MVP Health Care Medicare Advantage Training

2023 Medicare Basics Certification Program

August 2023

Module 1: Medicare Basics

Medicare Basics

The Four Parts of Medicare

Medicare and its benefits can be broken into four parts:

- **Part A - Hospital Insurance**
- **Part B – Medical Insurance**
- **Part C – The Medicare Advantage (MA) program**
- **Part D – The Prescription Drug Plan (PDP)**

Part A and Part B are referred to as **Original Medicare** because these benefits are administered, and the claims are paid by Medicare.

Part C and Part D are offered by private insurers. The Centers for Medicare and Medicaid Services (CMS) pays private insurers to administer benefits and pay claims on behalf of CMS.

Note: often, private insurers will offer both the Part C and Part D plans in one combined plan.

These plans are known as MA-PD plans (Medicare Advantage-Prescription Drug plans).

Medicare Basics

Medicare Part A - Overview

Medicare Part A is also known as Hospital Insurance. Part A covers:

- **Inpatient hospital**
- **Skilled Nursing Facility (SNF)**
- **Nursing home care**
- **Home health services**
- **Hospice care**

Medicare Basics

Medicare Part A – Eligibility

In order to be eligible for Part A, you must:

- be a U.S. citizen and 65 years old or older or;
- be a permanent U.S. resident for five or more continuous years and be 65 years old or older

If you are not 65 or older, you can still qualify for Part A if:

- you are a U.S. citizen or legal resident under 65 years old but have a qualifying disability, such as blindness, or a qualifying medical condition, such as Lou Gehrig's Disease
- you have received disability benefits from Social Security or the Railroad Retirement Board for 24 months
- you are a disabled widow or widower between age 50 and age 65 but have not applied for disability benefits because you're already getting another kind of Social Security benefit

Medicare Basics

Medicare Part A – Premium Information

Most people don’t have to pay a monthly premium for Part A because they (or a spouse) paid Medicare taxes for **at least 40 quarters (10 years)** while they were working. Other ways that a person may qualify for premium-fee Part A include:

- You already get retirement benefits from Social Security or the Railroad Retirement Board
- You're eligible to get Social Security or Railroad benefits but haven't filed for them yet.
- You or your spouse had Medicare-covered government employment.

If you're under 65, you can get premium-free Part A if:

- You got Social Security or Railroad Retirement Board disability benefits for 24 months

Medicare Basics

Medicare Part B – Overview, Eligibility, and Premium Information

Medicare Part B is also known as Medical Insurance and covers:

- **Doctor services**
- **Mental Health services**
- **Lab work**
- **X-rays**
- **Durable medical equipment (DME)**
- **Other medical services not covered under Part A**
- **Certain drugs not covered under Part D**

Anyone receiving ***or*** entitled to Part A is eligible for Part B. Unlike Part A, signing up for Part B is voluntary and everyone must pay a monthly premium based on their income.

Medicare Basics

Should My Client Choose Part B?

Beneficiaries should be encouraged to enroll in Part B when they first become eligible. Here are some points to remember for beneficiaries hesitant to enroll in Part B:

- Costs for medical services will be higher without Part B
- To participate in a Medicare Advantage or Medigap plan, Part B is required
- Not enrolling may incur a Late Enrollment Penalty (LEP). The LEP increases the beneficiary's Part B premium and remains in place for the lifetime of the beneficiary's Part B coverage
- Coverage for some dialysis and kidney transplant services requires both Part A and Part B

Medicare Basics

Enrolling in Original Medicare – The Initial Enrollment Period (IEP)

New Medicare beneficiaries need to contact the Social Security Administration (SSA) no sooner than three months prior to and no later than three months after the month of their 65th birthday to apply for Medicare Part A and B benefits

Example:

Sara Smith turns 65 on May 14th. She will need to contact the SSA between February 1st (3 months before May) and August 31st (3 months after May)

Medicare Basics

Medicare Part C – Overview and Premium Information

Medicare Part C is also known as Medicare Advantage (MA). MA plans are health plans approved by Medicare and run by private insurance companies as an alternative to Original Medicare. CMS pays these private insurers to administer benefits and pay claims on behalf of CMS. MA plans must have the same or better benefits than Original Medicare. MA plans may include additional coverage such as wellness education, eye care, or dental coverage.

MA plan members **do not show** their Medicare card for coverage. They show the MA plan's benefit card to obtain services.
Members joining an MA plan must continue to pay their premiums for both Medicare Parts A (if they have one) and B and may have to pay an additional premium for their MA plan.

Medicare Basics

Part C – Eligibility

To be eligible for an MA plan, individuals must:

- Be currently enrolled in and continue to pay applicable premiums for both Medicare Parts A* and B
- Be permanent residents in the MA plan's service area**
- Pay an MA plan's premium, if needed

*Most beneficiaries do not pay a monthly premium for Part A coverage if they paid the applicable Medicare taxes while working.

