National Medicare
TRAINING PROGRAM

Module 11

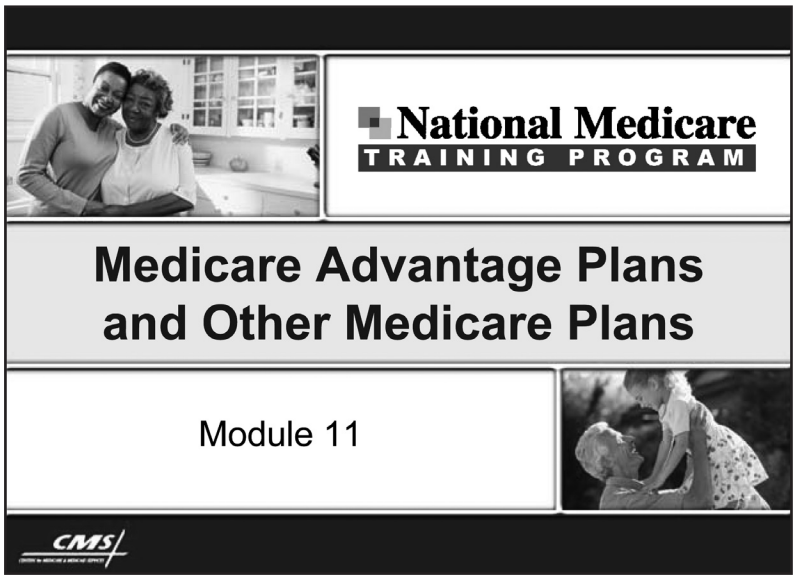
Medicare Advantage Plans and Other Medicare Plans

Training Workbook

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Revised: April 2008

Module 11: Medicare Advantage Plans and Other Medicare Plans

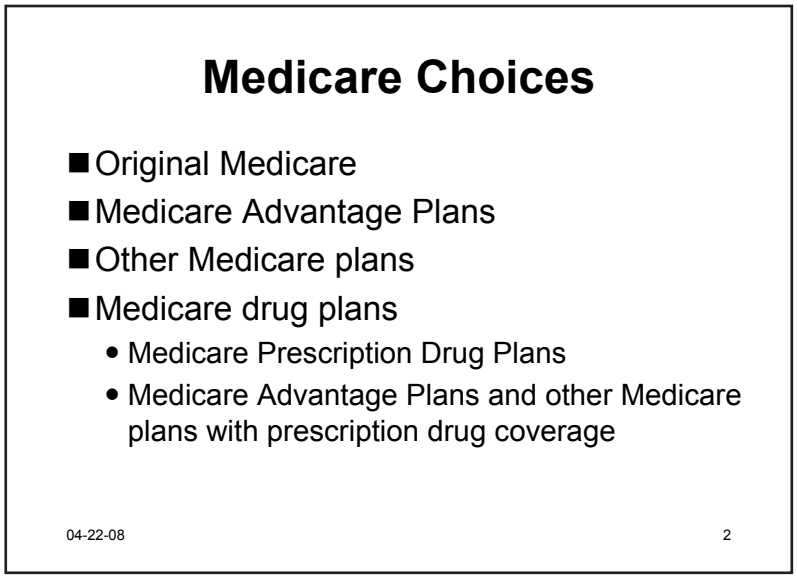


This module, Medicare Advantage and Other Medicare Plans, is designed for Medicare partners, trainers, and other information intermediaries.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare and Medicaid. This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings. The information in this module was correct as of April 2008. To check for an updated version of this training module, visit ***www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp*** on the web.

My Health.
My Medicare.

Module 11: Medicare Advantage Plans and Other Medicare Plans



People with Medicare may be able to get health care coverage in several ways. Original Medicare, available nationwide, is a fee-for-service plan managed by the Federal government. In Original Medicare, people with Medicare Part A (hospital coverage) and Part B (medical coverage) can get all medically-necessary Medicare-covered services and preventive services.

In addition, there are other ways besides Original Medicare that people can get their Medicare health coverage.

Congress created Medicare Advantage to let more private insurance companies offer coverage to people with Medicare, giving them more choices in how to get their Medicare benefits. Medicare Advantage Plans (sometimes called Part C) and other Medicare plans are health plan options that are part of the Medicare program. If people join one of these plans, they generally get all their Medicare-covered health care through that plan. Not all types of Medicare Advantage and other Medicare plans are available in all areas.

People can also choose to get Medicare prescription drug coverage (sometimes called Part D) in one of two ways:

- Join a stand-alone Medicare Prescription Drug Plan (PDP). People can enroll in a stand-alone PDP to add drug coverage to Original Medicare, Medicare Cost Plans, Medicare Medical Savings Account Plans, and Private Fee-for-Service Plans that do not offer Part D drug coverage.
- Join a Medicare Advantage Plan (like an HMO or PPO) or other Medicare plan that includes prescription drug coverage as part of the plan.

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My Health. My Medicare.

Module 11: Medicare Advantage Plans and Other Medicare Plans

In this training session, we'll be talking about Medicare Advantage Plans and other Medicare plans. When we use the term "Medicare Advantage Plans," we mean those with and without prescription drug coverage. Unless we state otherwise, we also intend the term to include other Medicare plans. (We will not be covering Original Medicare or stand-alone Medicare Prescription Drug Plans.)

Let's look at the topics we'll cover.

We'll explain what Medicare Advantage Plans are. We'll cover who is eligible to join a plan, and the times they can join or switch plans. Next we'll describe how Medicare Advantage Plans work and the differences between types of plans. We'll end with a discussion of rights and protections in an MA plan and a review of the marketing guidelines plans follow.

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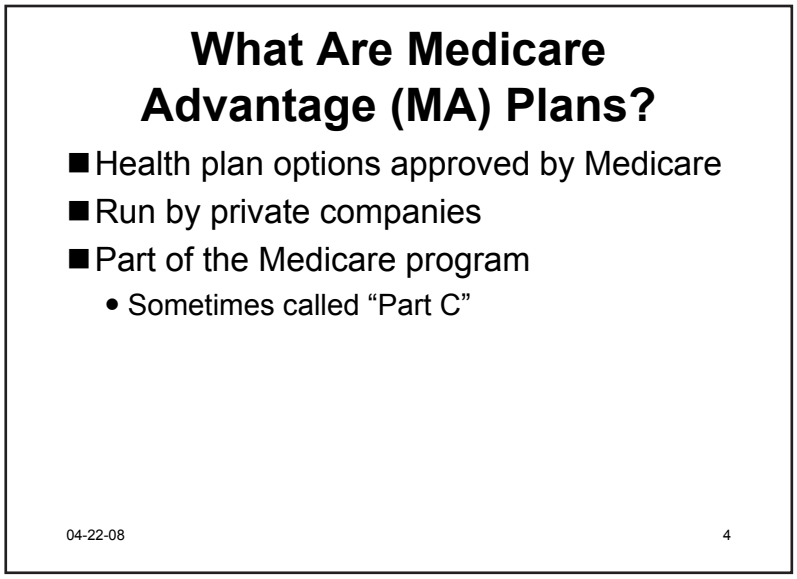
Module 11: Medicare Advantage Plans and Other Medicare Plans



Medicare Advantage (MA) Plans are health plan options that are approved by Medicare and run by private companies. They are part of the Medicare program and are sometimes called "Part C."

Medicare Advantage Plans are offered in many areas of the country by private companies that sign a contract with Medicare. Medicare pays a set amount of money to these private health plans for their members' health care. **People must have both Medicare Part A and Part B to join a Medicare Advantage Plan**.

Medicare Advantage Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Medicare doesn't cover, such as vision or dental services. Members may have to pay an additional monthly premium for the extra benefits. The plan may have special rules that its members need to follow.

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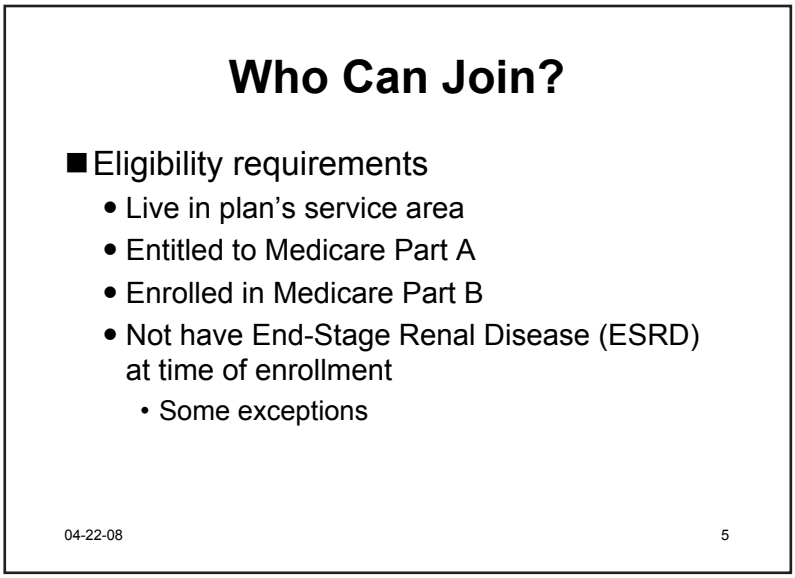

Medicare Advantage Plans are available to most people with Medicare. To be eligible to join a Medicare Advantage Plan, a person must:

- Live in the plan's geographic service area or continuation area
- Be entitled to Medicare Part A and enrolled in Medicare Part B

People with End-Stage Renal Disease (ESRD) usually can't join a Medicare Advantage Plan or other Medicare plan. However, there are some exceptions. (For example, an individual who develops ESRD while enrolled in an MA plan may continue to be enrolled in the MA plan, and some Medicare Advantage Special Needs Plans accept people with ESRD.) A person who receives a kidney transplant and who no longer requires a regular course of dialysis is not considered to have ESRD for purposes of MA eligibility.

