroll in the private plan offered by your employer or union.	Whenever your employer or union allows you to make changes in your plan.
You have or are enrolling in other drug coverage as good as Medicare prescription drug coverage (like TRICARE or VA coverage).	Drop your current Medicare Advantage Plan with drug coverage or your Medicare Prescription Drug Plan.	Anytime.
You enroll in a Program of All-inclusive Care for the Elderly (PACE) Plan.	Drop your current Medicare Advantage or Medicare Prescription Drug Plan.	Anytime.
You live in the service area of one or more Medicare Advantage or Medicare Prescription Drug Plans with an overall quality rating of 5 stars.	Join a Medicare Advantage, Medicare Cost, or Medicare Prescription Drug Plan with an overall quality rating of 5 stars.	One time between December 8–November 30.

Medicare Part C & D Enrollment Periods

Changes in your plan’s contract with Medicare

If this describes you...	You can...	At this time...
Medicare takes an official action (called a “sanction”) because of a problem with the plan that affects you.	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Your chance to switch is determined by Medicare on a case-by-case basis.
Your plan’s contract ends (terminates) during the contract year.	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Your chance to switch starts 2 months before and ends 1 full month after the contract ends.
Your Medicare Advantage Plan, Medicare Prescription Drug Plan, or Medicare Cost Plan’s contract with Medicare isn’t renewed for the next contract year.	Switch from your Medicare Advantage or Medicare Prescription Drug Plan to another plan.	Between October 15 and the last day in February.

Changes due to other special situations

If this describes you...	You can...	At this time...
<p>You're eligible for both Medicare and Medicaid.</p>	<p>Join, switch, or drop a Medicare Advantage Plan or Medicare prescription drug coverage.</p>	<p>(New for 2019) Once during each of these periods:</p> <ul style="list-style-type: none"> ▪ January–March ▪ April–June ▪ July–September <p>(You can also make a change from October 15–December 7, and the change will take effect on January 1.)</p>
<p>You get Extra Help paying for Medicare prescription drug coverage.</p>	<p>Join, switch, or drop Medicare prescription drug coverage.</p>	<p>(New for 2019) Once during each of these periods:</p> <ul style="list-style-type: none"> ▪ January–March ▪ April–June ▪ July–September <p>(You can also make a change from October 15–December 7, and the change will take effect on January 1.)</p>
<p>You're enrolled in a State Pharmaceutical Assistance Program (SPAP).</p>	<p>Join either a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.</p>	<p>Once during the calendar year.</p>
<p>You're enrolled in a State Pharmaceutical Assistance Program (SPAP) and you lose SPAP eligibility.</p>	<p>Join either a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.</p>	<p>Your chance to switch starts either the month you lose eligibility or are notified of the loss, whichever is earlier. It ends 2 months after either the month of the loss of eligibility or notification of the loss, whichever is later.</p>
<p>You dropped a Medicare Supplemental Insurance (Medigap) policy the first time you joined a Medicare Advantage Plan.</p>	<p>Drop your Medicare Advantage Plan and enroll in Original Medicare. You'll have special rights to buy a Medigap policy.</p>	<p>Your chance to drop your Medicare Advantage Plan lasts for 12 months after you join the Medicare Advantage Plan for the first time.</p>
<p>You have a severe or disabling condition, and there's a Medicare Chronic Care Special Needs Plan (SNP) available that serves people with your condition.</p>	<p>Join a Medicare Chronic Care SNP that serves people with your condition.</p>	<p>You can join anytime, but once you join, your chance to make changes using this SEP ends.</p>

Medicare Part C & D Enrollment Periods

If this describes you...	You can...	At this time...
<p>You joined a plan, or chose not to join a plan, due to an error by a federal employee.</p>	<ul style="list-style-type: none"> ▪ Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan. ▪ Switch from your current plan to another Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan. ▪ Drop your Medicare Advantage Plan with drug coverage and return to Original Medicare. ▪ Drop your Medicare prescription drug coverage. 	<p>Your chance to change coverage lasts for 2 full months after the month you get a notice of the error from Medicare.</p>
<p>You weren't properly told that your other private drug coverage wasn't as good as Medicare drug coverage (creditable coverage).</p>	<p>Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you get a notice of the error from Medicare.</p>
<p>You weren't properly told that you were losing private drug coverage that was as good as Medicare drug coverage (creditable coverage).</p>	<p>Join a Medicare Advantage Plan with drug coverage or a Medicare Prescription Drug Plan.</p>	<p>Your chance to join lasts for 2 full months after the month you get a notice of the error from Medicare.</p>
<p>You don't have Part A coverage, and you enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31).</p>	<p>Join a Medicare Prescription Drug Plan.</p>	<p>Between April 1–June 30.</p>

Medicare Part C & D Enrollment Periods

Get more information

For more detailed information about signing up, including instructions on how to join, visit [Medicare.gov](https://www.Medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Extra Help is available!

If you have limited income and resources, you may be able to get Extra Help paying your prescription drug coverage costs. People who qualify may be able to get their prescriptions filled and pay little or nothing out of pocket. You can apply for Extra Help at any time. There's no cost to apply for Extra Help, so you should apply even if you're not sure if you qualify. To apply online, visit [socialsecurity.gov/i1020](https://www.socialsecurity.gov/i1020). Or, call Social Security at 1-800-772-1213 to apply by phone or get a paper application. TTY users can call 1-800-325-0778.

Medicare Part C & D
Enrollment Periods

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html](https://www.Medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Paid for by the Department of Health & Human Services.



CMS Module 11: Medicare Advantage plans and other Medicare health plans

This module provides a comprehensive overview of Medicare Advantage plans. It also includes a detailed lesson on marketing guidelines and the ways health plans may or may not market their plans.

The module starts on page 25.

Notes



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS
NTP
NATIONAL
TRAINING PROGRAM
MODULE **11**

Medicare Advantage and Other Medicare Health Plans

WA SHIBA Version - Updated November 2018

Slide 1

Module 11, “Medicare Advantage and Other Medicare Health Plans,” explains Medicare health plan options other than Original Medicare. This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the federally-facilitated Health Insurance Marketplace.

The information in this module was correct as of August 2018. To check for an updated version, visit [CMSnationaltrainingprogram.cms.gov](https://www.cms.gov/nationaltrainingprogram).

The CMS National Training Program provides this as an informational resource for our partners. It’s not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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This version has been updated for WA SHIBA.	
Slide 2	
November 2018	Medicare Advantage and Other Health Plans

The lessons in this module, “Medicare Advantage and Other Medicare Health Plans,” explain Medicare health plan options other than Original Medicare. For more information on Original Medicare, refer to our “Understanding Medicare” training module.

The materials are designed for information givers/trainers that are familiar with the Medicare Program, and would like to have prepared information for their presentations. It can be easily adapted for presentations to people with Medicare.

The WA SHIBA version module consists of 47 PowerPoint slides with corresponding speaker’s notes and check-your-knowledge questions. It can be presented in about 45 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be needed for add-on activities.

Session Objectives

- This session should help you
 - Define Medicare Advantage (MA) Plans
 - Describe how MA Plans work
 - Explain eligibility requirements and enrollment
 - Recognize types of MA Plans
 - Identify other Medicare health plans
 - Explain rights, protections, and appeals
 - Summarize the Medicare Marketing Guidelines—know the rules for gifts, rewards and incentives, educational and promotional activities, and agents and brokers

Slide 3

November 2018

Medicare Advantage and Other Health Plans

3

This session should help you

- Define Medicare Advantage (MA) Plans
- Describe how MA Plans work
- Explain eligibility requirements and enrollment
- Recognize types of MA Plans
- Identify other Medicare health plans
- Explain rights, protections, and appeals
- Summarize the Medicare Marketing Guidelines—know the rules for gifts, rewards and incentives, educational and promotional activities, and agents and brokers
- Explain what to do when the new Medicare card arrives in the mail

Lesson 1—Medicare Advantage (MA) Plan Overview

- What's a Medicare Advantage (MA) Plan?
- What are the types of MA Plans?
- How do MA Plans work?
- When can you join or switch plans?

Slide 4

November 2018

Medicare Advantage and Other Health Plans

4

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

- What's a Medicare Advantage (MA) Plan?
- What are the types of MA Plans?
- How do MA Plans work?
- When can you join a plan or switch plans?

What are Medicare Advantage (MA) Plans?