**There are certain employer group waivers that may allow retirees to be covered outside of the MA plan's employer group service area

There is no pre-existing condition requirement for any MA plan, including the age and income of the beneficiary. Premiums for MA plans are not rated based on pre-existing conditions, age or income.

Medicare Basics

Part D – Medicare Prescription Drug Plan Overview

Part D is Medicare's prescription drug plan. Part D provides coverage for basic and catastrophic non-Part B prescription drug costs and is administered by private insurance companies contracted through CMS.
Beneficiaries can receive Part D coverage from a stand-alone Prescription Drug Plan (PDP) or as prescription drug coverage included in the benefits of an MA plan (MA-PD).

Beneficiaries cannot purchase a Part C plan with one company and a Part D plan from another company. If a beneficiary has a Part C plan with one company and elects a Part D plan from another company, they will be automatically disenrolled from the Part C plan and enrolled in Original Medicare.

Exceptions: Beneficiaries can purchase a Medicare Medical Savings Account (MSA) or a Private Fee-For-Service (PFFS) plan with one company and purchase a Part D plan with another company.

Medicare Basics

Part D – Eligibility and Premium Information

Unlike Part C, where a beneficiary must be enrolled in Part A ***and*** enrolled in Part B; to be eligible for Part D, individuals can be enrolled in Part A ***or*** Part B. **Creditable Coverage is prescription drug coverage that is at least equal to the benefits provided by the CMS Standard Medicare Part D benefit**.

- Like MA plans, PDPs and MA-PDs can only offer equivalent or better coverage than the CMS Standard Medicare Part D benefit.
- Plans may charge a premium for Part D coverage. If a member delays enrollment into a Part D plan, or switches from prescription drug coverage that is not creditable to a Part D plan, a Part D Late Enrollment Penalty (LEP) may be added to the beneficiary's monthly Part D premium, and will remain for as long as the member is enrolled in Part D.

Medicare Basics

Part D – Cost Sharing Subsidies for Low-Income Individuals

There are both state funded programs and Medicare funded programs that may be available to help beneficiaries with their prescription drug costs.
State funded assistance programs are known as State Prescription Assistance Plans or SPAPs**. The SPAP for New York is the Elderly Pharmaceutical Insurance Coverage, or EPIC. Vpharm is the name of Vermont's SPAP. Not all states have a SPAP.**

LIS (low income subsidy), or "Extra Help" is a Medicare program to help people with limited income and resources pay Medicare prescription drug costs, such as premiums, deductibles, coinsurance, and copayments. The LIS program is available to anyone who meets Medicare's income requirements. If a person would like to know if they qualify, they should call the Social Security Administration (SSA) Office.

Note: If a person qualifies for LIS with their Medicare prescription drug coverage costs, Medicare will pay part of their plan's premium. The person will be billed for the amount that Medicare does not cover.

Medicare Basics

Cost Plans (Including Section 1876 Cost Plans) – Overview, Eligibility, and Premium Information

Cost Plans and Section 1876 Cost Plans are Medicare health plans that pay for services outside their service area only if there is an emergency or urgently needed services. These plans are not Medicare Advantage plans. Cost Plan beneficiaries who receive routine services outside the plan's network area will get their Medicare covered services paid by Original Medicare, and the beneficiaries will be responsible for Original Medicare deductibles and coinsurance. Cost plans may offer a Part D benefit. Members may have to pay a premium for a Cost Plan or an 1876 Cost Plan. MVP does not currently offer any form of Cost Plan.

In order to be eligible to enroll in a cost plan, a beneficiary must:

- Be entitled to benefits under Part A and enrolled in Part B, or enrolled in Part B only
- Permanently reside within the geographic area of the cost plan
- Complete the application during the enrollment period
- Agree to abide by the membership rules disclosed during the enrollment process.

Medicare Basics

Medicare-Medicaid Plans (MMPs)

Medicare-Medicaid plans, or MMPs, are plans that combine the benefits of Medicare and Medicaid. MMPs are not Medicare Advantage plans. In order to be eligible to enroll in an MMP, the following requirements need to be met:

- The individual is entitled to/enrolled in Part A, enrolled in Part B, and eligible for Part D
- The individual meets the specific state requirements for Medicaid
- The individual permanently resides in the MMPs service area
- The individual or legal representative completes the enrollment request and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS

MVP does not currently offer Medigap plans

Medicare Basics

Medigap

Medigap plans, also known as **Medicare Supplement Insurance**, are plans sold by private insurance companies that work with Original Medicare to help pay some of the health care costs, or “gaps”, that Original Medicare doesn’t cover - like copayments, coinsurance and deductibles. Medigap coverage enhances Original Medicare’s benefits. Medigap plans do not work with Medicare Advantage plans – only Original Medicare. It is illegal for anyone to sell a Medicare Advantage member a Medigap policy, unless the beneficiary is switching back to Original Medicare.