To join an MA plan, a person must also:

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

To find out what Medicare Advantage Plans are available in a certain area, visit ***www.medicare.gov*** and choose the link Compare Health Plans and Medigap Policies in Your Area, or call 1-800-MEDICARE (1-800-633-4227). More information on the enrollment exceptions for people with ESRD can be found in Section 20.2 of the Medicare Advantage enrollment and disenrollment guidance available at: ***http://www.cms.hhs.gov/MedicareMangCareEligEnrol/Downloads/MAEnrollmentGuidanceUpdate.pdf***

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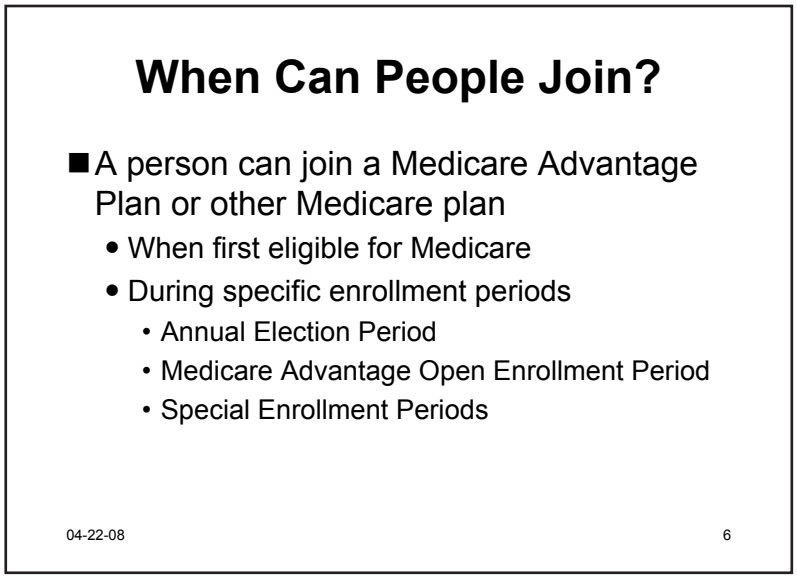

People can join a Medicare Advantage Plan when they first become eligible for Medicare (i.e., during their Initial Coverage Election Period, which begins 3 months immediately before the individual's first entitlement to **both** Medicare Part A and Part B), the Medicare fall open enrollment period (also known as the "Annual Election Period"), the Medicare Advantage Open Enrollment Period, or in certain special situations that provide a Special Enrollment Period.

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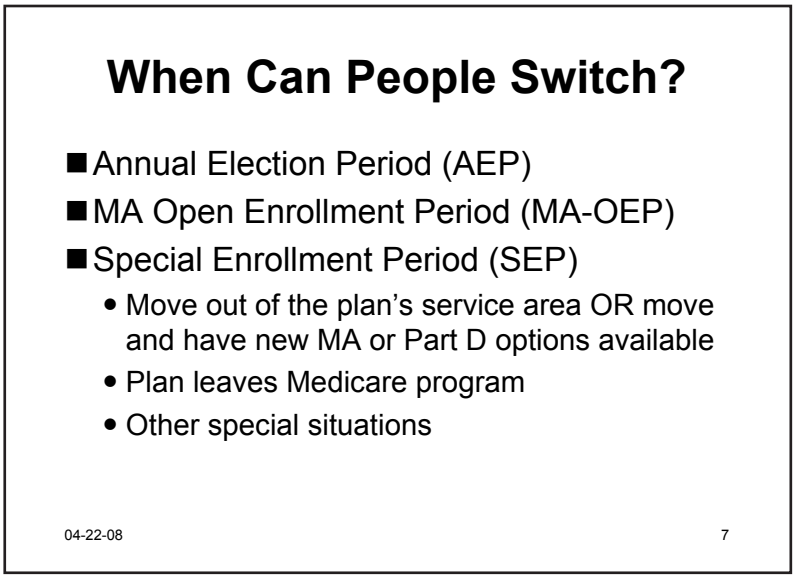

Generally, enrollment in a plan is for a year. People can only join one plan at a time.

A person can make changes:

- During the Medicare fall open enrollment period, also referred to as the "Annual Election Period" (AEP)
- During the Medicare Advantage Open Enrollment Period (OEP)
- Under special circumstances, a Special Enrollment Period (SEP). For example, if a person moves out of the service area or moves and new MA or Part D options are now available to them, if a person qualifies for extra help to pay for Medicare prescription drug coverage, or if the plan decides to leave the Medicare program or reduce its service area at the end of the year, there are special rules that allow for enrollment in a different Medicare Advantage Plan, or Original Medicare and a Medigap policy.

The changes the individual can make depend on the enrollment period. For example, the Annual Enrollment Period (AEP) allows individuals to join or leave a Medicare Advantage Plan, switch to Original Medicare, or join or leave a Medicare prescription drug plan. However, during the Medicare Advantage open enrollment period (OEP), the individual can join or change Medicare Advantage plans but cannot add or drop Medicare prescription drug coverage. We'll discuss that in more detail in a couple of slides.

Let's look at an example of a Special Enrollment Period available for people who have joined a Medicare Advantage plan for the first time in more detail.

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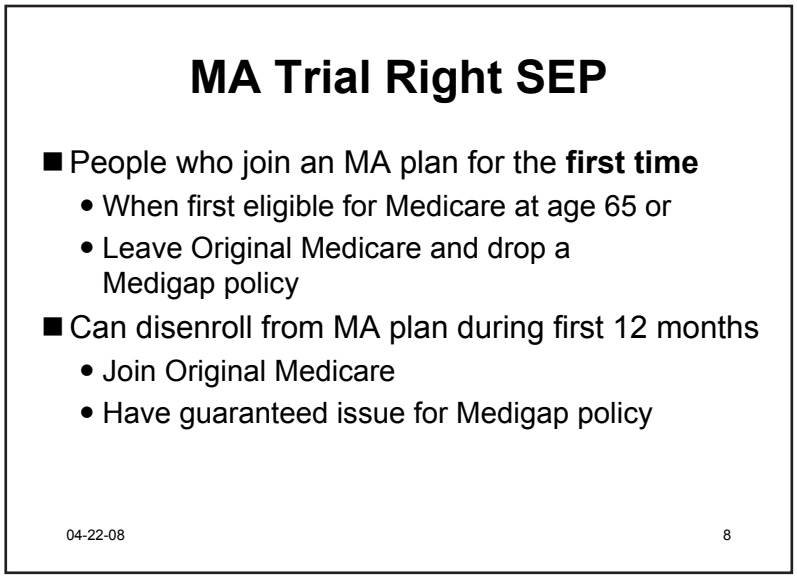

There are special trial rights available for people who have joined a Medicare Advantage plan for the first time. They can drop their MA plan and enroll in Original Medicare anytime within the first 12 months of their Medicare Advantage plan coverage. People are eligible for this trial right if they either

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

The trial right allows them to disenroll from the MA plan during the first 12 months to join Original Medicare. They also have a guaranteed issue opportunity to purchase a Medigap (Medicare supplement) policy.

This is one example of an SEP. Now let's take a look at the Medicare fall open enrollment period (also called the Annual Election Period), and the Medicare Advantage Open Enrollment Period in more detail on the next few slides.

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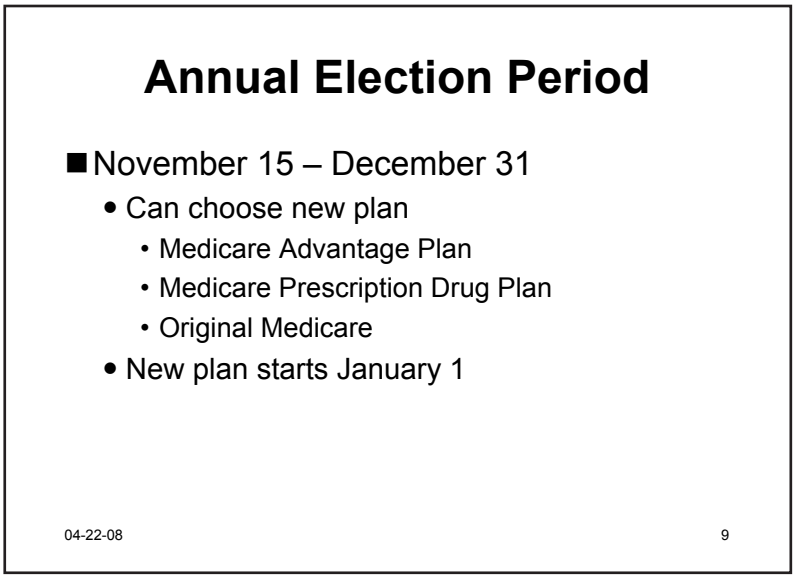
Module 11: Medicare Advantage Plans and Other Medicare Plans



First, let's talk about the Annual Election Period, which is now often referred to in Medicare publications as the Medicare fall open enrollment period. This occurs every year from November 15 – December 31. People can make changes in their plan enrollment, including choosing which Medicare Advantage Plan or Medicare Prescription Drug Plan they want to join for the upcoming year. They can also choose to return to Original Medicare. Their new plan will start the following January 1.

This is the key time for individuals to review their health care and drug coverage and make changes for the follow year, if they choose.

Unless they have a capacity limit waiver, Medicare Advantage Plans must accept eligible new members between November 15 and December 31 of each year. A capacity limit waiver means that the plan has been authorized to close enrollment because it has already reached a certain number of enrollees.

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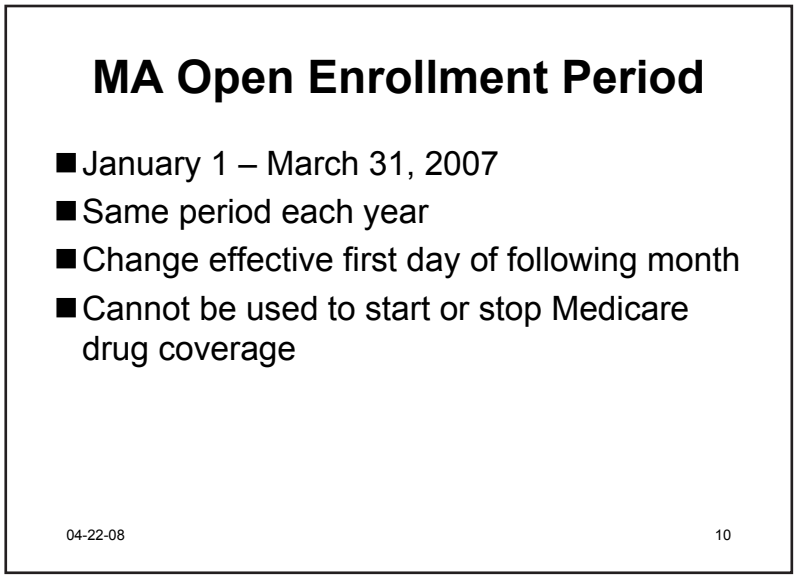

In addition to the Annual Election Period each year, people have the opportunity to change how they get their Medicare benefits during the Medicare Advantage Open Enrollment Period (OEP) each year. During the OEP they can join a new plan, switch plans, or return to Original Medicare. This occurs from January 1 through March 31 every year.

Changes made during this period will be effective the first day of the month after the plan gets the person's enrollment form.

The Medicare Advantage Open Enrollment Period can be used to switch to a different type of Medicare plan, but it **cannot be used to change whether or not a person is enrolled in Medicare prescription drug coverage**.

The OEP cannot be used to enroll or disenroll in a Medicare Medical Savings Account. Other Medicare plans, such as Cost plans, may follow different rules.