Medicare Advantage includes



- Offered by Medicare–approved private companies
 - Must follow Medicare rules
 - Another way to get Medicare coverage
 - Your Part A and Part B coverage is from the MA Plan
- In most cases you have to use healthcare providers in the plan’s network
 - Some plans offer out-of-network coverage
- You can’t enroll in (and don’t need) a Medicare Supplement Insurance (Medigap) policy while you’re in an MA Plan

Slide 5

November 2018

Medicare Advantage and Other Health Plans

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Medicare Advantage (MA) Plans (also called Part C plans) are health plan options approved by Medicare and run by private companies. MA Plans are part of the Medicare Program; they’re just another way to get Medicare coverage. Medicare pays the plan a certain amount for each member’s care. If you join an MA Plan, you may have to use a network (facilities, providers, and suppliers your plan has contracted with to provide health care services) of doctors and/or hospitals. There are 6 main types of MA Plans. Not all types of plans are available in all areas:

- Medicare Health Maintenance Organization (HMO) Plans – You get your care and services from doctors or hospitals in the plan’s network. If you get care outside the plan network, you may have to pay the full cost.
- Medicare Preferred Provider Organization (PPO) Plans – You have a network of doctors and hospitals, but with a PPO plan, you can also use out-of-network providers for covered services, usually for a higher cost.
- Medicare Private Fee-for-Service (PFFS) Plans – You can go to any Medicare-approved doctor 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 also choose an out-of-network doctor, hospital, or other provider who accepts the plan’s terms, but you may pay more. THERE ARE NONE IN WA.
- Medicare Special Needs Plans (SNP) – SNPs are 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.
- HMO Point-of-Service (HMOPOS) Plans – In some HMO Plans, you may be able to go out of network for certain services, usually for a higher cost. This is called an HMO plan with a point-of-service (POS) option.
- Medicare Savings Account (MSA) Plans – Plans that combine 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. THERE ARE NONE IN WA.

You can’t enroll in (and don’t need) a Medicare Supplement Insurance (Medigap) policy while you’re in an MA Plan.

PFFS and MSA plans aren’t coordinated care plans, so an enrollee in these plan types won’t necessarily have a network of providers or a provider to coordinate their care.

MA Plans can vary in benefits and costs. Read individual plan materials carefully to make sure that 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

Medicare Health Maintenance Organization (HMO) Plan	
Can you get your health care from any doctor or hospital?	No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis). In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service option in certain geographic areas.
Are prescription drugs covered?	In most cases, yes. Ask the plan. If you want Medicare drug coverage, you must join an HMO plan that offers prescription drug coverage.
Do you need to choose a primary care doctor?	In most cases, yes.
Do you need a referral to see a specialist?	In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.
What else do you need to know about this type of plan?	<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.
<small>November 2018</small>	<small>Medicare Advantage and Other Health Plans</small>

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- In a Medicare 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, you usually can't leave the MA Plan until a valid enrollment period. Your plan will notify you, and you can choose another doctor in the plan.
 - If you get care outside of 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 (like dental or vision services) than Original Medicare, but you may have to pay more for these benefits.

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- In a Medicare PPO Plan you have PPO network doctors and hospitals, but you can also use out-of-network providers for covered services, usually for a higher cost.
- In most cases, prescription drugs are covered. 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 you 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 Medicare Supplement Insurance (Medigap) policies.
 - Medicare PPO Plans may also offer extra benefits that aren't available under Original Medicare, but you may have to pay more 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.

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Medicare SNPs are MA Plans that limit membership to people with specific diseases or characteristics.

- 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) (continued)

<p>What else do you need to know about this type of plan?</p>	<ul style="list-style-type: none"> ▪ SNPs must limit plan membership to people in one of the following groups: <ol style="list-style-type: none"> 1. Institutional SNP (I-SNP): Those living in certain institutions (like a nursing home), or who require nursing facility-level of care at home 2. Dual Eligible SNP (D-SNP): Those eligible for both Medicare and Medicaid 3. Chronic Condition SNP (C-SNP): Those with specific chronic or disabling conditions ▪ Plans may further limit enrollment based on rules for the specific type of SNP ▪ Plans should coordinate your needed services and providers ▪ Plans should make sure that providers you use accept Medicaid if you have Medicare and Medicaid ▪ Plans should make sure that the plan's providers serve people where you live, if you live in an institution
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There are other things you need to know about Medicare SNPs:

- SNPs must limit plan membership to people in one of the following groups:
 1. Institutional SNP (I-SNP): People who live in certain institutions (like a nursing home), or who require nursing facility-level care at home
 2. Dual Eligible SNP (D-SNP): People who are eligible for both Medicare and Medicaid
 3. Chronic Condition SNP (C-SNP): People who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia)
- Plans may further limit enrollment based on rules for the specific type of SNP. For example, a D-SNP can further limit membership per the State Medicaid Agency Contract; an I-SNP enrollee must meet institutional level of care per the state requirements or the enrollee must agree to reside in a certain assisted living facility (within the network) if the enrollee meets that level of care; and, an a C-SNP can make further limitations per the chronic condition they are focusing on (i.e., a Cardiovascular/ Diabetes C-SNP can only enroll people who have cardiovascular disease or diabetes or both).
- 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 doctors or other health care providers you use accept Medicaid
- If you live in an institution, make sure that the plan's doctors or other health care providers serve people where you live

How do Medicare Advantage (MA) Plans work?

- In an MA Plan you
 - Are still in Medicare with all rights and protections
 - Still get those services covered by Part A and Part B but the MA Plan covers those services
 - May choose a plan that includes prescription drug coverage
 - Can be charged different out-of-pocket costs
 - Can't be charged more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility care
 - May choose a plan with extra benefits like vision, dental or fitness and wellness benefits
 - Have a yearly limit on your out-of-pocket costs

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Medicare Advantage and Other Health Plans

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- In an MA Plan you
 - Are still in Medicare with all rights and protections
 - Still get those services covered by Part A and Part B, but the MA Plan covers those services instead of Original Medicare (must have both Part A and Part B to join an MA Plan)
 - May choose a plan that includes prescription drug coverage
 - Can be charged different out-of-pocket costs
 - Can't be charged more than Original Medicare for certain services, like chemotherapy, dialysis, and skilled nursing facility (SNF) care
 - May choose a plan that includes extra benefits like vision, dental, or fitness and wellness benefits offered at the plan's expense (not covered by Medicare)
 - Have a yearly limit on your out-of-pocket costs

Medicare Advantage (MA) Plan Costs

- You still pay the standard Part B premium
 - A few plans may pay all or part for you
 - State assistance is available for some
- You may pay an additional monthly premium to the plan
- Plan 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 and Other Health Plans

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- If you join an MA Plan, you must continue to pay the standard monthly Medicare Part B premium. The monthly Part B premium in 2018 is \$134.
 - A few plans may pay all or part of the Part B premium for you. NOT IN WA.
 - Some people may be eligible for state assistance (programs for people with Medicare who have limited income and resources).
- When you join an MA Plan there are other costs you may have to pay, like
 - An additional monthly premium to the plan
 - Deductibles, coinsurance, and copayments (required by most plans). These costs may
 - Be different from Original Medicare
 - Vary from plan to plan
 - Be higher if you go out of the plan's network

Who Can Join a Medicare Advantage Plan?

- To be eligible, you must
 - Be enrolled in Medicare Part A (Hospital Insurance)
 - Be enrolled in Medicare Part B (Medical Insurance)
 - Live in the plan's service area
 - Be a United States (U.S.) citizen or lawfully present in the U.S.
 - Not be incarcerated
- To join you must also
 - Provide necessary information to the plan
 - Follow the plan's rules
 - Only belong to one plan at a time

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Medicare Advantage and Other Health Plans

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

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

Medicare Advantage (MA) Plans and End-Stage Renal Disease (ESRD)

- Usually you can't enroll if you have ESRD
- There are limited exceptions
 - Transition from one plan to another within the same parent organization
 - No break between coverage
 - Must meet all other enrollment requirements
 - If you joined the plan without ESRD, but developed ESRD while in the plan, you may stay in the plan
- If you've had a successful kidney transplant or no longer require a regular course of dialysis
 - You aren't considered to have ESRD for MA eligibility purposes

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People with End-Stage Renal Disease (ESRD) usually can't join an 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 (like, non-Medicare), can enroll in another plan, if the plan is part of the same parent organization and meets the criteria for doing so. For example, an individual who develops ESRD while enrolled in an employer group health plan may be allowed to enroll in an MA Plan offered by the same plan parent organization, if there's no break between coverage. People with Medicare with ESRD who are already enrolled in an MA Plan may also enroll in another MA Plan within the same parent organization as long as:

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

The Centers for Medicare & Medicaid Services (CMS) will permit a change from an HMO to a PPO or a PFFS Plan within the same parent organization, as long as the change meets all of the criteria. The term "parent organization" is defined as an entity that owns one or more contracts (H numbers) with CMS to provide MA Plans.