Medicare Basics

Options for Receiving Medicare

There are several options for receiving Medicare, including:

Original Medicare (Parts A and B) only
Original Medicare plus a Part D prescription drug plan (PDP)
Original Medicare plus a Medigap policy
Medicare Advantage-Prescription Drug plan (MA-PD)
Medicare Advantage (MA) plan or Cost Plan without a PDP
Private Fee-for-Service MA or Cost Plan with a PDP
MSA plan, with or without a PDP
Medicare-Medicaid Plan (MMP)

Medicare Basics

Medicare Beneficiary Protections

All Medicare beneficiaries have the same rights and protections, **no matter how they get their Medicare**. These protections cover all parts of Medicare. These universal protections are:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Have personal, health, and prescription drug information kept private
- Get information in a way that is understandable from Medicare, health care providers, and Medicare contractors
- Have questions about Medicare answered
- Have access to doctors, other health care providers, specialists, and hospitals

- Learn about your treatment choices in clear language and participate in treatment decisions
- Get emergency care when and where its needed
- Get a decision about health care payment, coverage of services, or prescription drug coverage
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage
- File complaints (grievances), including complaints about the quality of your care

Medicare Basics

Appeals and Grievances

Appeal is the action a beneficiary can take if they disagree with a coverage or payment decision made by Medicare, the Medicare health plan, or the Medicare Prescription Drug Plan. Filing an appeal is a right of all Medicare beneficiaries. Appeals start at the plan level – meaning the beneficiary starts the process by contacting the plan.

Grievance is a complaint about the way a Medicare health plan or Medicare drug plan is giving care. Filing a grievance is also a right of all Medicare beneficiaries. A grievance may be filed if the beneficiary feels they have been mistreated in any way. If the complaint is about a plan's refusal to cover a service, supply, or prescription, an appeal needs to be filed, not a grievance. A grievance can also be filed on the quality of care received from a provider or hospital. A grievance must be filed within 60 days of the incident. Grievances can be filed by contacting the plan or by calling 1-800-MEDICARE.

Medicare Basics

Medicare Part C – Coordinated Care Plans

MVP Health Care currently offers these types of MA Plans:

Health Maintenance Organization-Point Of Service (HMO-POS) – An HMO-POS plan works like an HMO plan, but allows the beneficiary to see non-par providers. Generally, the member's non-par benefits (POS) are limited and are more costly to the member.

Preferred Provider Organization (PPO) – In a PPO plan, all services that are covered for par providers are also covered for non-par providers. The cost-share for non-par providers is generally higher for the beneficiary.

Medical Savings Account (MSA) – A Medicare MSA is a type of Medicare Advantage plan that combines a high-deductible health plan with a medical savings account. Medicare MSA plans provide Medicare beneficiaries with more control over health care utilization, while still providing coverage against catastrophic health care expenses.

Medicare Basics

Medicare Part C – Coordinated Care Plans

Health Maintenance Organization (HMO) – An HMO is a type of health plan that limits beneficiaries to coverage from par providers and generally won't cover out-of-network care except in an emergency. HMOs often focus on prevention and wellness.

Private Fee-For-Service (PFFS) – PFFS plans have no network, so beneficiaries can see any provider who is eligible to receive payment from Medicare and agrees to accept payment from the PFFS Medicare Advantage Organization.

Regional Preferred Provider Organization (RPPO)– An RPPO has the same features as a regular PPO, except an RPPO serves one of the 26 regions outlined by CMS.

Special Needs Plans (SNP) – coordinated care plan that specifically targets enrollment to beneficiaries who are institutionalized, dually eligible and/or individuals with severe or disabling chronic conditions.

Special Needs Plans

Dual-Eligible Special Needs Plans (D-SNP) – individuals who are entitled to both Medicare and Medicaid

Chronic Condition SNP (C-SNP) – restrict enrollment to special needs individuals with specific severe or disabling chronic conditions

Institutional Special Needs Plans (I-SNPs)- restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.

Medicare Basics

Medicare Part C – Provider Networks

MA plans contract with providers and facilities to provide health care services for its members. These contracted providers are part of the MA plan's **Provider Network**. Providers are paid based on a negotiated rate. The level of provider participation in an MA plan's network will vary.

- **In-Network, or participating (par) providers** are contracted to administer health care services to an MA plan's members
- **Out-Of-Network, or non-participating (non-par) providers** are not contracted to administer health care services to an MA plan's members. Depending on the type of MA plan, a member's out of pocket costs may be higher
- The provider network for an MA plan may be different than that of Original Medicare. Par providers can be found in an MA plan's Provider Directory.