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MA Open Enrollment Period Limits

If coverage is	Can use OEP to get	Cannot use OEP to get
Medicare Advantage with prescription drug coverage (MA-PD)	A different MA-PD **or** Original Medicare + PDP **or** MA-PFFS + PDP	MA-only **or** Original Medicare only (cannot drop drug coverage)
Medicare Advantage with no prescription drug coverage (MA-only)	A different MA-only **or** Original Medicare only	MA-PD **or** Original Medicare + PDP (cannot add drug coverage)
MA-only PFFS + PDP	MA-PD **or** different MA-only PFFS and same PDP **or** Original Medicare and same PDP	MA-only **or** Original Medicare only (cannot drop drug coverage)
Original Medicare and a prescription drug plan (PDP)	MA-PD **or** MA-PFFS and the same PDP	MA-only **or** A different PDP to use with Original Medicare (cannot drop drug coverage)
Original Medicare only	MA-only	MAPD **or** Original Medicare + PDP (cannot add drug coverage)
MSA	N/A	The MA OEP does not apply to enroll into or disenrollment from an MSA plan

This chart shows the various options during the Medicare Advantage (MA) Open Enrollment Period, depending on the type of coverage the person is starting with. For example, a person who has a Medicare Advantage Plan with prescription drug coverage (MA-PD) can use the OEP to get a different MA-PD, to switch to Original Medicare and a PDP, or to enroll in a Medicare Advantage Private-Fee-for-Service Plan without drug coverage and in a separate PDP. This person could not use the OEP to enroll in a MA-only plan or to switch to Original Medicare without enrolling as well in a stand-alone PDP. Remember, the Medicare Advantage Open Enrollment Period can be used to switch to a different plan or type of plan, but it **cannot be used to change whether or not a person is enrolled in Medicare prescription drug coverage.**

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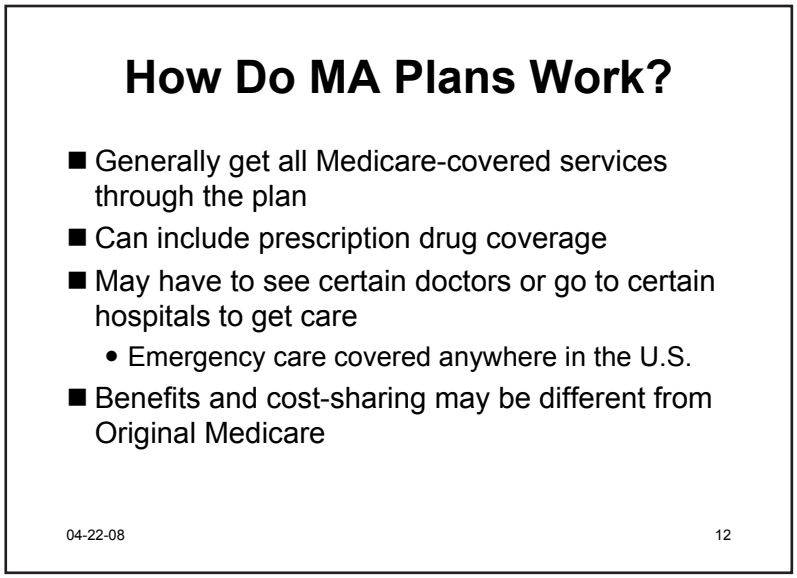

Let's talk more about how Medicare Advantage Plans work.

In most Medicare Advantage Plans, members generally get all their Medicare-covered health care through that plan. Some plans also include Medicare prescription drug coverage. Medicare pays a set amount of money for a person's care every month to these private health plans, whether or not the member uses services.

In some plans, like Medicare Health Maintenance Organizations (HMOs), people may only be able to see certain doctors or go to certain hospitals. However, members have the right to get emergency care anywhere in the United States when they need it, without any prior approval from the plan.

Benefits and cost-sharing in a Medicare Advantage Plan may be different from those in Original Medicare. Since each plan can vary, it's important that people review plan materials carefully for details about copayment and coverage information.

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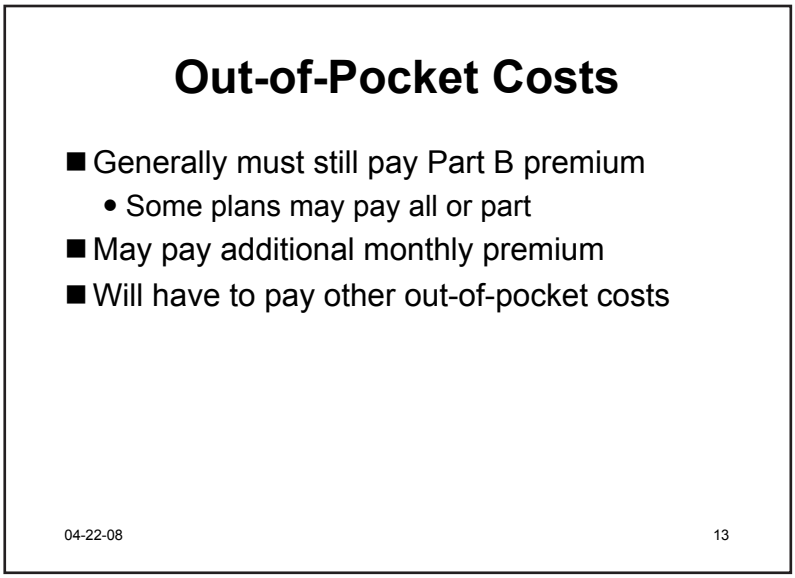
NOTE TO INSTRUCTOR: In Provider Networks this is referred to as "Actuarially Equivalent"



People who join a Medicare Advantage Plan or other Medicare plan need to know:

- They must continue to pay the monthly Medicare Part B premium ($96.40 for most people in 2008). However, some Medicare Advantage Plans may offer an additional benefit by reducing the amount members pay for their Medicare Part B premiums. The Federal government pays plans a set amount each month to cover services the plan members receive. The Part B premium amount a person with Medicare pays is included in that monthly payment amount.
- They may pay an additional monthly premium to the plan.
- They will have to pay other costs (such as copayments or coinsurance) for services they get.

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It's important to note that people who join a Medicare Advantage Plan or other Medicare plan:

- Are still in the Medicare program
- Still have Medicare rights and protections
- Through the plan, they still get all their regular Medicare-covered services that are offered under Part A and Part B
- May get additional benefits offered through the plan, including Medicare prescription drug coverage. Other extra benefits could include coverage for vision, hearing, or dental care and/or health and wellness programs. Extent or duration of coverage may vary.

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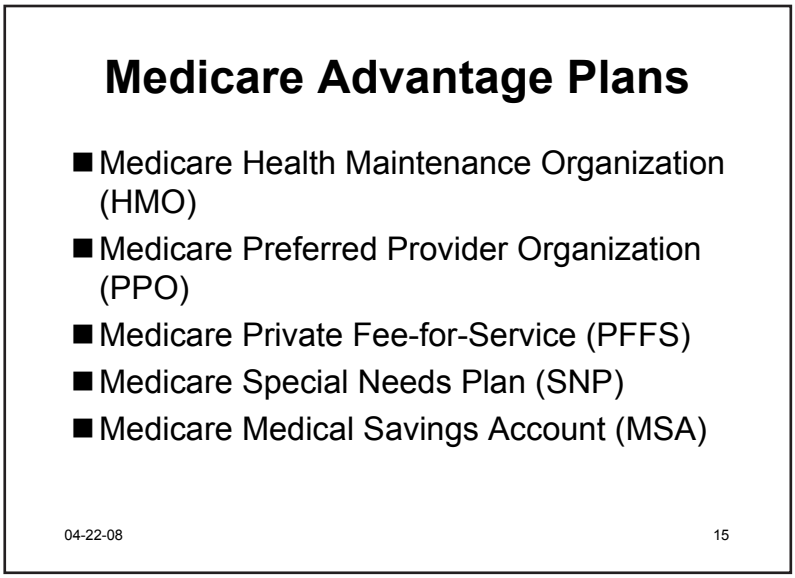

There are currently five main types of Medicare Advantage Plans:

- **Medicare Health Maintenance Organizations (HMO) Plans**—managed care plans that cover all Part A and B services and may provide extra services. You can generally only go to doctors, specialists, or hospitals that are part of the plan's network, except in an emergency.
- **Local Medicare Preferred Provider Organization (PPO) Plans**—similar to an HMO plan but members can see any doctor or provider that accepts Medicare and don't need a referral to see a specialist. Going to a provider who isn't part of the plan's network will usually cost more. A Medicare Regional Preferred Provider Organization (RPPO) is structured like a local PPO and has a contracted network but serves an entire region or regions.
- **Medicare Special Needs Plans (SNP)**—membership limited to certain groups of people, such as those in some institutions (like a nursing home), eligible for both Medicare and Medicaid, or with certain chronic or disabling conditions.
- **Medicare Private Fee-for-Service (PFFS) Plans**—members can go to any provider that accepts the plan's terms and conditions of payment, and may get extra benefits. The private company decides how much it will pay and how much members pay for services.
- **Medicare Medical Savings Account (MSA) Plans**—new plans that began being offered January 1, 2007.

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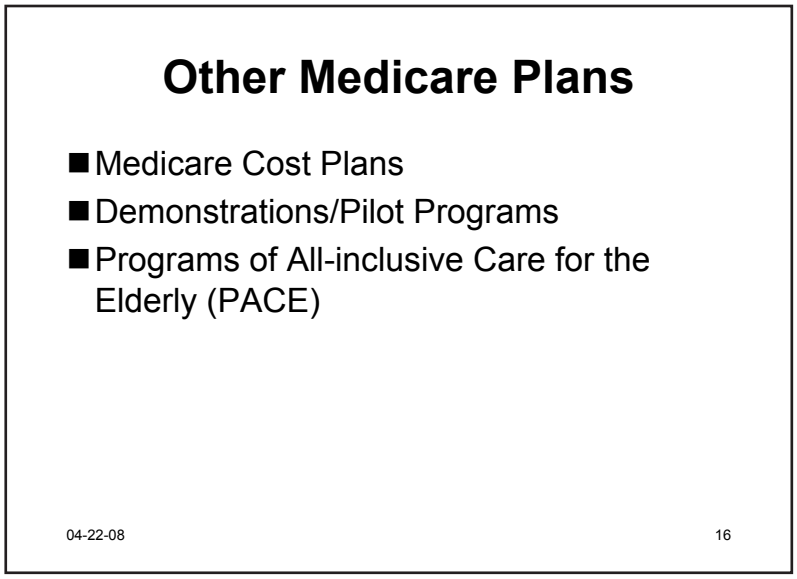

There are three other types of Medicare plans:

- **Medicare Cost Plans**—similar to an HMO, but services received outside the plan are covered under Original Medicare
- **Demonstrations and pilot programs**—special projects that test possible future improvements in Medicare coverage, costs, and quality of care
- **PACE (Programs of All-inclusive Care for the Elderly)**—combine medical, social, and long-term care services for frail elderly people

Note to speaker: The next several slides provide a brief overview of each of the types of Medicare Advantage and other Medicare plans. You are encouraged to insert slides and information specific to the plans available in your area.