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

NOTE: For more information on the enrollment exceptions for people with ESRD, see the MA enrollment and disenrollment guidance in Chapter 2 of the "Medicare Managed Care Manual," section 20.2.2, available at [CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2018_MA_Enrollment_and_Disenrollment_Guidance_6-15-17.pdf](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2018_MA_Enrollment_and_Disenrollment_Guidance_6-15-17.pdf) and [Medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/esrd-and-medicare-advantage-plans.html](https://www.Medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/esrd-and-medicare-advantage-plans.html).

When You Can Join Medicare Advantage (MA) Plans

- Generally during your Initial Enrollment Period (IEP)
 - If so, can change to another MA Plan (with or without drug coverage) or go back to Original Medicare (with or without drug coverage) within the first 3 months you have Medicare
- Medicare due to a disability
 - 7-month period begins 3 months before the 25th month of disability benefits
 - Ends 3 months after the 25th month of disability benefits

NOTE: If you drop a Medigap policy to join an MA Plan, you might not be able to get it back. Check with your state.

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You can join an MA Plan when you first become eligible for Medicare, generally during your Initial Enrollment Period (IEP), which begins 3 months immediately before your first entitlement to both Medicare Part A and Part B.

If you get Medicare due to a disability, you can join during the 7-month period that begins 3 months before your 25th month of getting Social Security or Railroad Retirement disability benefits, and ends 3 months after your 25th month of disability benefits.

NEW Medicare Advantage Open Enrollment Period (MA OEP)

Starts
Jan 1

Continues
Feb

Ends
Mar 31

Coverage
Begins first of
month after
you enroll

- 3-Month period each year during which you can
 - ✓ Switch MA Plans (MA-PD to MA, or MA to MA-PD)
 - ✓ Drop MA Plan and return to Original Medicare
 - If you do, you can enroll in a Part D plan
 - You won't have a Guaranteed Issue Right for a Medigap policy
- You must already be in an MA Plan on January 1 to use this enrollment period.
- Doesn't apply to MSA or Cost Plans.

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New in 2019

The new MA Open Enrollment Period (OEP) starts in 2019. It's from January 1 – March 31 each year. Your coverage begins the first day of the month after you enroll in the plan. You must be in an MA Plan already on January 1 to use this enrollment period.

During the MA OEP you can

- Switch MA Plans. You can switch from an MA Plan with Part D drug coverage (MA-PD) to one without Part D coverage, but you would not be able to add a stand-alone Part D plan. You can switch from one MA-PD Plan to another one. And you can switch from an MA-only Plan to an MA-PD.
- Drop your MA or MA-PD Plan and return to Original Medicare. If you do this, you can also enroll in a Part D plan. However, you might not be able to get a Medigap policy. Check with your state.

You can only make one change during the MA OEP.

People new to Medicare who enroll in an MA Plan during their IEP have 3 months to use the MA OEP to make a change.

Medicare Savings Accounts (MSAs) and Cost Plans are not included in the MA OEP.

This change was made through Regulation CMS-4182.

When You Can Join or Switch Medicare Advantage (MA) Plans (continued)

- If you have Part A and enroll in Medicare Part B during a General Enrollment Period (GEP), you can enroll in an MA Plan April 1–June 30 with coverage starting July 1
- During Special Enrollment Period (SEP) in certain circumstances
 - Examples include:
 - You move out of your plan’s service area
 - You have or lose Medicaid or Extra Help
 - You live in an institution (like a nursing home)
- 5-star Special Enrollment Period – None in Washington
 - Can switch to an MA Plan or Medicare Cost Plan that has 5 stars for its overall star rating
 - Once from December 8, 2018 – November 30, 2019

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Medicare Advantage and Other Health Plans

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- If you have Part A and enroll in Medicare Part B during a General Enrollment Period (GEP), you can enroll in an MA Plan April 1–June 30 with coverage starting July 1
- During Special Enrollment Period (SEP) in certain circumstances
 - Examples include:
 - You move out of your plan’s service area
 - You have or lose Medicaid or Extra Help
 - You live in an institution (like a nursing home)
- 5-star Special Enrollment Period NONE IN WA
 - Can switch to an MA Plan or Medicare Cost Plan that has 5 stars for its overall star rating
 - The next 5-star SEP will be December 8, 2018 – November 30, 2019

To find out which MA Plans are available in your area, visit [Medicare.gov/find-a-plan](https://www.medicare.gov/find-a-plan) to use the Medicare Plan Finder, or call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048.

NOTE: In the case of retroactive entitlement, there are special rules that allow for enrollment in an MA Plan or Original Medicare and a Medigap policy.

More information about conditions that allow an exception can be found in Chapter 2 of the “Medicare Managed Care Manual,” Section 30.4, at [CMS.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2018_MA_Enrollment_and_Disenrollment_Guidance_6-15-17.pdf](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2018_MA_Enrollment_and_Disenrollment_Guidance_6-15-17.pdf).

Low Performing Drug Plan

- **Low performing star rating status**
 - You may have a one-time option to switch to another Medicare drug plan with a rating of 3, 4, or 5 stars if your plan's summary rating was less than 3 stars for 3 years
 - Low Performance Icon appears on Plan Finder 
 - Plans can't attempt to discredit their low performing status by showcasing a separate higher rating
 - None in Washington

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A contract that gets less than 3 stars for its Part C or Part D summary rating for at least the last 3 years gives these members a one-time option to switch to another Medicare drug plan with 3 stars or better.

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

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

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

Reference: [Medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx](https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx)

Medicare Advantage (MA) Trial Rights and Medigap

- Special Medigap rights for people who join an MA Plan for the first time
 - When first eligible at 65, or
 - Drop a Medigap policy
- Can disenroll during the first 12 months
 - Return to Original Medicare
 - Have guaranteed issue rights for Medigap

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Medicare Advantage and Other Health Plans

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If you join an MA Plan for the first time, 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 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 PDP. You can buy a Medigap policy anytime a plan will sell you one. Visit [Medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf](https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf) for more information about Medigap policies.

Medicare Advantage (MA) Plan Network Changes

- Many types of MA Plans have provider networks
- Plans may change networks at any time
 - Must protect you from interruptions in medical care
 - Must maintain adequate access to services
 - Must notify enrollees who see affected providers
 - At least 30 days prior to the provider's contract termination
- In most cases, network changes aren't a basis for an SEP
 - CMS determines eligibility on a case-by-case basis

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Network-based MA Plans (like, HMOs, PPOs, and PFFS with networks) can make changes to their network of contracted providers at any time during the year. It's important to note that CMS has safeguards in place to ensure that you are protected from medical care interruptions.

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

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

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

Check Your Knowledge—Question 1

Medicare Advantage
(MA) Plans are
sometimes called

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

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Medicare Advantage and Other Health Plans

Check Your Knowledge—Question 1

Medicare Advantage (MA) Plans are sometimes called

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

Answer: c. Part C. MA Plans are part of the Medicare Program and are sometimes called Part C.

Check Your Knowledge—Question 2

Most people enrolled in a Medicare Advantage (MA) Plan will continue to pay a monthly Medicare Part B premium.

- a. True
- b. False

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Medicare Advantage and Other Health Plans

Check Your Knowledge—Question 2

Most people enrolled in a Medicare Advantage (MA) Plan will continue to pay a monthly Medicare Part B premium.

- a. True
- b. False

Answer: a. True. If you join an MA Plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium for 2018 is \$134.

- A few plans may pay all or part of the Part B premium for you
- Some people may be eligible for help from their state (programs for people with Medicare who have limited income and resources)

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

- Is a Medicare and Medicaid Program
- Combines services for frail, elderly people
 - Medical, social, and long-term care services
 - Includes 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 (Medicaid) office for information
- PACE in King county only

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

Call your state Medical Assistance (Medicaid) office to find out about eligibility and if you live in the service area of a PACE plan. Contact the Medicaid office phone number in your state. You can look up that contact information at [Medicaid.gov/about-us/contact-us/contact-state-page.html](https://www.Medicaid.gov/about-us/contact-us/contact-state-page.html). You can also visit [Medicare.gov/find-a-plan/questions/pace-home.aspx](https://www.Medicare.gov/find-a-plan/questions/pace-home.aspx) to look up PACE plans in your area.

NOTE: Instructor may highlight local plans.

Providence PACE (“Providence Elder Place”) is the only one in WA with locations all in King county. Beneficiaries must live in specific zip codes.