Medicare Basics

Medicare Part C – Emergent and Urgent Care

MA members will be covered outside of the plan's service area, and **worldwide**, for all:

- Urgently needed care
- Emergency care

MA members will be covered outside of the plan's service area, and **nationwide**, for:

- Dialysis

These services would be treated as in-network for purposes of the member's financial responsibility (copays, coinsurance and/or deductibles).

Medicare Basics

Medicare Part C – Treatment Plan

MVP Health Care offers three types of coordinated care plans to our members – **HMO-POS, PPO, and MSA plans**:

With an HMO-POS, a Primary Care Physician (PCP) is required. The PCP is in charge of coordinating a patient's care and referring to specialists as needed.

With a PPO plan, a PCP is not required, although members can have one if they wish. Members of a PPO plan can see in and out of network providers without a referral.

With an MSA plan, members can see any provider that accepts payment from Medicare. A PCP is not required.

Medicare Basics

Medicare Part C – Maximum Out-of-Pocket Limits (MOOP)

MA plans have an Out Of Pocket Maximum (OOP max) limit to help protect members from catastrophic medical expenses. The OOP max limits how much a member must pay in copays, coinsurance, and deductibles before the plan will pick up 100% of covered expenses.

For example, if a member has MVP Medicare WellSelect (PPO) plan with a $8,300 OOP max, once the member has paid $8,300 worth of copays, coinsurance and/or deductibles, the member will be covered at 100% for all covered medical services.

Non-medical expenses, such as Part D copays and eyewear allowances, do not count towards a member's OOP max.

Note: The OOP max amount may differ between plans

Medicare Basics

Medicare Part C – Prior Authorization and Step Therapy

MA plans cover all services that Original Medicare covers, however, they do not cover all services. There are benefit limitations in place, which are plan specific, to protect the MA plan and enrollees from catastrophic medical expenses and to assure that the right treatment is being used. Some services require approval from the MA plan.

Prior authorization: is a requirement that a health care provider obtain approval from the MA plan to provide a given service. The provider must show that the requested service is medically necessary. MA plans often require prior authorization to see specialists, get out-of-network care, get non-emergency hospital care, and more. Each MA plan has different requirements, so MA enrollees should contact their plan to ask when prior authorization is needed.

Step Therapy: is a type of prior authorization for drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions. For example, by using step therapy plans could ensure that an enrollee who is newly diagnosed with a condition begin treatment with a cost-effective drug before progressing to a more costly drug should the initial treatment prove ineffective. By implementing step therapy along with care coordination and drug adherence programs, it will lower costs and improve the quality of care for Medicare beneficiaries.

Medicare Basics

Medicare Part D – Plan Types

Part D is prescription drug coverage subsidized by the Federal government and administered by private companies. For many beneficiaries, a Part D plan may be their only way to save on drugs and protect them from catastrophic drug costs. There are two different types of Part D plans:

- **Stand Alone Prescription Drug Plan (PDP) –** PDPs are plans that provide coverage for Part D prescription drugs only. PDPs can be combined with Original Medicare, Medigap, or some Part C plans.
- **Medicare Advantage Prescription Drug Plan (MA-PD) –** combines Part C and Part D plans from one health insurer, such as MVP Health Care.

Medicare Basics

Medicare Part D – Standard Benefit

The Medicare Part D Standard Benefit is CMS's standardized Part D benefit structure. The Part D Standard Benefit is amended each year by CMS. All plans offering Part D coverage must assure that their plans offer, **at minimum**, the standard Part D benefit. Most plans offering Part D coverage have plan options that exceed the minimum coverage set by CMS. For 2023, the Medicare Part D Standard Benefit is:

- Deductible - $505
- Coinsurance – 25% on all drugs after deductible is met, up to the Initial Coverage limit
- Initial Coverage Limit - $4,660 – 25% coinsurance on generic drugs and brand name drugs in coverage gap
- Out-Of-Pocket Cost Threshold - $7400 - once this has been reached, coinsurance for generic drugs will be $4.15 or 5%, whichever is greater, brand names will be $10.35 or 5%, whichever is greater.

Medicare Basics

Medicare Part D – Key Concepts

To understand Part D, there are several key concepts that you'll need to be familiar with:

- Part D Cost Sharing
- Deductibles, Copays, and Coinsurance
- The Coverage Gap
- The Medicare Coverage Gap Discount Program
- True Out of Pocket (TrOOP)
- Catastrophic Coverage
- Pharmacy Networks
- Preferred and Non-Preferred Cost-Sharing Pharmacies
- Prior Authorization

Medicare Basics

Part D Cost Sharing

Medicare Part D plans are designed to help beneficiaries with their prescription drug costs through **cost sharing.** Part D plans may accomplish this through:

Deductibles –the amount a beneficiary must pay out of pocket for prescription drug costs before a Part D plan's benefits "kick in". Some Part D plans have deductibles, some do not.
Coinsurances –the percentage of drug cost a beneficiary must pay for their prescription drugs. For example, if a beneficiary's Part D plan has a 25% coinsurance for prescription drugs, the beneficiary shares 25% of the cost of the drug – the plan pays 75%.
Copays –similar to coinsurances, but instead of paying a percentage of the cost of a prescription drug, the beneficiary pays a set fee.
Tiers –a level or category of prescription drugs in a prescription drug plan, usually depending on the type of drug (generic, brand name, specialty, etc.). Each tier has a specific copay or coinsurance.