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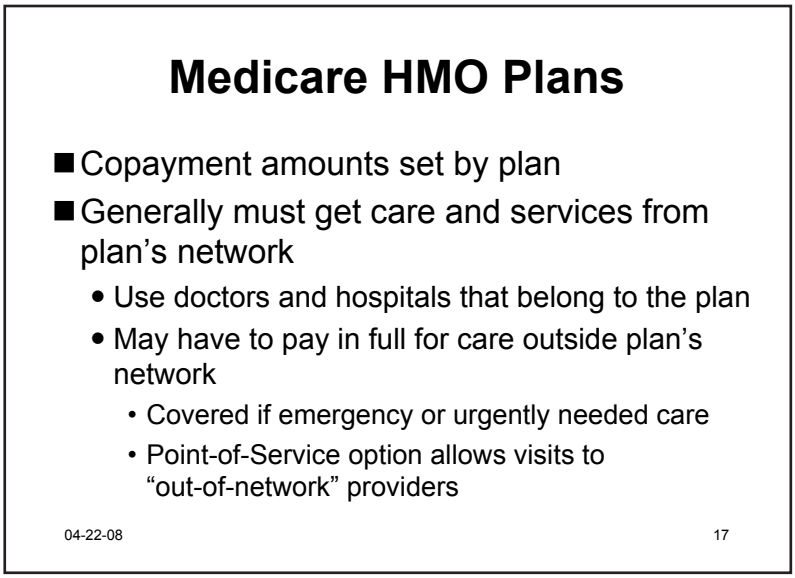

These are the general rules for how Medicare HMOs work. For some of these rules, plans may differ slightly, so it's important to read the plan materials carefully.

In Medicare HMOs, the copayment or coinsurance amounts a member pays for services received are set by the plan. There are doctors and hospitals that contract with the plan (called the plan's "network"). People generally must get their care and services from the plan's network. Call or get a list from the plan to see which doctors and hospitals are in the plan's network.

People who get health care outside of the plan's network may have to pay for these services themselves. In most cases, neither the Medicare HMO nor Original Medicare will pay for these services. The service area is where the plan accepts members and where plan services are provided. Members are covered if they need emergency or urgently needed care and aren't in their HMO's service area.

Some Medicare HMOs offer a Point-of-Service option. This allows people to go to other doctors and hospitals who aren't a part of the plan ("out-of-network"), but they may pay more.

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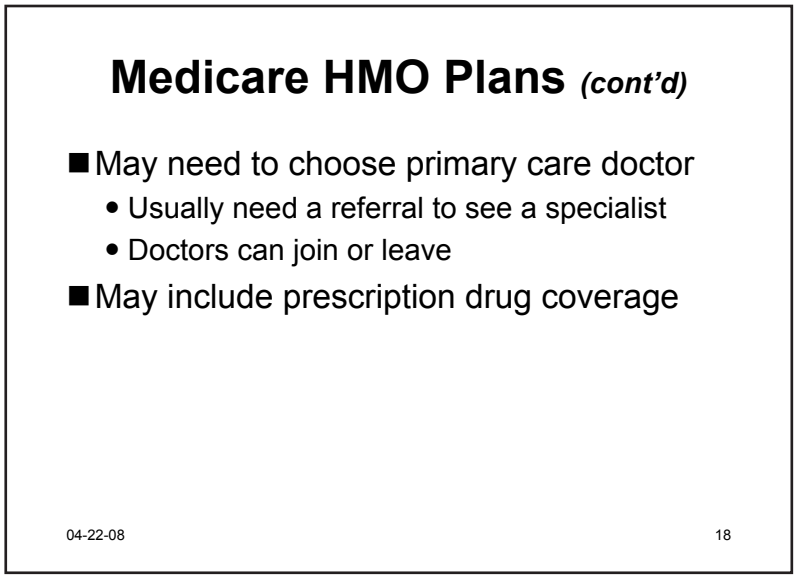

People who join a Medicare HMO Plan may be asked to choose a primary care doctor. The primary care doctor is the doctor they see first for most health problems. In many HMOs, members must see their primary care doctor before they can see any other health care provider. They usually need a referral to see a specialist (such as a cardiologist). A referral is a written OK from the primary care doctor for the member to see a specialist or get certain services.

People who are considering joining a Medicare HMO and want to keep seeing their current doctor should call and ask if he or she is in the Medicare HMO's network and can continue to see them if they join the plan. People who are in a Medicare HMO and want to change their primary care doctor can ask their plan for the names of other plan doctors in their area. Doctors can join or leave Medicare HMOs. When a primary care doctor leaves a Medicare HMO plan, the plan will notify his or her patients, **generally 30 days in advance when possible**, and provide an opportunity to pick a new doctor.

There are special rules for certain services. Women can go once a year without a referral for a screening mammogram. They can go every other year to a specialist in the network for Medicare-covered routine and preventive women's care services.

If the type of specialist a person needs isn't available, the plan will arrange for care outside the network.

If a Medicare HMO includes prescription drug coverage, members will pay a copayment or coinsurance for each covered prescription. In most situations, if a person is in a Medicare Advantage plan, he or she may not join a separate Medicare Prescription Drug Plan to get Medicare drug coverage.

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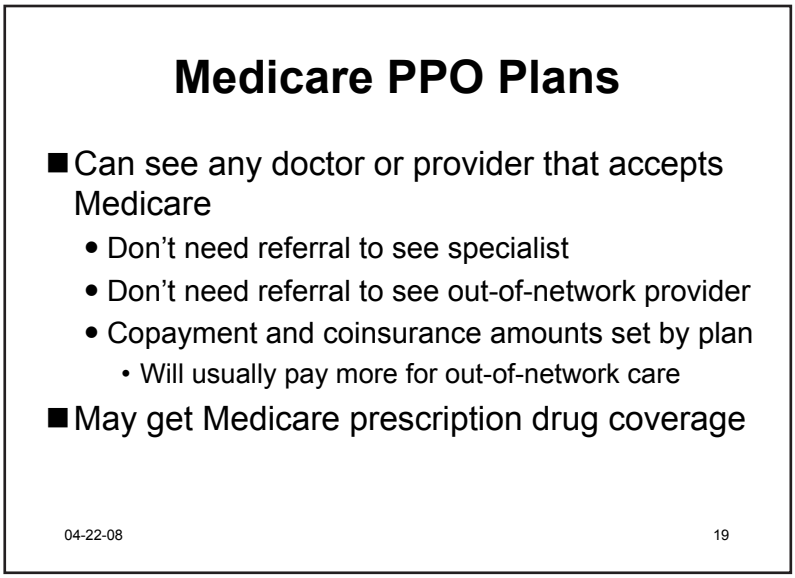

Medicare PPOs use many of the same rules as Medicare HMOs discussed on the previous slides. However, people in a PPO generally can see any doctor or provider that accepts Medicare. They don't need a referral to see a specialist. If they go to doctors, hospitals, or other providers that aren't part of the plan ("out-of-network" or "non-preferred"), they don't need a referral, but they will usually pay more. Every Medicare PPO Plan must pay for all covered services received out-ofnetwork, but every plan is different in what their members must pay.

PPO members may also be able to get their Medicare prescription drug coverage from the PPO plan.

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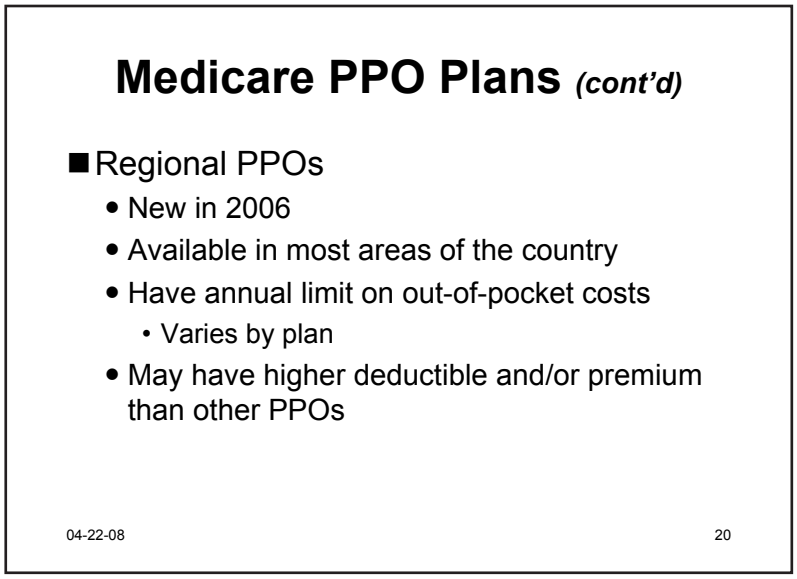

Starting in 2006, **regional** PPOs became available in most areas of the country. Unlike local PPOs, which serve individual counties, regional PPOs serve an entire region, which may be a single state or multi-state area. This helps bring more plan options to people with Medicare. In a regional PPO, members will have an added protection for Medicare Part A and Part B benefits because regional PPOs limit members' annual out-of-pocket costs. The annual out-of-pocket limit varies by plan. Regional PPOs may have a higher yearly deductible and/or premium than other PPOs.

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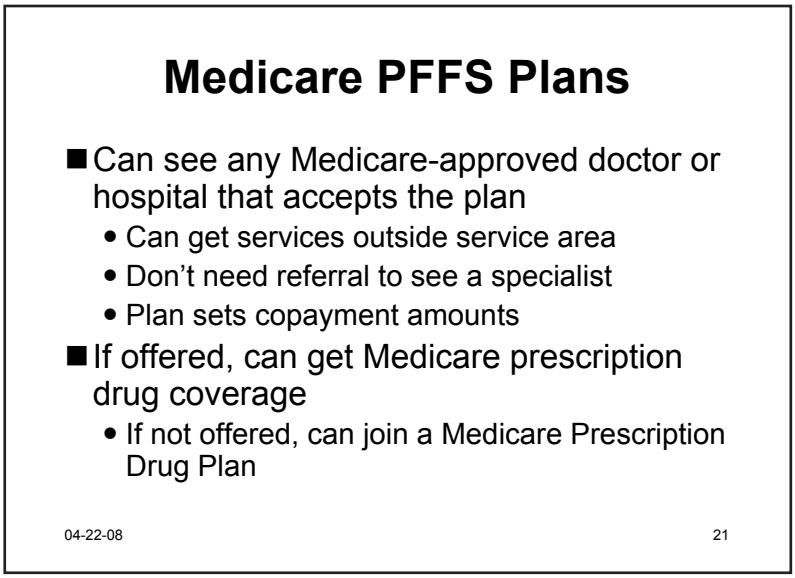

A Private Fee-for-Service plan is a Medicare Advantage Plan offered by a private insurance company under contract to the Medicare program. Some companies may offer more than one plan in an area, with different benefits and costs. PFFS plans may not be available in all areas. The general rules for how Medicare Private Fee-for-Service Plans work are below.

- Members can choose which provider they will see, do not need a referral to see a specialist, and can get services outside their service area. However, while they can go to any Medicare-approved doctor or hospital, that provider must accept the terms and conditions of their-plan's payment.
- Members may get extra benefits not covered under Original Medicare, such as extra days in the hospital.
- The private company, rather than the Medicare program, decides what members pay for the services they get.
- They can get Medicare prescription drug coverage from the Medicare Private Fee-for-Service Plan if it's offered, or they can join a stand-alone Medicare Prescription Drug Plan to add prescription drug coverage if drug coverage isn't offered by the plan.