Lesson 3—Rights, Protections, and Appeals

- Guaranteed rights and protections
- Appeals
- Required notices
- Medicare Advantage (MA) Plan marketing reminders
- Plan rewards and incentive programs

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Medicare Advantage and Other Health Plans

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

- Guaranteed rights and protections
- Appeals
- Required notices
- Medicare Advantage (MA) Plan marketing reminders
- Plan rewards and incentive programs

Guaranteed Rights

- Get needed health care services
- Get easy-to-understand information
- Have personal medical information kept private

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

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

To view the full list of rights and protections for people with Medicare, visit [Medicare.gov/claims-and-appeals/medicare-rights/everyone/rights-for-everyone.html](https://www.medicare.gov/claims-and-appeals/medicare-rights/everyone/rights-for-everyone.html).

Rights in Medicare Health Plans

- Choice of health care providers within the plan
- 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

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

- Choose health care providers in the plan so you can get covered health care.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need to. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.
- Know how your doctors are paid if you ask your plan. Medicare doesn't allow a plan to pay doctors in a way that interferes with your getting needed care.
- Have a fair, efficient, and timely appeals process to resolve payment and coverage disputes with your plan. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued.
- File a grievance about other concerns or problems with your plan (e.g., if you believe your plan's hours of operation should be different, or there aren't enough specialists in the plan to meet your needs). Check your plan membership materials, or call your plan to find out how to file a grievance.
- Get a coverage decision (sometimes called an organization determination) or coverage information from your plan before getting a service to find out if the item or service will be covered, or to get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.
- Maintain privacy of personal health information.

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

Appeals in Medicare Advantage (MA) and Other Health Plans

- Plan must tell you in writing how you can appeal if it
 - Won't pay for a service
 - Doesn't allow a service
 - Stops or reduces course of treatment
- You and your doctor can file an appeal
- 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

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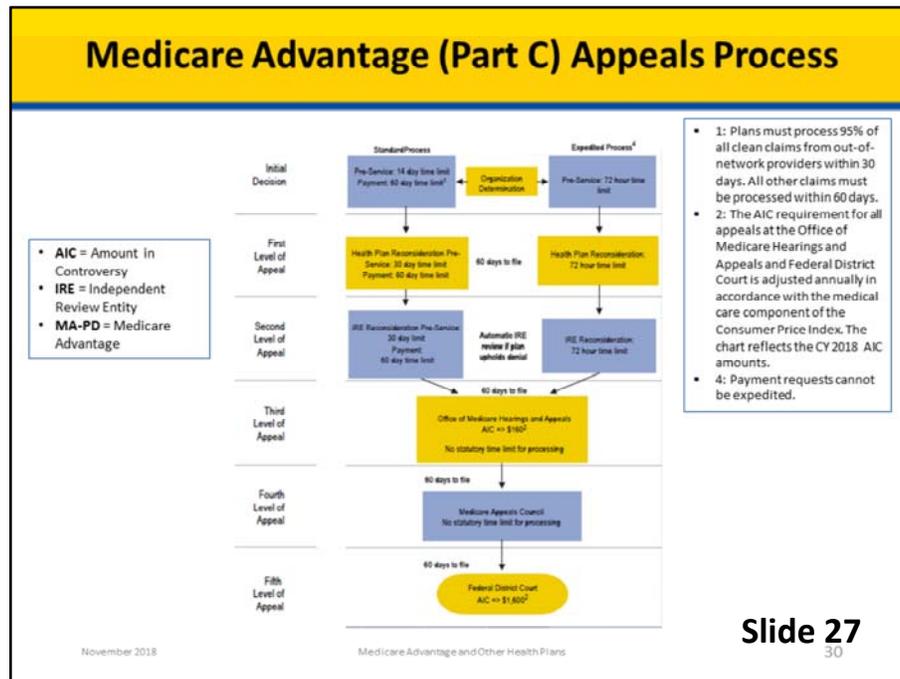
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The plan must tell you in writing how you can appeal if your plan won't pay for, doesn't allow, or stops or reduces a previously authorized course of treatment that you think should be covered or provided. You and your doctor can file an appeal. If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

If a doctor requests or supports an expedited decision, the plan must make a decision within 72 hours. You or the plan may extend the time frame up to 14 days to get more medical information. After an appeal is filed, the plan will review its decision. Then, if the plan doesn't decide in your favor, an independent organization that works for Medicare—not for the plan—automatically reviews the decision.

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



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

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

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

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

1. Reconsideration by the plan
2. Reconsideration by the Independent Review Entity
3. Decision by Office of Medicare Hearings and Appeals (OMHA)—the amount of your claim must meet a minimum dollar amount, a figure that's updated yearly (\$160 in 2018)
4. Review by the Appeals Council
5. Judicial 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 (\$1,600 in 2018)

For more information, visit [CMS.gov/Medicare/Appeals-and-Grievances/MMCAG/](https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/).

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

Rights If You File an Appeal With Your Medicare Health Plan

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

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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 coverage you requested.

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

Lesson 4—Medicare Marketing Guidelines

- Marketing and disclosure
- Gifts
- Promotional educational activities
- Agents/brokers
- Rewards and incentives

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Lesson 4 provides information on the following:

- Marketing and disclosure
- Gifts
- Promotional educational activities
- Agents/brokers
- Rewards and incentives

Marketing Materials

- The Centers for Medicare and Medicaid Services (CMS) requires review and approval of certain materials
 - Exceptions are listed in Section 20 of the Medicare Marketing Guidelines.
 - For more information visit [CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY-2018-Medicare-Marketing-Guidelines_Final072017.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY-2018-Medicare-Marketing-Guidelines_Final072017.pdf)
 - Plans must maintain materials and make them available at CMS's request
- CMS creates standardized and model marketing materials

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

For more information [CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY-2018-Medicare-Marketing-Guidelines_Final072017.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY-2018-Medicare-Marketing-Guidelines_Final072017.pdf). Also see the resources slide at the end of this presentation for the link to the MMG.

Marketing Reminders

- Marketing for upcoming plan year
 - May not occur before October 1
- Marketing star ratings in materials must get equal or greater prominence
 - Individual measures may be marketed/ communicated with overall performance rating
 - Low-performing star rating status
 - Low Performance Icon 
 - Plans may not try to discredit their low performing status by showcasing a separate higher rating

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Marketing for the upcoming plan year may not occur before October 1. Plan sponsors must stop current year marketing activities to existing people with Medicare once they begin marketing the plan benefits for the new contract year. **NOTE:** Individuals eligible for a valid enrollment, like age-ins or Special Enrollment Periods (SEPs), are exempt.

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

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

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

Disclosure of Plan Information for New and Renewing Members

- MA and PDPs must disclose plan information
 - At time of enrollment and at least annually
 - Required ANOC/EOC (*new requirements appear on next slide*)
 - Low Income Subsidy (LIS) rider
 - Comprehensive or abridged formulary
 - Member ID card at the time of enrollment/as needed
 - Must provide the hard copy pharmacy and provider directories or a notice describing where they can be found online together with how to request a hardcopy
 - Documents for new enrollees must be provided no later than 10 calendar days or the last day of the month before the effective date, whichever is later

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To ensure that enrollees receive comprehensive plan information regarding their health care options, CMS requires MA and PDP organizations to disclose certain plan information both at the time of enrollment and at least annually, 15 days before the Open Enrollment Period (OEP).

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

Nominal Gift Reminders

- Organizations can offer gifts to potential enrollees
 - Must be of nominal value
 - Defined in Medicare Marketing Guidelines
 - Currently \$15 or less per individual gift based on retail value
 - There's a maximum aggregate of all gifts of \$75 per person, per year
- Given regardless of beneficiary enrollment and without discrimination
- May not be in the form of cash or other monetary rebates, even if worth is \$15 or less

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Organizations can offer gifts without discrimination to potential enrollees as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the plan. CMS currently defines nominal value in the Medicare Marketing Guidelines, Section 110.1 (Promotional Activities), as an item worth \$15 or less, based on the fair market value of the item. There's a maximum aggregate of \$75 per person, per year. Nominal gifts may not be in the form of cash or other monetary rebates.

NOTE: Refer to the Office of Inspector General's website regarding advisory opinions on gifts and gift cards.

Unsolicited Beneficiary Contact

- Prohibited unsolicited marketing activities
 - Electronic communications
 - Unless express permission is given
 - Door-to-door solicitation
 - Calls/visits after attending sales event
 - Unless permission is given
 - Common areas (e.g., parking lots, hallways, sidewalks, etc.)