Medicare Basics

Part D Benefit Four Stages:

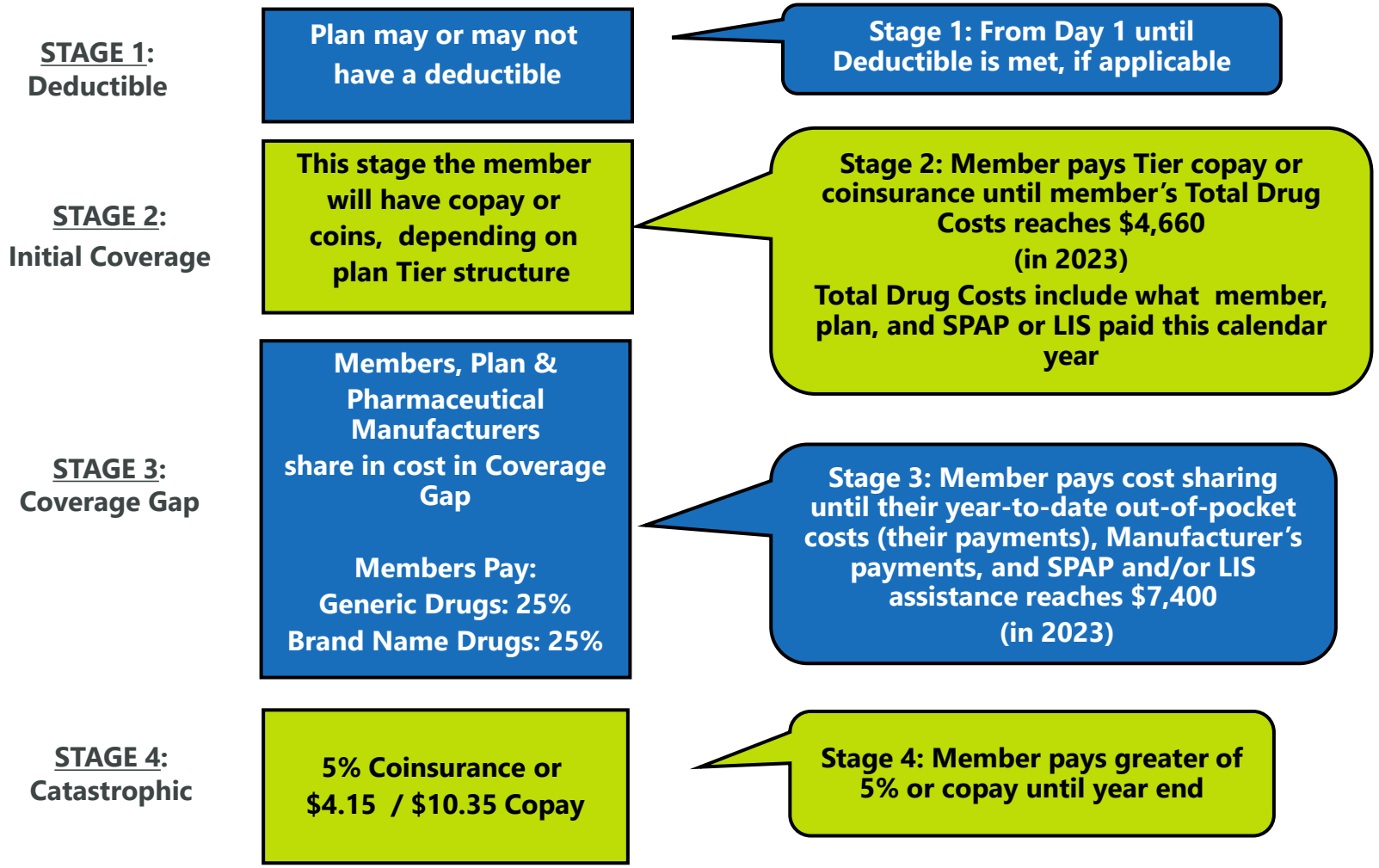
Deductible Stage –the beneficiary pays for prescription drugs out of pocket until the deductible amount is reached. Not all Part D plans have a deductible.

Initial Coverage Stage –the beneficiary pays either a coinsurance or copay for their prescription drugs. The Initial coverage stage lasts until the total drug cost - the amount the member has paid out of pocket, plus the amount paid by the plan and any assistance programs, such as SPAPs or LIS - reaches $4,660.