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Medicare Special Needs Plans are Medicare Advantage plans designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions. For example, a Medicare Special Needs Plan for people with diabetes might have additional providers with experience caring for conditions related to diabetes, have focused special education or counseling, and/or nutrition and exercise programs designed to help control the condition. A Medicare Special Needs Plan for people with both Medicare and Medicaid might help members access community resources and coordinate many of their Medicare and Medicaid services.

Medicare Special Needs Plans must include Medicare prescription drug coverage.

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Special Needs Plans *(cont'd)*

- Three types of SNPs
  - May limit all or most of membership to people
    - With certain chronic or disabling conditions
    - Eligible for Medicare and Medicaid
    - In certain institutions
- Available in some areas
  - Visit www.medicare.gov
    - Select "Search Tools" at top of the page
  - Call 1-800-Medicare

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There are three types of Medicare Special Needs Plans. Medicare SNPs limit all or most of their membership to people with certain chronic or disabling conditions, those eligible for both Medicare and Medicaid, and people in certain institutions (like a nursing home). Medicare Special Needs Plans are only available in some areas. To find out if any Medicare Special Needs Plans are available in your area

- Visit ***www.medicare.gov*** on the web. Select "Search Tools" at the top of the page, or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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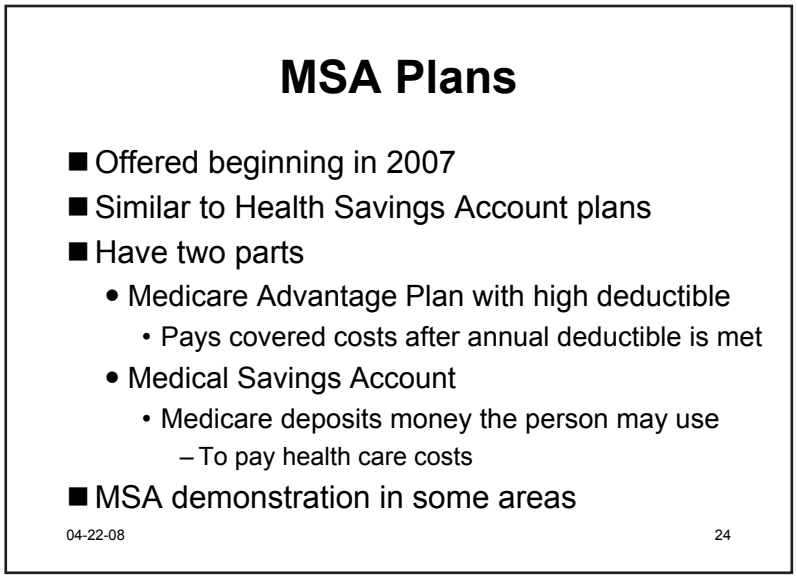
Module 11: Medicare Advantage Plans and Other Medicare Plans



Medicare Medical Savings Account (MSA) Plans became available in 2007. These Medicare plans are similar to Health Savings Account plans available outside of Medicare, and they have two parts. The first part is a Medicare Advantage Plan with a high deductible. This health plan won't begin to pay covered costs until the person has met the annual deductible, which varies by plan. The second part is a Medical Savings Account into which Medicare deposits money that the person with Medicare may use to pay health care costs.

There is a MSA demonstration program available in some areas that allows preventive services before the deductible is met, and has cost-sharing after the deductible is met, up to a separate out-of-pocket limit.

For more information on MSA Plans, visit ***www.medicare.gov/Publications/Pubs/pdf/11206.pdf*** or call 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048) and ask for a copy of *Your Guide to Medicare Medical Savings Account Plans*, CMS Pub #11206. To learn which Medicare MSA Plans are available in a specific area of the country, use the Medicare Options Compare tool on the ***www.medicare.gov*** website.

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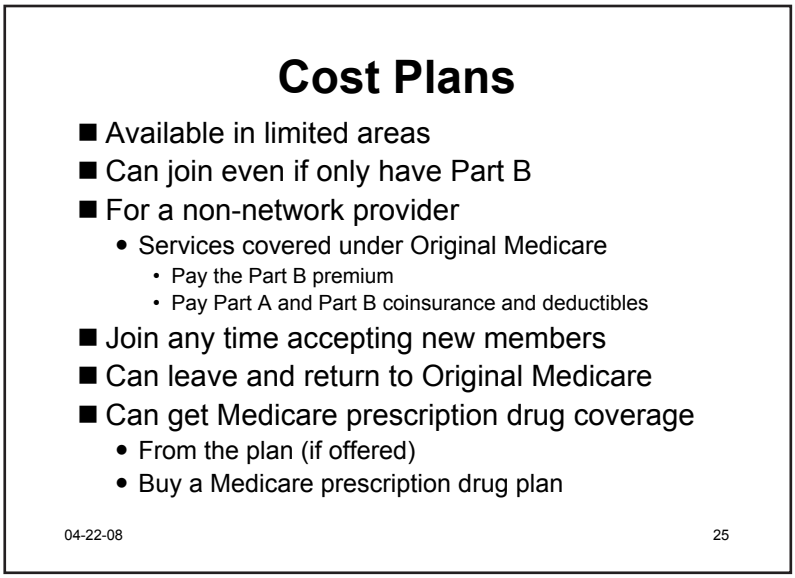

Medicare Cost Plans are a type of Medicare health plan available only in certain areas of the country.

Medicare Cost Plans work like this:

You can join even if you only have Part B. If you go to a non-network provider, the services are covered under Original Medicare. You would pay the Part B premium, and the Part A and Part B coinsurance and deductibles. You can join a Medicare Cost Plan any time it is accepting new members. You can leave a Medicare Cost Plan any time and return to Original Medicare You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a Medicare prescription drug plan to add prescription drug coverage. For more information about Medicare Cost Plans, contact the plan you're interested in. You can also visit ***www.medicare.gov*** on the web. Your State Health Insurance Assistance Program (SHIP) can also give you more information. See pages 98–101 in the *Medicare & You* 2008 Handbook for the telephone number.

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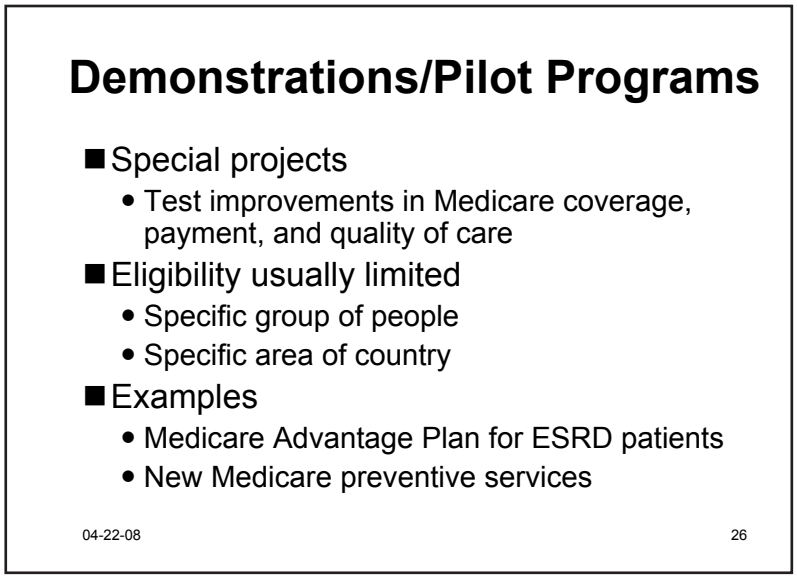

Medicare Demonstrations and Pilot Programs are special projects that test improvements in Medicare coverage, payment, and quality of care. They are usually for a specific group of people and/or are offered only in specific areas. Some follow Medicare Advantage Plan rules, but others don't. The results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

Check with the demonstration or pilot program for more information about how it works. To find more information, visit ***www.cms.hhs.gov/DemoProjectsEvalRpts/*** or ***www.medicare.gov*** on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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Medicare PACE Plans

- Programs of All-inclusive Care for the Elderly
- Combine medical, social, and long-term care services for frail elderly people
  - Include prescription drug coverage
  - Might be better choice than nursing home
- Only in states that offer it under Medicaid
- Qualifications vary from state to state
  - Contact state Medical Assistance office for information

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Programs of All-inclusive Care for the Elderly (PACE) combine medical, social, and long-term care services for frail elderly people who live in and get health care in the community. PACE programs provide all medically-necessary services, including prescription drugs. PACE is a joint Medicare and Medicaid program that may be available in states that have chosen it as an optional Medicaid benefit. PACE might be a better choice for some people instead of getting care through a nursing home. PACE is available only in states that have chosen to offer it under Medicaid, and the qualifications for PACE vary from state to state.

Call your State Medical Assistance (Medicaid) office to find out about eligibility and if a PACE site is near you. You can also visit ***www.cms.hhs.gov/pace/pacesite.asp*** on the web for PACE locations and telephone numbers.

Note: Instructor may highlight local plans.

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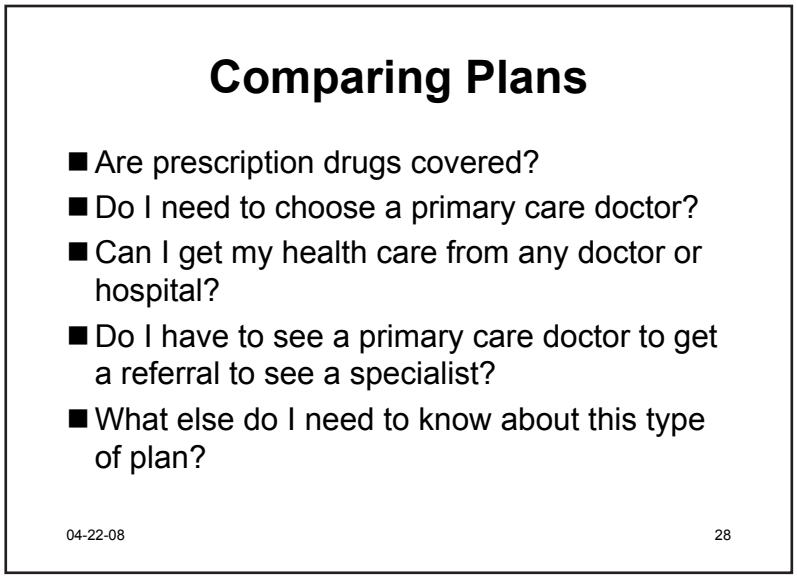

Since each plan can vary, it's important that people with Medicare read the plan materials carefully. There are several questions they can use when considering enrolling in a Medicare Advantage Plan. These questions include

- Are prescription drugs covered?
- Do I need to choose a primary care doctor?
- Can I get my health care from any doctor or hospital?
- Do I have to see a primary care doctor to get a referral to see a specialist?
- What else do I need to know about this type of plan?