NOTE: Prohibited activities don't include conventional mail or other print media

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

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

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

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

Organizations may do the following:

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

Cross-Selling Prohibition

- Prohibited during any MA or Part D sales activity or presentation
- Can't market non-health related products
 - Annuities
 - Life insurance
 - Other products
- Allowed on inbound calls per the request of the person with Medicare

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

People with Medicare already face difficult decisions regarding Medicare coverage options and should be able to focus on Medicare options without confusion. Plans should not imply that the health and the non-health products are a package. Plans may sell non-health-related products on inbound calls when a person with Medicare requests information on other non-health-related products. Marketing to current plan members of non-MA Plan-covered health care products, and/or non-health care products, is subject to Health Insurance Portability and Accountability Act (known as HIPAA) rules.

Scope of Appointment Reminders

- Must specify product type
 - MA, Medicare Prescription Drug, and Cost Plans
- 48 hours before personal/individual marketing and/or in-home appointment
- Additional products can only be discussed
 - With person with Medicare's request
 - At separate appointment

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

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

Example: A person with Medicare attends a sales presentation and schedules an appointment. The agent must get the person with Medicare to sign written documentation agreeing to the products that will be discussed during the appointment.

- Organizations should use their existing systems to monitor and track calls where there's interaction with people with Medicare. Organizations that contact a person with Medicare in response to a reply card may only discuss the products that were included in the advertisement.
- Organizations may not discuss additional products unless the person with Medicare requests the information. Moreover, any additional lines of plan business that aren't identified before the in-home appointment will require a separate appointment.

Marketing in Health Care Settings

- Marketing allowed in health care common areas
 - Hospital or nursing home cafeterias
 - Community or recreational rooms
 - Conference rooms
- No marketing in health care settings where patients get care
 - Waiting rooms
 - Exam rooms and hospital patient rooms
 - Dialysis centers and pharmacy counter areas

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Organizations may not conduct marketing activities in health care settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreation rooms, and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Plans may not conduct sales presentations and distribute and accept enrollment applications in areas where patients primarily get health care services. These restricted areas generally include, but aren't limited to: waiting rooms, exam rooms, hospital patient rooms, dialysis centers, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medications).

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

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

Promotional Activity Reminders

- 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

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MA and Medicare PDP organizations may not give prospective enrollees meals, or subsidize meals, at sales events or any meeting at which they discuss plan benefits and/or distribute plan materials.

Agents and/or brokers are allowed to provide refreshments and light snacks to prospective enrollees. Plans must use their best judgment on the appropriateness of food products they provide, and must ensure that items they provide couldn't be reasonably considered a meal, and/or that they aren't "bundling" and providing multiple items as if they are a meal.

As with all marketing regulations and guidance, it's the responsibility of MA and PDP organizations to monitor the actions of all agents selling their plan(s) and take proactive steps to enforce this prohibition. Oversight activities CMS conducts will verify that plans and agents are complying with this provision, and CMS will take enforcement actions.

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

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

Educational events for prospective members may not include sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. 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 shouldn't be used to steer or attempt to steer a beneficiary toward a specific plan or plans. Plan sponsors or their representatives may not

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

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

Licensure and Appointment of Agents

- MA and PDP organization agents/brokers or other marketing representatives
 - Must comply with state-licensure laws
 - Applies to all agents/brokers
 - Must be appointed by the plan, if required by the state

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MA organizations and Medicare 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.

Agent/Broker Training and Testing

- All agents/brokers must be trained and tested annually
 - Medicare rules and regulations
 - Plan details specific to plan products sold
 - Applies to all agents/brokers
- Completed prior to marketing the product
 - Must pass test with 85%

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

Medicare Advantage and Other Medicare Health Plans Resource Guide

Centers for Medicare & Medicaid Services (CMS)	<ul style="list-style-type: none"> ▪ Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. ▪ Medicare.gov ▪ CMS.gov
Social Security	<ul style="list-style-type: none"> ▪ Call 1-800-772-1213. TTY: 1-800-325-0778. ▪ socialsecurity.gov
Railroad Retirement Board	<ul style="list-style-type: none"> ▪ Call 1-877-772-5772. TTY: 1-312-751-4701. ▪ RRB.gov
Medicare Marketing Guidelines	<ul style="list-style-type: none"> ▪ CMS.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY-2018-Medicare-Marketing-Guidelines_Final072017.pdf
Medicare Managed Care Manual	<ul style="list-style-type: none"> ▪ CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html
State Health Insurance Assistance Programs and State Insurance Departments	<ul style="list-style-type: none"> ▪ shiptacenter.org ▪ Call 1-877-839-2675 ▪ info@shiptacenter.org



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

"Medicare & You Handbook"	▪ CMS Product No. 10050
"Have You Done Your Yearly Medicare Plan Review?"	▪ CMS Product No. 11220
"Understanding Medicare Part C & D Enrollment Periods"	▪ CMS Product No. 11219
"Understanding your Medicare Advantage Plan's provider network"	▪ CMS Product No. 11941
"Your Guide to Medicare Medical Savings Account Plans"	▪ CMS Product No. 11206

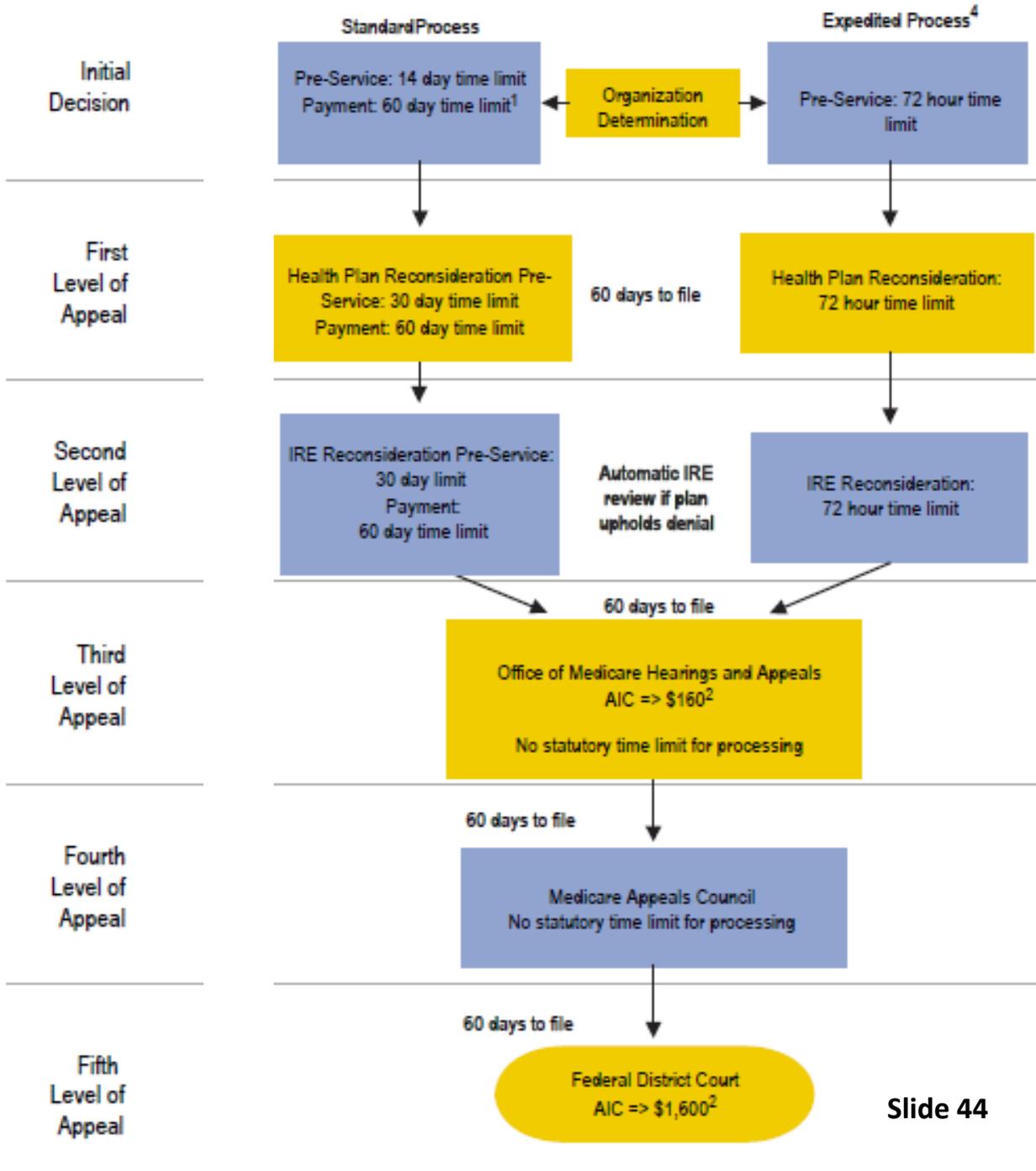
To access these products:

- View and order single copies at [Medicare.gov/publications](https://www.medicare.gov/publications).
- Order multiple copies (partners only) at [Productordering.cms.hhs.gov](https://productordering.cms.hhs.gov).