Coverage Gap –also known as the "Donut Hole". During this stage, there is a "gap" in coverage from the plan – meaning the Part D plan pays a lesser share of the cost of prescription drugs, and the beneficiary pays a greater share. Drug manufacturers also pay a percentage for brand name drugs. **This stage continues until the total amount paid by the member, manufacturer, SPAPs, and LIS reaches $7,400 annually. This is called True Out of Pocket, or TrOOP.**

Catastrophic Coverage Stage – After TrOOP reaches $7,400, beneficiaries are considered to be in the Catastrophic Coverage Stage. Beneficiaries will pay a 5% coinsurance or $4.15 for generic drugs, $10.35 for brand name drugs, whichever is greater.

Part D Stages



Medicare Basics

Medicare Coverage Gap Discount Program

As part of Health Care Reform, beneficiary cost sharing in the Coverage gap has been decreasing annually since 2010. **The Medicare Part D Coverage Gap Discount Program** is an agreement set forth by the Affordable Care Act of 2010, where Medicare contracted Brand Name Drugs will have a 70% manufacturer's discount while in the coverage gap.

Medicare Basics

Pharmacy Networks and Prior Authorization

In-Network Pharmacies are pharmacies that an MA plan has contracted with to provide its members with prescription drugs.

Out-of-Network Pharmacies are pharmacies that are not contracted by the MA plan. Plans may only pay for prescriptions filled through an out-of-network pharmacy on a limited, non-routine, or emergency situation when an in-network pharmacy is not available.

Preferred Cost Sharing for in-network pharmacies means that there may be certain pharmacies, contracted by a plan, that will charge the beneficiary less than the standard cost-sharing amount on copays and coinsurances.

Non-Preferred cost-sharing for an in-network pharmacy means that the plan has not contracted with the pharmacy to charge the beneficiary less. Beneficiaries will pay the copays and coinsurances outlined by their plan. This is also called Standard cost-sharing.

Plans may require a prior authorization to make sure certain prescription drugs are used correctly and only when medically necessary. This means before a plan will cover a certain drug, the prescribing provider must first contact the plan and show there's a medically necessary reason why the beneficiary must use that particular prescription drug.

Medicare Basics

Employer Group Plans

An Employer Group plan is a medical plan **offered by an employer** to its **current employees and retirees**. Employer Groups can elect to offer their retirees Medicare plans administered by private insurers for medical coverage. **Employer Groups can choose to offer retirees several options for Medicare Coverage**, including MA plans, Part D PDP plans, Medigap plans, or Cost plans.

In most cases, the Employer Group is billed by the plan, and retirees pay the group for their coverage. MVP currently offers Employer Groups MA, MA-PD, MSA, and PDP plans.

Module 2: Enrollment and Disenrollment

Enrollment and Disenrollment

Eligibility for Enrollment in MA Plans

An individual is eligible to enroll in an MA plan when each of the following requirements are met:

- The individual is currently enrolled in and continues to pay applicable premiums for both Medicare Parts A and B.
- The individual is a U.S. citizen or lawfully present in the United States.
- The individual permanently resides in the service area of the MA plan.
- The individual or legal representative completes an enrollment request and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS.
- The individual is fully informed of and agrees to abide by the rules of the MA organization that were provided during the enrollment request.
- The individual makes a valid enrollment request that is received by the plan during an election period.

Enrollment and Disenrollment

Non-Discrimination Requirements for Enrollment

An MA organization may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS. MA organizations cannot deny enrollment based on current health, race, sex, age, or medical history.

Enrollment and Disenrollment

Enrollment Procedures – Use of Approved Enrollment Mechanisms

- MA organizations must have, at minimum, a paper enrollment form available for potential enrollees to enroll in an MA plan. MA organizations must also process auto and facilitated enrollment requests into MA plans.
- MA organizations have the option to accept enrollment requests using an online enrollment form as well as enrollment via telephone.
- CMS has developed a model short enrollment form and a model plan selection form to allow for enrollment requests into another plan offered by the same parent organization. Organizations must ensure that the short form contains all elements required for enrollment requests into a particular plan type.
- Plans can also offer a Simplified (Opt-In) Enrollment Mechanism, where a plan can use data it has from its non-Medicare lines of business to obtain some of the information it would normally need to receive from the beneficiary in the enrollment request. MA organizations may offer simplified enrollment via paper, telephone or electronically. Plans are not required to use simplified enrollment.