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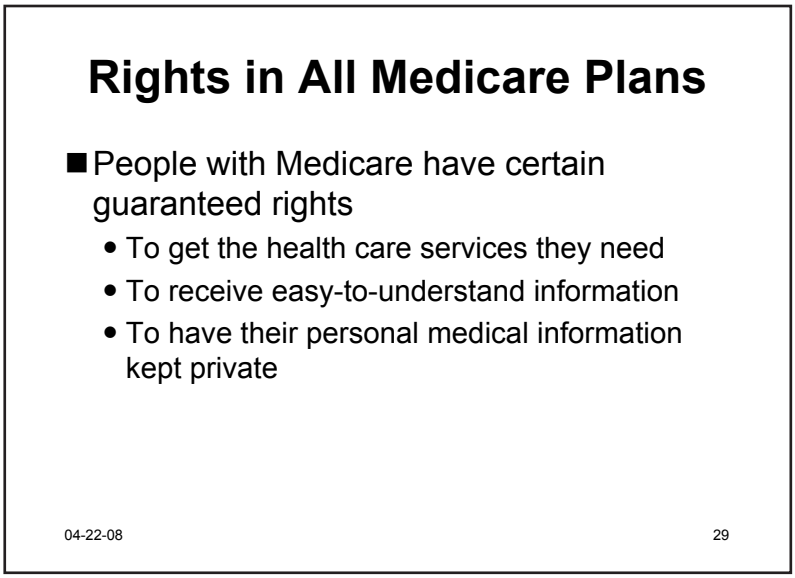

All people with Medicare have certain guaranteed rights and protections. They have them whether they are in Original Medicare, in a Medicare Advantage Plan or other Medicare plan, have a Medicare drug plan, or have a Medigap (Medicare Supplement Insurance) policy.

These rights

- To get the health care services they need
- To receive easy-to-understand information
- To have their personal medical information kept private

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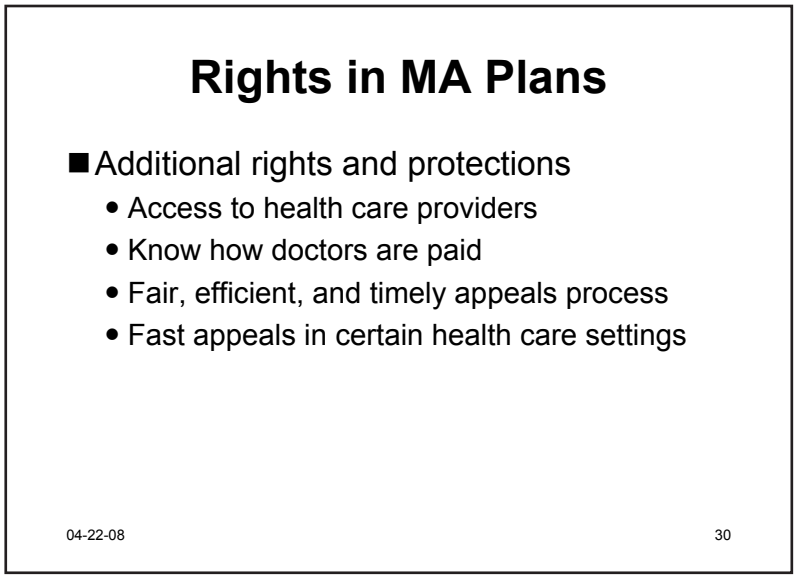

People also have additional rights when they are enrolled in a Medicare Advantage Plan.

- If they have a complex or serious medical condition, they have the right to get a treatment plan that lets them see a specialist within the plan as many times as they and their doctor think they need to. Women have the right to go directly to a women's health care specialist within the plan for routine and preventive health care services.
- When people in a Medicare Advantage Plan ask their plan how it pays its doctors, the plan must tell them. Medicare doesn't allow a health plan to pay doctors in a way that wouldn't let its members get the care they need.
- People in a Medicare Advantage Plan have the right to file an appeal or complaint, and to a fair, efficient, and timely process to resolve differences with their health plan. This process includes the initial decision made by the plan, an internal review, and an independent external review. They have the right to ask their plan to provide or pay for a service they think should be covered, provided, or continued. We'll talk about the appeals process in more detail in a few minutes.
- Members also have the right to a fast appeals process whenever they are getting services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility.

NOTE: You can get a list of PACE-specific rights and protections by visiting ***www.cms.hhs.gov/pace/downloads/prtemp.pdf*** on the web. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. People who have a Medicare Cost Plan will need to follow Original Medicare appeal process for any services they receive outside the plan's network.

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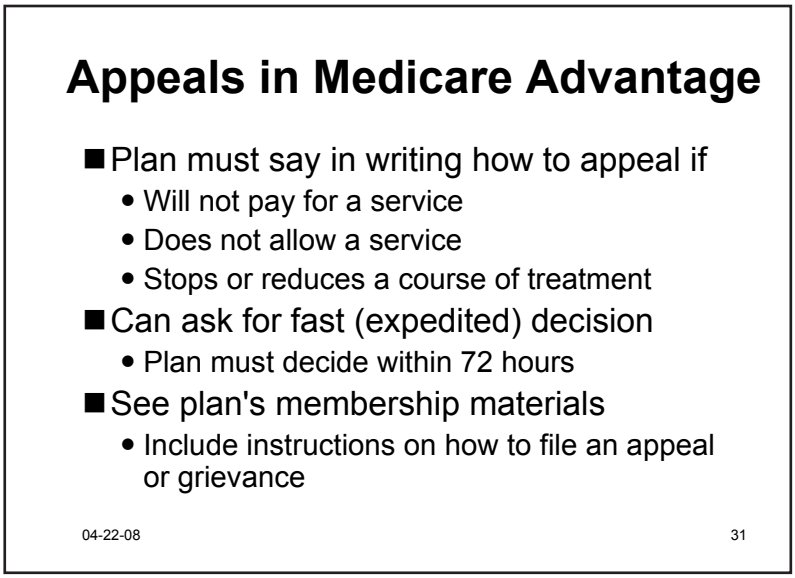

The plan must tell members in writing how to appeal. People in a Medicare Advantage Plan or other Medicare plan can appeal if their plan will not pay for, does not allow, or stops or reduces a course of treatment that they think should be covered or provided. If they think their health could be seriously harmed by waiting for a decision about a service, they should ask the plan for an expedited appeal decision.

If a request for an expedited decision is requested or supported by a doctor, the plan must make a decision within 72 hours. The member or the plan may extend the time-frame up to 14 days to get more medical information. After an appeal is filed, the plan will review its decision. Then, if the plan does not decide in the member's favor, an independent organization that works for Medicare—not for the plan—reviews the decision. See the plan's membership materials or contact the plan for details about its members' Medicare appeal rights.

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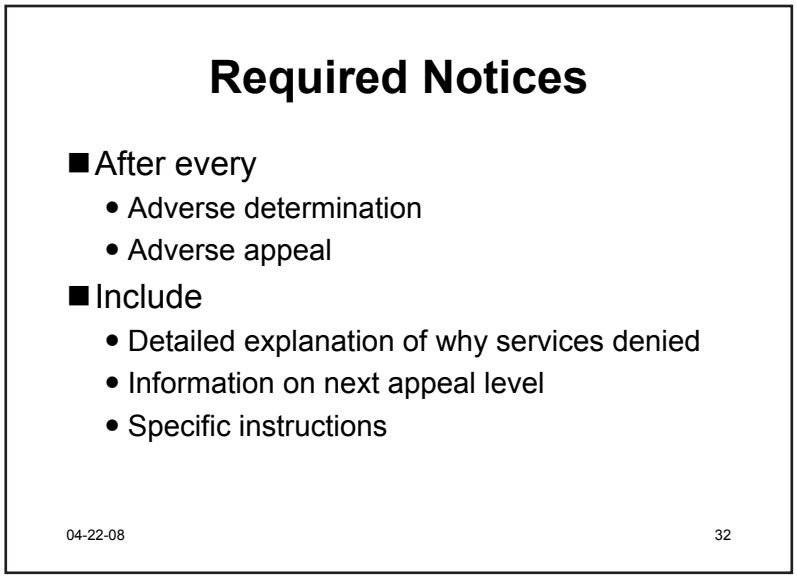

Plans sponsors are required to provide notices after every adverse coverage determination (plan's initial decision) or appeal.

In addition, all appeal entities are required to send written notice when they make adverse decisions. These notices will explain the decision, including a detailed explanation of why the services were denied, information on the next appeal level, and specific instructions about how to file the appeal.

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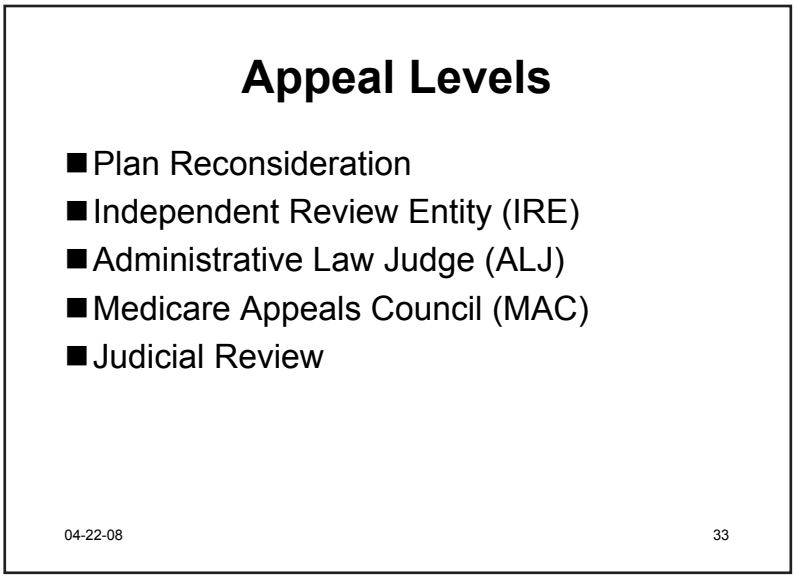

This slide outlines the appeal process in Medicare Advantage Plans.

- **Plan Reconsideration:** must be filed within 60 days of the date of the determination notice; no minimum amount in controversy needed; health plan has jurisdiction.
- **Independent Review Entity:** automatic if Plan Reconsideration does not change initial determination; no minimum amount in controversy needed; Independent Review Entity has jurisdiction.
- **Administrative Law Judge (ALJ)** hearing: must be filed within 60 days of the date of Independent Review Entity decision; minimum amount $120 in 2008, this amount is adjusted annually based on inflation.
- **Review by the Medicare Appeals Council (MAC):** Must be made in writing within 60 days from the date of receiving the unfavorable ALJ decision.
- **Judicial Review:** must be filed within 60 days of receipt of DAB decision/declination; minimum amount in 2008 is $1,180, to be adjusted annually; jurisdiction of U.S. District Court.