You must register your organization.

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Part C (MA) Process



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Appendix: Part C (MA) Appeals Process and Footnotes (continued)

- 1: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.
- 2: The AIC requirement for all appeals at the Office of Medicare Hearings and Appeals and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2018 AIC amounts.
- 4: Payment requests cannot be expedited.

AIC = Amount in Controversy

IRE = Independent Review Entity

MA-PD = Medicare Advantage

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- 1: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.
- 2: The AIC requirement for all appeals at the Office of Medicare Hearings and Appeals and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2018 AIC amounts.
- 4: Payment requests cannot be expedited.

AIC = Amount in Controversy

IRE = Independent Review Entity

MA = Medicare Advantage

Acronyms

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

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Notes

Q&A and scenarios

Spend about 15 minutes asking questions about Module 11. Consider some scenarios you have encountered. Feel free to share these on the back evaluation page. These examples could be useful for future training.

For example: In your county, what would you share with a client who spends six months a year in Arizona?

Notes

Volunteer advisor resources

These resources are designed to help you with advising clients on Medicare Advantage plans:

- Decision Tree, separate handout
- Comparing Medicare Supplement (Medigap) and Medicare Advantage plans, see page 76
- SMP Medicare Minute Script: Original Medicare and Medicare Advantage Providers, see page 81

Decision Tree: Traditional Medicare or Medicare Advantage



1 page

See handout

Also on [My SHIBA](#) under January 2019 training materials

Source:

www.medicareadvocacy.org/wp-content/uploads/2018/10/Fully-Informed-Traditional-Medicare-v.-Medicare-Advantage-Infographic.pdf

Comparing Medicare Supplement (Medigap) and Medicare Advantage Plans

- See following three pages
- Also on [My SHIBA](#) under January 2019 training materials
- Also see *Medicare & You*, pages 6-7 for supplemental information.

Source:

www.insurance.wa.gov/sites/default/files/documents/ma-medigap-compare-chart.pdf Search “comparing Medicare supplement” on [My SHIBA](#) to locate the current version of this document.

Comparing Medicare Supplement (Medigap) and Medicare Advantage plans

Medicare Supplement (Medigap) plans (Original Medicare)		Medicare Advantage (MA) plans aka Part C (HMO, PPO or Private Fee-for-Service)
How it works	Private insurance that fills the gaps in Original Medicare Parts A and B.	Private insurance that replaces Original Medicare Parts A and B.
Who's eligible	<ul style="list-style-type: none"> You must have Medicare Parts A and B; people under age 65 have very limited options for Medigaps. You may be required to take a health screen if you enroll outside your Open Enrollment Period (OEP)*. You may also have a waiting period of up to 90 days for any pre-existing condition to be covered after the plan starts. 	<ul style="list-style-type: none"> You must have Medicare Parts A and B, regardless of your age. There's no health screen and no wait period. MA plans will reject you if you have End Stage Renal Disease (ESRD). ESRD is kidney failure requiring dialysis or a kidney transplant. You must live in the plan's service area. Be aware, not every county has a plan.
What are the benefits?	<ul style="list-style-type: none"> Covers Medicare Parts A and B copays, coinsurance and deductibles ("gaps") in Original Medicare. Plans are standardized. Plans A-N cover the same as other insurer's plans with the same letter. 	<ul style="list-style-type: none"> Plans must cover all Medicare Parts A and B covered services. Plans are not standardized; coverage varies by plan based on insurer and plan type (Health Maintenance Organization or HMO, Preferred Provider Organization or PPO, and Private-Fee-for-Service or PFFS).
Are there extra benefits?	<ul style="list-style-type: none"> There are some additional benefits, such as foreign travel emergency coverage and excess charges. 	<ul style="list-style-type: none"> Some plans offer extra coverage, such as dental, vision, alternative medicine or health club memberships. Some extras require additional premiums.
Costs associated with the plan	<ul style="list-style-type: none"> Monthly premiums vary by plan. Plans (except K and L) have no annual out-of-pocket limits. You must pay Part B premiums unless enrolled in a Medicare Savings Program. Premiums often change once a year, but plans may change rates at different times of the year. 	<ul style="list-style-type: none"> Monthly premium varies by plan (some plans have \$0 premiums). Copays or coinsurance are set by the plan. Some plans have deductibles. Plans have yearly maximum out-of-pocket limit (MOOP). You must pay Part B premiums unless you're enrolled in a Medicare Savings Program. All costs may change every Jan. 1.

*Medigap Open Enrollment Period (OEP) = This period lasts for 6 months and starts on the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B.

Comparing Medicare Supplement (Medigap) and Medicare Advantage plans

Medicare Supplement (Medigap) plans (Original Medicare)		Medicare Advantage (MA) plans (HMO, PPO or Private Fee-for-Service)	
<p>Is the plan renewable?</p>	<ul style="list-style-type: none"> Plans are guaranteed renewable and benefits will not change as long as you pay the premiums and your application was correct. You may switch plans at any time. 	<ul style="list-style-type: none"> It is renewable, but costs and benefits may change yearly. You remain in the plan unless you disenroll or switch during an enrollment period, or the plan leaves the area. If you're enrolled in a plan and do nothing during the Open Enrollment Period (OEP), you will remain in your current plan. 	<ul style="list-style-type: none"> Providers bill the MA plan for most services, not Medicare. HMOs maintain provider network and only cover in-network providers; they must have available providers to accept new members; referrals may be required to see a specialist. PPOs maintain provider networks, but also cover out-of-network at a higher cost. PPOs may not need a referral to see a specialist; check with the plan. PFFS don't have a provider network; may be hard to find providers who accept this in some areas. Check with the provider's office for a list of MA plans they accept.
<p>Provider choice and availability</p>	<ul style="list-style-type: none"> Providers bill Medicare directly, and in most cases, the Medigap pays providers directly after Medicare pays its portion. You can see any provider in the U.S. who takes Medicare. Plans don't require referrals for specialty care. 	<ul style="list-style-type: none"> Often bundled with the plan's benefits and you can't usually buy a separate Part D plan. If you want coverage, you must enroll in the Part D coverage offered by your MA plan. Only PFFS plans with no prescription coverage allow you to buy a separate Part D plan. 	<ul style="list-style-type: none"> PFFS don't have a provider network; may be hard to find providers who accept this in some areas. Check with the provider's office for a list of MA plans they accept.
<p>Prescription drug coverage</p>	<ul style="list-style-type: none"> Prescription drugs are not included. For drug coverage, you may want to enroll in a Part D prescription drug plan. 	<ul style="list-style-type: none"> Often bundled with the plan's benefits and you can't usually buy a separate Part D plan. If you want coverage, you must enroll in the Part D coverage offered by your MA plan. Only PFFS plans with no prescription coverage allow you to buy a separate Part D plan. 	<ul style="list-style-type: none"> PFFS don't have a provider network; may be hard to find providers who accept this in some areas. Check with the provider's office for a list of MA plans they accept.
<p>Switching plans</p>	<ul style="list-style-type: none"> You can switch plans at any time. You must contact the plan to enroll; if you switch you must cancel the old plan. 	<ul style="list-style-type: none"> You can only change plans during an enrollment period. Enrolling in the new plan will disenroll you from your current MA or Part D stand-alone plan. 	<ul style="list-style-type: none"> PFFS don't have a provider network; may be hard to find providers who accept this in some areas. Check with the provider's office for a list of MA plans they accept.