Enrollment and Disenrollment

Enrollment Procedures – Acknowledgement and Consent

Enrollment applications must include the applications acknowledgement of the following:

- Understanding the requirement to continue to keep Medicare Part A and Part B
- Agreement to abide by the MA plan's membership rules, as outlined in member materials
- Consent to the disclosure and exchange of information necessary for the operation of the MA program
- Understanding that he/she can be enrolled in only one Medicare health plan and that enrollment in an MA plan automatically disenrolls him/her from any other MA plan or PDP
- Understanding the right to appeal service and payment denials made by the organization

Enrollment and Disenrollment

Enrollment Procedures

Agents and brokers will need to record all enrollment calls/video calls with beneficiaries in their entirety

Enrollment and Disenrollment

Processing Enrollment Requests – Notifications

CMS requires MA plans to send beneficiaries an acknowledgement letter notifying them of receipt their applications. If any immediate services, such as prescriptions, urgent or emergent care, or office visits are needed, the new member should use this acknowledgement letter as a temporary benefit card.

CMS will review the data submitted to determine if the person is eligible to enroll, and if approved, complete the application

Once CMS approves the enrollment request, a **new member packet** and **ID card** are sent to the beneficiary.

The packet includes important materials like the Formulary **(if the plan sends it**), Member Handbook, and the Evidence of Coverage, also known as the member's contract **(if the plan sends it).** Upon the member's effective date with the plan, the member should use their plan ID card to access all services.

Enrollment and Disenrollment

Initial Coverage Election Period (ICEP) and Part D Initial Enrollment Period (IEP for Part D)

The Initial Coverage Election Period, or ICEP, and the Initial Enrollment Period or IEP for Part D are defined the same way. This is the election period where someone is newly eligible for Medicare. This election period begins three months before the month the beneficiary is first eligible for Medicare Part B until three months after their initial eligibility month.

- The Initial Coverage Election Period, or ICEP is for Part C
- Initial Enrollment Period or IEP for Part D is for Part D

Part C and Part D coverage begin two ways:

- Individuals enrolling in the three months prior to their initial eligibility month will have the coverage start on the first day of their initial eligibility month.
- Individuals enrolling any of the other four months will have their coverage start on the first day of the month following receipt of their completed application.

Enrollment and Disenrollment

Annual Election Period

The Annual Election Period (AEP) is available each calendar year to all Medicare beneficiaries. **Annual Election Period is October 15th through December 7th.**

- Benefits selected during the AEP are effective on January 1st of the following year.
- A beneficiary's last completed choice made during the AEP will be the election that takes effect.
- MA, MA-PD, or PDP plans can submit enrollment requests to CMS from October 15th - December 7th.
- MA plans may not solicit enrollment applications prior to the start of the AEP.

Enrollment and Disenrollment

Open Enrollment Period for Institutionalized Individuals (OEPI)

The Open Enrollment Period for Institutionalized Individuals (OEPI) is for individuals who move into, reside in, or move out of an institution. The OEPI is continuous for eligible individuals residing in an institution.

The OEPI ends two months after the month the individual moves out of the institution. The effective date of coverage will begin on the first of the month following the election.

Enrollment and Disenrollment

Special Election Periods

Special Election Periods, or SEPs, are determined by CMS. These periods are very unique circumstances when a beneficiary would have an opportunity to make an election change (enroll or disenroll) mid-year. Typical SEPs are:

- Beneficiary permanently moves out of the plan's service area
- Add or loss of Employer Group Health Coverage
- Involuntary loss of creditable coverage
- Change in income assistance status, including those who are dual eligible
- Beneficiary moves into or out of a long-term care institution
- CMS or State auto-assignment

A beneficiary's SEP ends when the beneficiary has made an election, or the time frame determined by CMS has ended. The effective date of coverage begins on the first of the month following the election

Enrollment and Disenrollment

SEP for Dual-eligible Individuals and Other LIS-Eligible Individuals

There is a SEP for individuals who have Medicare Part A and Part B and receive any type of assistance from the Medicaid program. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid and individuals who qualify for LIS. This SEP begins the month the individual becomes eligible and exists as long as he or she receives Medicaid benefits or LIS; however there are limits to how often it can be used. This SEP allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods:

January – March,
April – June, and
July – September

Note: It may not be used in the 4th quarter of the year (Oct – Dec) and the effective date of an enrollment request made using this SEP is the first of the month following receipt of an enrollment request.

Enrollment and Disenrollment

Limitation of Dual-Eligible/LIS SEP for "At-Risk" and "Potential At-Risk" Beneficiaries

An individual can be identified by an MA-PD plan as a "potential at-risk" or "at-risk" beneficiary for prescription drug overutilization and can be barred from using the SEP for Dual-Eligible Individuals and Other LIS-Eligible Individuals. The plan must send a written notice to the individual stating that the individual cannot use this SEP to change plans while this designation is in place. The plan can evaluate and remove the designation of "potential at-risk" or "at-risk" if the plan determines that the beneficiary no longer meets the criteria.

Enrollment and Disenrollment

5-Star Special Enrollment Period

MA Plans with 5 stars will have a Special Enrollment Period all year. This will allow MA Plans with 5 Stars to accept enrollment for members throughout the year, and not just during the Annual Enrollment Period. The plan's Star Rating is reviewed each year and results are available each fall.