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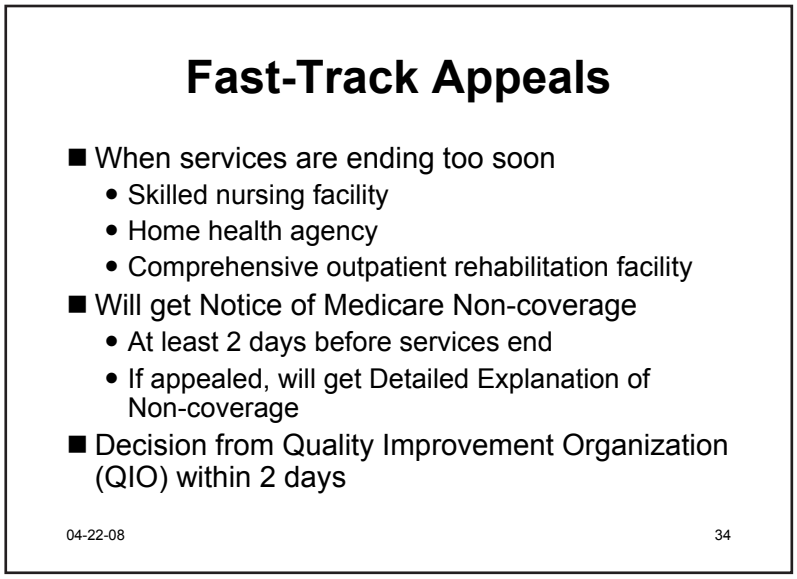

As we mentioned earlier, people in Medicare Advantage Plans* also have the right to a fast-track appeals process. This process is available when a person believes his or her services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility are ending too soon. The provider or plan must give the person a Notice of Medicare Non-coverage (NOMNC) at least 2 days before their services are expected to end. These fast-track appeals are not automatic, but if the person does appeal, the plan must provide a *Detailed Explanation of Non-coverage*. In general, the person will get a decision within approximately 2 days from the Quality Improvement Organization that will decide if services need to continue.

* The fast-track appeal process does not apply to Health Care Prepayment Plans (HCPP). An HCPP is an organization, union, or employer-sponsored plan that provides or arranges for some or all of Part B Medicare benefits on a prepayment basis. Payment for Part A services is made on a fee-for-service basis.

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Inpatient Hospital Appeals

- When services are ending too soon
- Provider/plan must give Notice of Discharge and Medicare Appeal Rights
  - At least the day before services end if
    - The enrollee disagrees with the discharge decision, or
    - The provider/plan is lowering the level of the enrollee's care within the same facility
- Decision from QIO usually within 2 days

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

The person can then appeal by sending a request to the QIO by noon of the first day after receiving the NODMAR. The decision from the QIO is usually received within 2 days. The enrollee remains in the hospital pending the QIO's decision, and generally incurs no financial liability.

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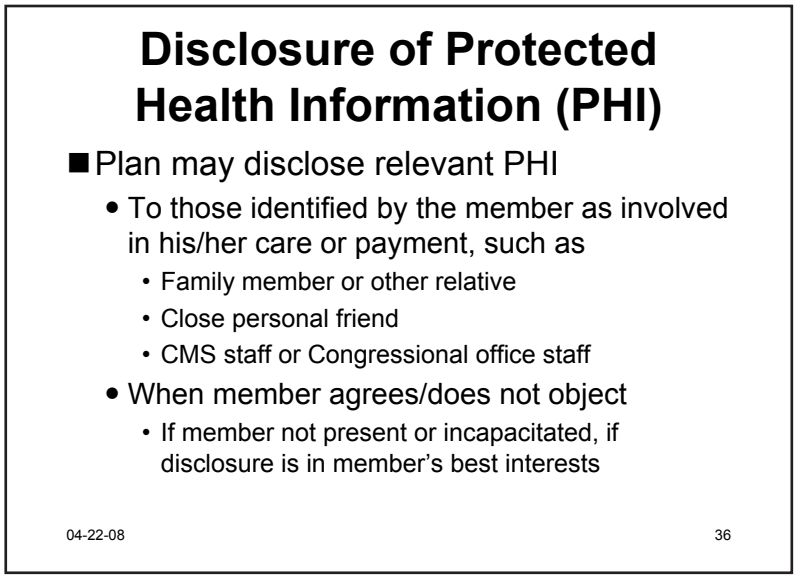

The privacy guidance shown on this slide was published by the Office for Civil Rights in the U.S. Department of Health and Human Services to clarify the HIPAA Privacy Rule for health plans and other covered entities. The guidance explains the circumstances under which a health plan, such as a Medicare Advantage Plan, may disclose relevant protected health information (PHI) to someone who is assisting the plan member. It's important to note that these health plans are permitted, but not required, to make these disclosures under the following conditions:

1. Plans may disclose relevant PHI to those identified by the plan member as being involved in his or her care or payment, such as helping to resolve a MA enrollment issue. This may include

- A family member or other relative
- A close personal friend
- Centers for Medicare & Medicaid Services (CMS) staff, Congressional staff, or other person providing assistance

2. Plans may disclose relevant PHI when:

- The member is present and agrees/does not object or the plan reasonably infers from the circumstances that he or she does not object
- The member is not present or is incapacitated, and the plan exercises its professional judgment to determine that disclosure is in the member's best interests

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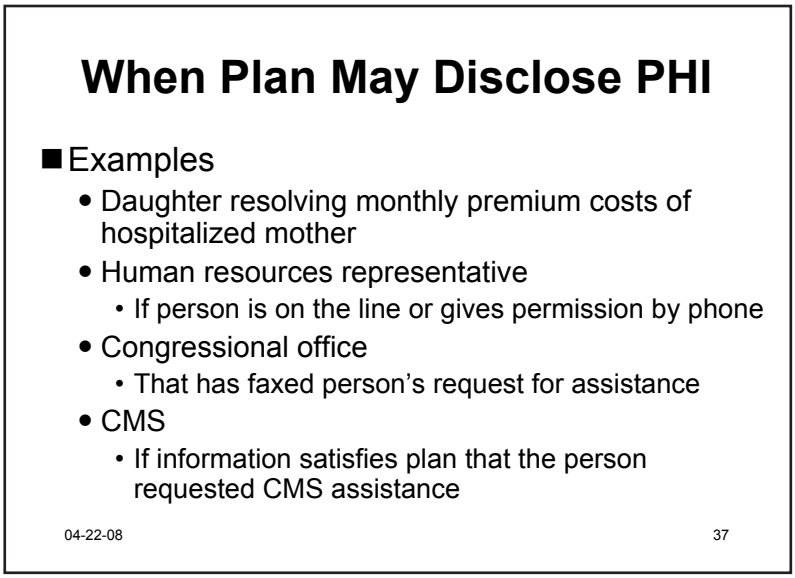

Examples of when a plan may disclose PHI:

- To the daughter of a person with Medicare, who is resolving monthly premium costs for her hospitalized mother
- To a human resources representative if the person with Medicare is on the line or gives permission by phone
- To a Congressional office or staff person that has faxed the person's request for Congressional assistance
- To CMS staff if the available information satisfies the plan that the individual requested CMS assistance

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Module 11: Medicare Advantage Plans and Other Medicare Plans

Starting October 1 every year Medicare Advantage Plans could send information or make calls to people with Medicare about the Medicare prescription drug coverage they are offering for the following year.

Organizations may conduct outbound telemarketing activities for health-related products to the extent permitted under the HIPAA Privacy Rule.

As long as they follow the processes outlined in section 12 (page 142) of the Medicare Marketing Guidelines, all prescription drug plans approved by Medicare may use the Medicare Rx seal in their materials. (The marketing guidelines can be found at ***www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf*** on the web.) People should call 1-800-MEDICARE if they aren't sure if a plan is approved by Medicare.

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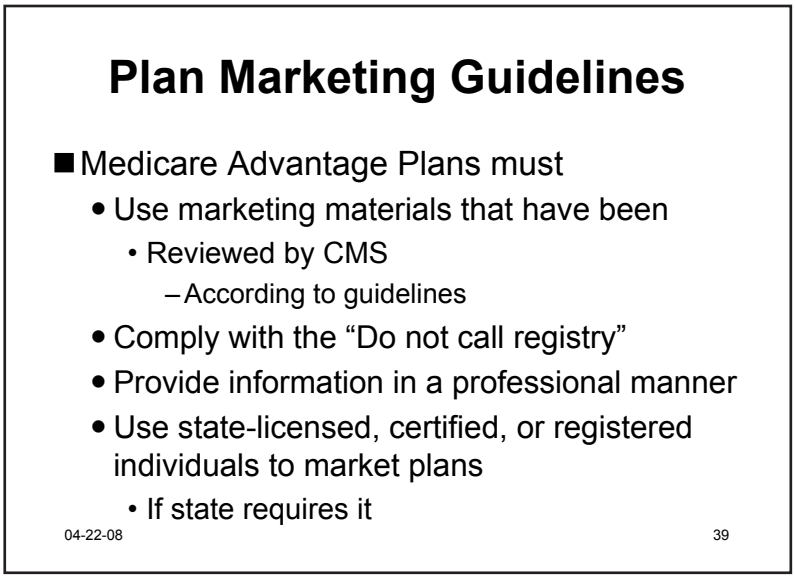

Medicare Advantage Plans must

- Use marketing materials that have been submitted to CMS and reviewed according to the marketing guidelines and other applicable guidance
- Comply with the "Do not call registry"
- Provide beneficiaries with information in a professional manner
- Use a state-licensed, certified, or registered individual to perform marketing, if the state has such a marketing requirement

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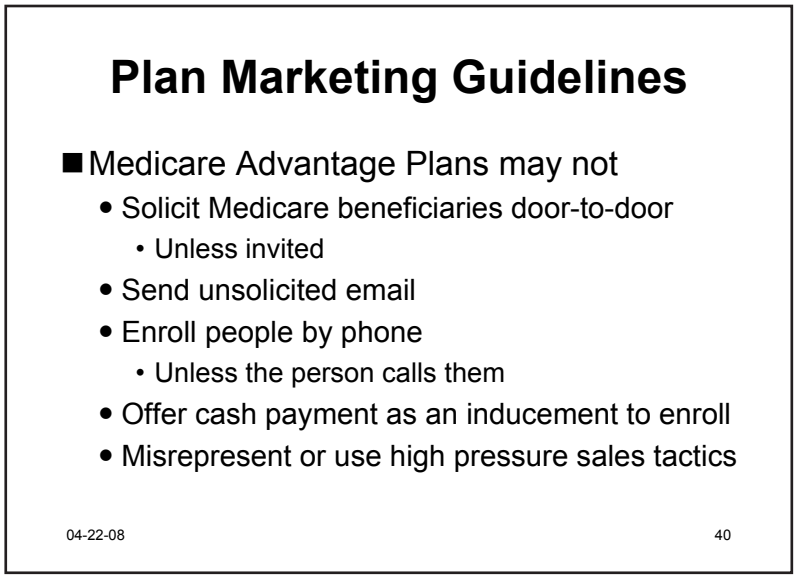

Medicare Advantage Plans may **not**

- Solicit Medicare beneficiaries door-to-door prior to receiving an invitation
- Send unsolicited email to a beneficiary
- Enroll people by phone, unless the person calls them
- Offer beneficiaries cash payment as an inducement to enroll
- Misrepresent or use high pressure sales tactics to enroll a beneficiary

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Module 11: Medicare Advantage Plans and Other Medicare Plans

In this training session, we reviewed Medicare Advantage Plans and other Medicare plans. We explained what Medicare Advantage Plans are, who is eligible to join a plan, and the times they can join or switch plans. We also covered how Medicare Advantage Plans work, the differences between types of plans, and the marketing guidelines plans follow.