Comparing Medicare Supplement (Medigap) and Medicare Advantage plans

Medicare Supplement (Medigap) plans (Original Medicare)		Medicare Advantage (MA) plans (HMO,PPO or Private Fee-for-Service)	
Which plan is the best fit	<ul style="list-style-type: none"> • Coverage is unlimited in the U.S. • Some plans cover all Medicare copays and deductibles. • People under age 65 have very limited options and they can be more expensive than for people age 65+. 	<ul style="list-style-type: none"> • Network plans may be good for people who can't find a provider who accepts Original Medicare. • Might save you money unless you need frequent appointments or treatments. • A pre-packaged plan may simplify your choices. • Can be eligible at any age, if you have Medicare A&B, live in the plan service area and don't have ESRD. 	<ul style="list-style-type: none"> • Plans are not standardized, and are approved by Medicare. • Refer to: <ul style="list-style-type: none"> ○ Medicare Plan Finder at www.medicare.gov ○ MA plan by county at www.insurance.wa.gov • When considering MA plans, you should conduct a drug cost comparison at www.medicare.gov. • Agents selling plans in Washington state are licensed by the Washington State OIC. CMS oversees MA plans' marketing activities. • Find a list of plans by county at: www.insurance.wa.gov or call 1-800-562-6900.
Comparison shop	<ul style="list-style-type: none"> • Because Medigaps are standardized, monthly premium and customer service are the only difference. • Refer to: <ul style="list-style-type: none"> ○ 10 Standardized Medigap plan chart at www.insurance.wa.gov • Plans are regulated by the Washington State Office of the Insurance Commissioner (OIC). • Find plans and rates at: www.insurance.wa.gov or call 1-800-562-6900. 		

Questions?

If you want individual help understanding all of your options, call our Insurance Consumer Hotline and ask to speak with a SHIBA counselor in your area:

1-800-562-6900

or
visit us online at:

www.insurance.wa.gov/shiba



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LOCAL HELP FOR PEOPLE WITH MEDICARE

SHP860-SHIBA-Medigap-MA-compare 08/16



Medicare Minute Script – November 2018

Original Medicare and Medicare Advantage providers

Depending on how clients get their Medicare coverage, they have different considerations when choosing health care providers. This handout will help clients learn about the factors they should consider to get the coverage they need at the lowest cost.

- See pages 83-84
- Also on [My SHIBA](#) under January 2019 training materials

Source:

www.smpresource.org/Handler.ashx?ItemResourceId=12410e4a-a22e-4267-8ccc-feb1826dd21c&ItemType=File

Notes

Medicare Minute Script – November 2018 Original Medicare and Medicare Advantage Providers

Depending on how you get your Medicare coverage, you have different considerations when choosing health care providers. Today we will learn about the factors you should consider to get the coverage you need at the lowest cost.

Point 1: Know the different kinds of Original Medicare Providers.

If you have Original Medicare and after you have met your deductible, your Part B costs can vary depending on the type of provider you see. There are three kinds of billing agreements that physicians, medical equipment suppliers, and other Part B providers can have with Medicare. They are called participating provider, non-participating provider, and opt-out agreements.

- **To pay the least for services, see a Participating Provider when possible.** Participating providers accept Medicare and always take assignment. Taking assignment means that the provider accepts Medicare's approved amount for health care services as full payment. The good news is, the vast majority of providers are participating providers. These providers are required to bill Medicare for care you receive. Medicare will process the bill and pay your provider directly for your care. If you see a participating provider, you are responsible for paying a 20% coinsurance for Medicare-covered services.
- **Non-participating providers** accept Medicare but do not agree to take assignment in all cases. They may do so only on a case-by-case basis. Non-participating providers can charge up to 15% more than Medicare's approved amount for the cost of services you receive. This is known as the limiting charge. This means you could be responsible for up to 35% of Medicare's approved amount for covered services instead of 20%.
- **Opt-out providers** do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. Medicare will not pay for care you receive from an opt-out provider except in emergencies. These providers can charge whatever they want for services, but they must follow certain rules to do so. An opt-out provider must give you a private contract describing their charges and confirming that you understand you are responsible for the full cost of your care and that Medicare will not reimburse you.

Point 2: Understand the kinds of providers in a Medicare Advantage Plan.

If you have a Medicare Advantage Plan, your plan must cover the same health care services and items as Original Medicare, but can do so with different costs and restrictions. Each type of Medicare Advantage Plan has different network rules. A network is a group of doctors, hospitals, and medical facilities that contract with a plan to provide services. There are various ways a plan may manage your access to specialists or out-of-network providers. For example, if you see a provider who is outside your plan's network, you may have to pay a higher copayment or coinsurance charge than you would for an in-network provider. You could also be responsible for paying the full cost of your visit out-of-pocket, depending on what type of Medicare Advantage Plan you have. Remember that your costs are typically lowest when you use in-network providers and facilities, regardless of your plan. It is important to note that not all Medicare Advantage Plans work the same way. Make sure you understand a plan's network and coverage rules before enrolling. If you have questions, contact your plan for more information.

SHIP National Technical Assistance Center: 877-839-2675, www.shiptacenter.org | info@shiptacenter.org

SMP National Resource Center 877-808-2468 | www.smpresource.org | info@smpresource.org

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Point 3: Get your prescription drugs from the right kind of pharmacy.

Medicare Part D is Medicare’s prescription drug benefit. Part D is offered through private companies either as a stand-alone plan for those enrolled in Original Medicare, or as a set of benefits included with your Medicare Advantage Plan. Part D plans generally have networks of pharmacies that they contract with to provide you with covered medications. Use a preferred, in-network pharmacy to fill your prescriptions. Many pharmacy networks include both preferred and non-preferred pharmacies. You typically pay less for your prescriptions at preferred pharmacies. If you need to find a preferred, in-network pharmacy, or if you have any issues accessing your covered medications at the pharmacy, contact your Part D plan.

Take action:

1. If you have Original Medicare, call 1-800-MEDICARE or visit www.Medicare.gov to find and compare providers who accept Medicare assignment.
2. If you have a Medicare Advantage Plan, contact your plan to find in-network providers and to learn about your plan’s rules and restrictions.
3. Contact your Part D plan to find preferred, in-network pharmacies where you can purchase plan-covered drugs.
4. Contact your State Health Insurance Assistance Program (SHIP) for help choosing Medicare coverage, finding providers, and appealing service denials. Contact your Senior Medicare Patrol (SMP) if you believe you have been the victim of Medicare fraud or attempted Medicare fraud. Examples include a provider who refuses to bill Medicare and won’t explain why, a provider who pressures you into signing a contract you don’t understand, or misleading plan marketing.

Local SHIP Contact Information	Local SMP Contact Information
<p>SHIP toll-free: SHIP email: SHIP website: To find a SHIP in another state: Call 877-839-2675 or visit www.shiptacenter.org.</p>	<p>SMP toll-free: SMP email: SMP website: To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org.</p>
<p><i>The production of this document was supported by Grant Numbers 90SATC0001 and 90MPCRC0001 from the Administration for Community Living (ACL). Its contents are solely the responsibility of the SHIP National Technical Assistance Center (SHIP TA Center) and Senior Medicare Patrol National Resource Center and do not necessarily represent the official views of ACL.</i></p>	

SHIP National Technical Assistance Center: 877-839-2675, www.shiptacenter.org | info@shiptacenter.org

SMP National Resource Center 877-808-2468 | www.smpresource.org | info@smpresource.org

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Counties without Medicare Advantage plans

Counties with no Medicare Advantage plans in 2019

No MA plans at all:

- Clallam
- Ferry
- Garfield
- Jefferson
- Klickitat
- Lincoln
- Pacific
- Pend Oreille
- Skamania

Only SNP Plans for people with Medicare/Medicaid:

- Benton
- Franklin
- Whitman

Limited access to only some zip codes in the county:

- Grays Harbor

Medicare Advantage plans – Why are there no plans in some Washington state counties?

While this may not be relevant to all volunteers, it's good to know that MA plans are not an option in every county. For those counties without MA plans, it's best to help clients to focus on what they can do. Not all Medicare beneficiaries have access to an MA plan. This IS NOT unique to Washington.

For 2019, at least one MA plan exists in 30 counties. There are nine counties with no MA plans and there are four others that have limited access to plans.

Insurance carriers bid to CMS to provide an MA plan in a specific state and county. Factors the carrier considers in making a business decision to bid:

1. **Reimbursement rate** – CMS sets the reimbursement rate to the MA plan based on its reimbursement level for that county.
2. **Health costs** – A high prevalence of cancer, cardiac conditions, occupational or environmental exposures, etc. contributes to more costs. The carrier's actuaries analyze the health data contributing to these health costs.
3. **Provider contracting and network requirements** – CMS increased its requirements for provider contracting and networks to lower costs. It's often very difficult for a plan to assemble such a network in a rural area, given the relatively low number of healthcare providers.
4. **Rural areas** - Counties around the country with no MA plans tend to be rural and isolated, with relatively few people on Medicare and relatively few health care providers. These conditions are generally sub-optimal for the private health insurance market.

- ❖ The Office of the Insurance Commissioner has no jurisdiction over these private plans, it's the federal government. Individuals living in counties with no MA plans are welcome to contact the plans they would like to see offer plans in the future.