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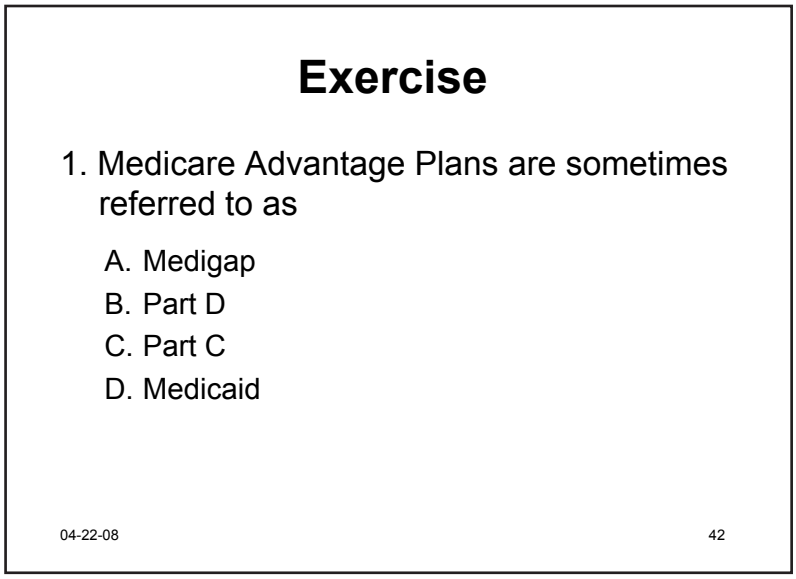
Exercise



1. Medicare Advantage Plans are sometimes referred to as
   A. Medigap
   B. Part D
   C. Part C
   D. Medicaid

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ANSWER: C. Part C

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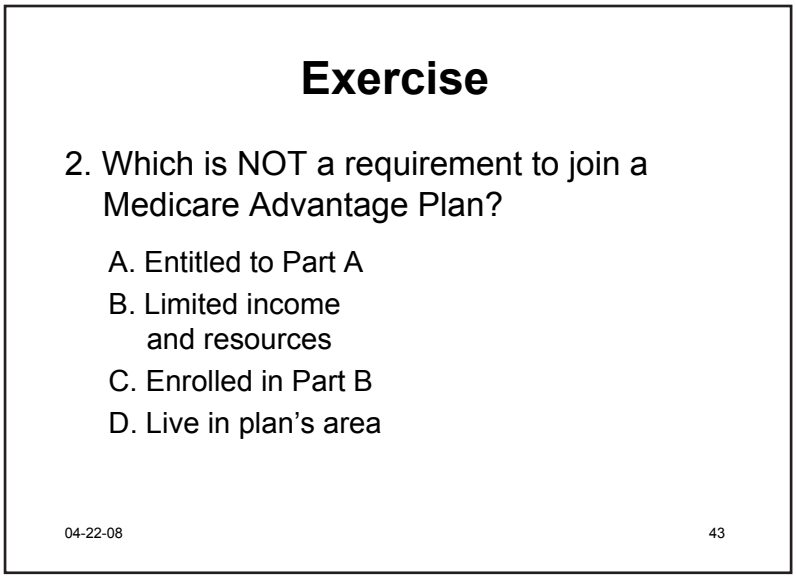
Exercise



2. Which is NOT a requirement to join a Medicare Advantage Plan?
   A. Entitled to Part A
   B. Limited income and resources
   C. Enrolled in Part B
   D. Live in plan's area

NOTES:

Answer: B. Limited income and resources

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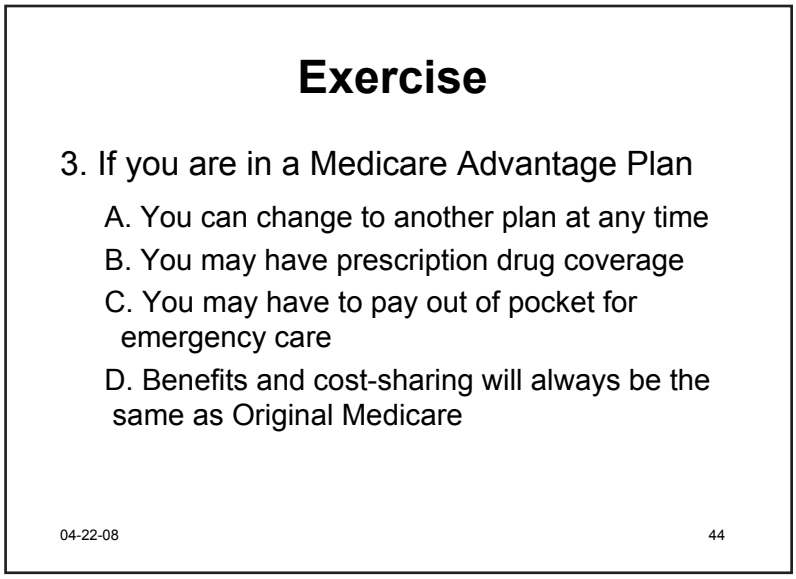
Exercise



3. If you are in a Medicare Advantage Plan
   A. You can change to another plan at any time
   B. You may have prescription drug coverage
   C. You may have to pay out of pocket for emergency care
   D. Benefits and cost-sharing will always be the same as Original Medicare

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ANSWER: B. You may have prescription drug coverage

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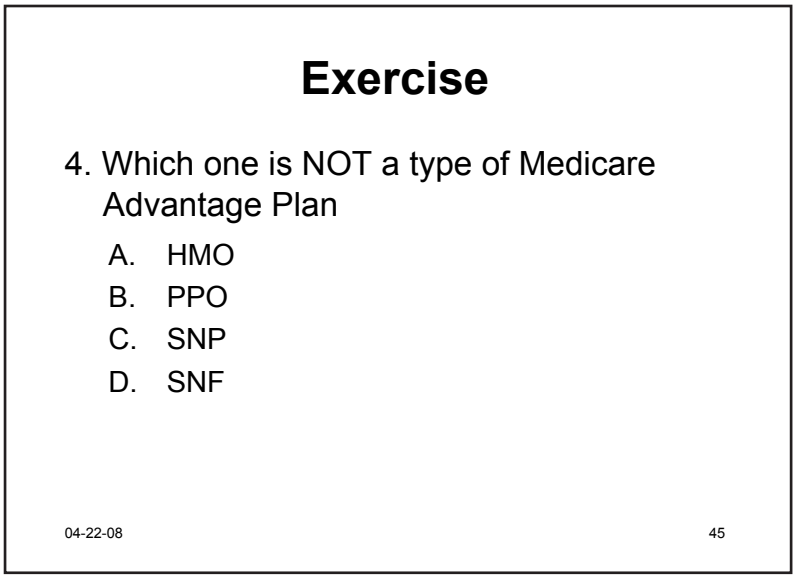
Exercise



4. Which one is NOT a type of Medicare Advantage Plan
   A. HMO
   B. PPO
   C. SNP
   D. SNF

NOTES:

Answer: D. SNF

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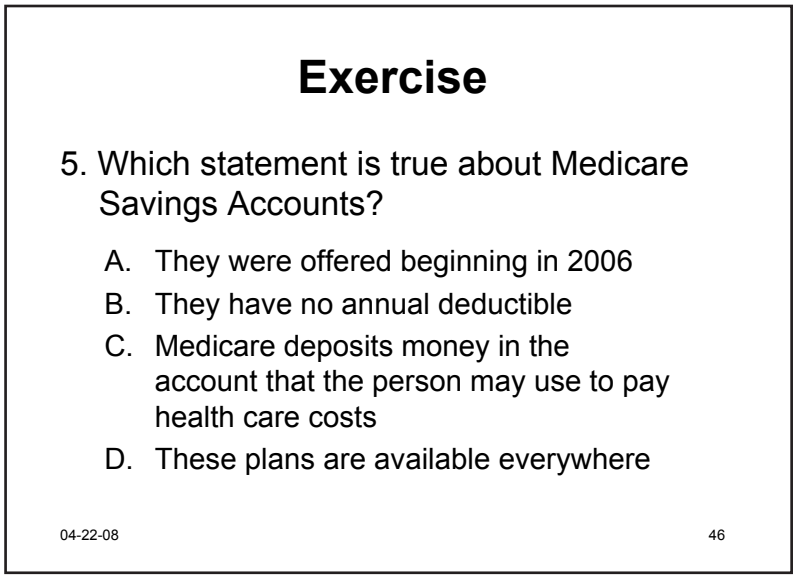
Exercise



5. Which statement is true about Medicare Savings Accounts?
   A. They were offered beginning in 2006
   B. They have no annual deductible
   C. Medicare deposits money in the account that the person may use to pay health care costs
   D. These plans are available everywhere

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ANSWER: C. Medicare deposits money in the account that the person may use to pay health care costs

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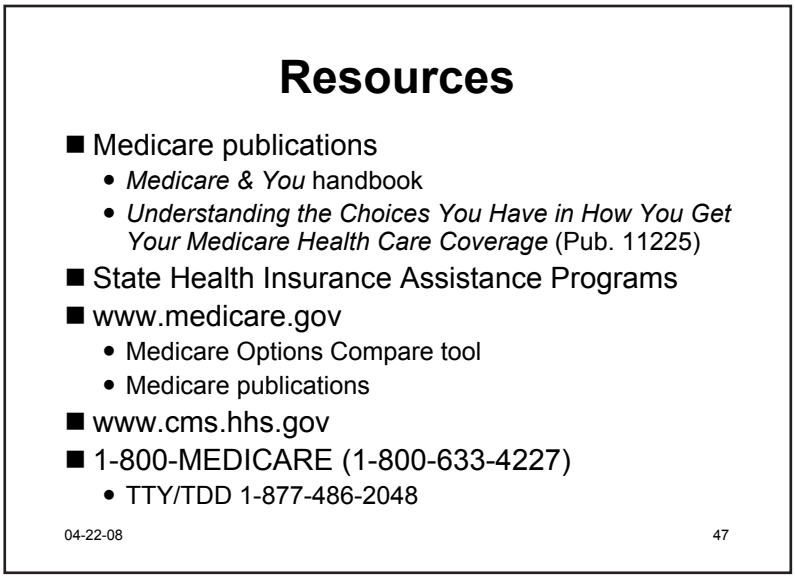

There are a number of resources you can use to get more information or assistance regarding Medicare Advantage and other Medicare plans:

- *Medicare & You* handbook
- *Understanding the Choices You Have in How You Get Your Medicare Health Care Coverage* brochure, CMS Pub. No. 11225
- Your local State Health Insurance Assistance Program (SHIP)
- ***www.medicare.gov***, where you can find the Medicare Options Compare tool, the Medicare publications listed above, and other publications on health plan choices
- ***www.cms.hhs.gov***
- 1-800-MEDICARE (1-800-633-4227)

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