Source:

www.kff.org/medicare/issue-brief/medicare-advantage-2018-data-spotlight-first-look/

Washington State Health Insurance Pool (WSHIP)

WSHIP is an independent, non-profit health plan created by the Washington State Legislature. It's the high risk health insurance pool for the state of WA. To be eligible for WSHIP you must meet specific requirements including:

General Eligibility Requirements (Basic Plan)

- You're a resident of Washington state;
- You're enrolled in Medicare Part A and Part B;
- You were rejected for coverage by a health carrier, offered substantially reduced coverage on a Medicare supplemental insurance policy, or you do not have comprehensive Medicare supplemental coverage available to you; and
- You don't have access to a reasonable choice of Medicare Advantage Plans (Part C).

Determining if you have reasonable choice of Medicare Advantage plans (Part C)

Under Washington state law, to qualify for coverage under WSHIP's Medicare-eligible Basic Plan you must live in a Washington state county where you do not have reasonable choice of comprehensive Medicare Advantage Plans (Part C).

Counties with a reasonable choice of MA plans in 2019:

- Clark
- Cowlitz
- King
- Pierce
- Snohomish
- Spokane
- Thurston

If you live in a county other than one of these, you may qualify for WSHIP if you meet all the other eligibility criteria.

Medicare due to End Stage Renal Disease (ESRD) is an automatic qualifier for WSHIP – even if the person lives in a county with reasonable access to an MA plan.

The 2019 rate for a person on Medicare under age 65 is \$430 per month and is \$342 for people age 65 or older.

See wship.org/medicare_eligibility.asp and www.wship.org/wship.asp for more details.

Options for clients in counties with no MA plans

- Focus on the Medicare Supplements that are available for Washingtonians statewide.
- Remind people under 65 that when they turn 65 they start a new Entitlement to Medicare known as “Medicare for the Aged.” They begin their six-month Medicare Open Enrollment Period described on page 71 of *Medicare and You 2019*. They can contact their selected plan and submit a completed application the month *before* turning 65 so that their Medigap will start as soon as the month they turn age 65.
- For people under age 65, let them know the availability of Medigap Plan F through the Washington HCA Premera Supplement (they generally must apply within six months of initial enrollment in Medicare Part B due to age or disability).
- Provide information about the Washington State High Risk Pool (WSHIP), which offers a Medicare Basic plan that supplements Medicare A and B if the person does not have adequate access to MA plans.
wship.org/medicare_eligibility.asp and
www.insurance.wa.gov/washington-state-health-insurance-pool-wship
- Other options include Original Medicare with:
 - No supplement
 - A Retiree or Employer plan
 - A Medicare Supplement (Medigap)
 - Medicaid or the Qualified Medicare Beneficiary Program (QMB) for people under 100% of the Federal Poverty Level (FPL). QMB can help Medicare beneficiaries of modest means pay all of Medicare A and B cost sharing amounts.

Health Home care coordination

A quick note on Health Homes: It's case management for people on Medicaid with high health needs and some who are also on Medicare. And it's jointly administered by the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA). Health Home care coordination is available in all Washington counties.

Health Home benefit – What it is and does

The Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) jointly administer the Health Home program.

Health Home is a benefit available to some people who have full-scope Medicaid (alias CN, CNP or SSI-related Medicaid), which provides the client with a social worker to help coordinate their care to increase their health and social goals, and reduce repeat visits to the hospital's emergency room.

If a beneficiary with the Health Home benefit enrolls in a Part C Medicare Advantage plan, the beneficiary will be dropped from the Health Home benefit.

Health Home is for people with multiple chronic conditions, a history of high emergency room visits, and other factors, as measured in a PRISM score of 1.5 or higher (1.0 representing the usage of the average SSI recipient).

About 7 percent of people on Medicaid in Washington state may be eligible for the Washington Health Home program. People who are not yet on Medicare typically get their "Apple Health" benefit through a managed

care plan, which may also offer the Health Home benefit. People who have both Medicare and Medicaid (dual eligible) may also have this benefit. Once HCA enrolls a client in the Health Home program, the client is assigned to a Care Coordinator who makes a person-centered, face-to-face home visit to the client.

During this first visit, the Care Coordinator creates a Health Action Plan (HAP) to address the client's objectives around their health, hopes and goals. The Care Coordinator is available for consultation and care coordination, as needed, conducting future visits at least once a month.

Health Home clients with Medicare and Medicaid coverage must have Original Medicare for their Part A and Part B benefits. If they enroll in Part C, also known as a Medicare Advantage plan, HCA will automatically disenroll them from Health Home program. This is because they will have duplicative care coordination benefits through their Medicare Advantage plan. If they want to re-enroll in the Health Home program, they can enroll (quarterly) in a Part D plan, which will disenroll them from their Medicare Advantage plan and they would then have Original Medicare plus Part D coverage. They then would still need to meet the usual Health Home eligibility requirements.

Additional information: www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes

Advanced study resources

These resources are supplemental to this month's topic and provide more in-depth content and information.

Note for the following references: Traditional Medicare is the same as Original Medicare.

10 must-ask questions for clients when comparing Medicare Advantage plans

- Questions to ask the providers
- Questions to ask MA plans before enrolling
- Questions to ask prescription drug plans before enrolling

www.mymedicarematters.org/2018/10/medicare-advantage-comparison-tool/?utm_source=newsletter&utm_medium=email&utm_campaign=10232018 NCOAWeek

10 questions to ask before deciding between Traditional Medicare and a Medicare Advantage Plan

www.medicareadvocacy.org/10-questions-to-ask-before-deciding-between-traditional-medicare-and-a-medicare-advantage-plan/

Choosing between traditional Medicare and Medicare Advantage

www.medicareadvocacy.org/choosing-between-traditional-medicare-and-a-medicare-advantage-plan/

2018 SHIP-designated phone numbers

www.insurance.wa.gov/sites/default/files/documents/ship-designated-phone-numbers.pdf

Medicare Advantage plan enrollment timelines

www.insurance.wa.gov/sites/default/files/documents/ma-plan-enrollment-timeline_0.pdf

Medicare Advantage plan network comparison chart

www.medicareinteractive.org/get-answers/medicare-health-coverage-options/medicare-advantage-plan-overview/medicare-advantage-plan-network-comparison-chart

Medicare Advantage plan overview

www.medicareinteractive.org/get-answers/medicare-health-coverage-options/medicare-advantage-plan-overview

Medicare Advantage plans - What you need to know before you buy

www.insurance.wa.gov/sites/default/files/documents/medicare-advantage-plans-before-buy_0.pdf

Medicare health coverage options

www.medicareinteractive.org/get-answers/medicare-health-coverage-options?utm_source=Medicare+Rights+Center&utm_campaign=600108fd1d-Medicare+Watch+2018+10+11+COPY+01&utm_medium=email&utm_term=0_1c591fe07f-600108fd1d-85073689&mc_cid=600108fd1d&mc_eid=218480aa0c

Medicare Outpatient Observation Notice (MOON)

www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html

January 2019 Medigap chart

www.insurance.wa.gov/shiba-publications

What would work better for you? Deciding between Traditional Medicare and a Medicare Advantage plan

www.medicareadvocacy.org/what-would-work-better-for-you-deciding-between-traditional-medicare-and-a-medicare-advantage-plan/

Reminders and future training

Training Evaluation

Please fill out the training evaluation. We value your feedback!

2019 training

February	Medicaid & Medicare working together
March	Hospitalization and Part A, binder content updates
April	Volunteer recognition, what it's like and what it means to you to be a volunteer
May	What are the benefits of Part B?
June	TBD
July	TBD
August	No training
September	TBD, preparing for open enrollment
October	TBD
November	TBD, year-end review
December	No training

Content ideas

If you have ideas, include them on your evaluation form and return it to your RTC.

Signature sheets

Be sure and turn in the signature sheet for your Volunteer Handbook if you have not yet done so.

Notes

Continuing education evaluation

Date of Training: _____ Training Location: _____

How can SHIBA improve the monthly trainings?

What additional trainings within our SHIBA scope would you like to see?

What SHIBA training materials — including Quick Reference Cards (QRCs) — would you like to see added to My SHIBA?

Other: _____

Optional: If you would like to be contacted, please provide your name and contact information. Someone in our office will contact you. Thank you!

Name: _____

Day Phone: _____ Email: _____

If you prefer to give electronic feedback about curriculum or training, please contact: Diana Schlesselman: dianas@oic.wa.gov or Liz Mercer: lizm@oic.wa.gov.

Thank you!