Enrollment and Disenrollment

Medicare Advantage Open Enrollment Period (OEP)

During the Medicare Advantage Open Enrollment Period (MA OEP), MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP.

For Individuals enrolled in MA plans as of January 1st, the OEP occurs January 1st – March 31st. For New Medicare beneficiaries who are enrolled in an MA plan during their ICEP, the OEP also occurs from the month of entitlement to Part A and Part B – the last day of the 3rd month of entitlement.

Individuals may add or drop Part D coverage during the MA OEP. Individuals enrolled in either MA-PD or MA-only plans can switch to:

- MA-PD
- MA-only
- Original Medicare (with or without a stand-alone Part D plan

Enrollment and Disenrollment

Medicare Advantage Open Enrollment Period (OEP) - continued

The effective date for an MA OEP election is the **first of the month** following receipt of the enrollment request.
The MA OEP does not provide an opportunity for an individual enrolled in Original Medicare to join a MA plan. It also does not allow for Part D changes for individuals enrolled in Original Medicare, including those enrolled in stand-alone Part D plans. The MA OEP is not available for those enrolled in Medicare Savings Accounts or other Medicare health plan types (such as cost plans or PACE).

Enrollment and Disenrollment

Late Enrollment Penalty (LEP)

If a beneficiary misses their ICEP (Part B) or their IEP for Part D (Part D), they must wait until the next AEP or have a SEP to enroll in a Part B or Part D plan. The Late Enrollment Penalty (LEP) for both Part B and Part D are similar. Both penalties are applied when a member chooses to delay enrollment for Medicare coverage and will apply as long as the member has coverage.

Part B LEP: Eligible individuals who delayed enrollment into Part B will be assessed an LEP of 10% for each 12 months that an individual could have enrolled in Part B but did not during their ICEP.

Part D LEP: Eligible individuals not covered under a medication plan with creditable coverage will have an LEP of 1% per month for each month enrollment in Part D was delayed during their Part D IEP. This penalty does not apply to any beneficiaries receiving assistance, such as Medicaid.

**if the group has 20 or more employees, under 20 they need to pick up Part B and Medicare is primary*

Note: LEPs do not apply if the member has a SEP. Members who are covered under an Employer Group health plan are not required to enroll in Part B when they turn 65 and are not required to enroll in Part D if they have creditable prescription drug coverage.*

Enrollment and Disenrollment

Voluntary Disenrollment

Voluntary Disenrollment is the member's choice to disenroll. Members may request disenrollment from an MA plan only during one of the election periods outlined earlier in this course.
As long as a member wants to continue their Part C and Part D coverage, they should **not** disenroll from Part B.
MA, MA-PD, or PDP Plans: When a member is enrolled in a Part C or D plan, and enrolls in another plan, the individual is automatically disenrolled from the first plan upon CMS's approval of the enrollment. The beneficiary does not need to contact their first MA plan to notify them of their disenrollment.
Non-MA plans: Beneficiaries with a Medigap plan should not disenroll from their current plan until they have received the confirmation letter from the Part C or Part D plan. Waiting until the approval is official ensures the beneficiary will not be without coverage.

Enrollment and Disenrollment

Involuntary Disenrollment

Involuntary Disenrollment occurs when a member does not choose to disenroll, but they are disenrolled for various reasons, including:

- A change in residence which makes the individual ineligible to remain enrolled
- The member loses entitlement to either Medicare Part A or Part B
- Premiums are not paid on a timely basis
- The member engages in disruptive behavior
- The member provides fraudulent information on an enrollment request.

Module 3: Communications and Marketing Requirements & other regulations

Communication, Marketing, and Other Regulations

- Sets forth general standards for plan communications, materials and activities
- Examples of what plans may and may not do, and how plans must conduct marketing
- Establishes rules for plan contact with Medicare beneficiaries and requirements plans must follow for activities in a healthcare setting
- Consolidates the requirements regarding agents, brokers and compensation to third parties.

Source: CMS Memo, MCMG, Final Technical Rule

Regulations and Requirements

HIPAA Privacy

As an Agent or Broker representing MVP Health Care, you will come into contact with both potential and current enrollees and will have access to their personal and medical information. It is imperative that all agents and brokers follow HIPAA – The Health Insurance Portability and Accountability Act - by keeping all potential and current member's protected health information private and confidential.

Regulations and Requirements

Responsibilities Required by MVP

MVP Health Care requires agents to frame its MA plans in a manner that is complete, fair and accurate. All people representing MVP Health Care to the community must abide by all Federal laws, rules, and regulations governing the Medicare program. In addition, they must also abide by New York State and Vermont's insurance laws, rules and regulations. Agents and Brokers are to follow Medicare's marketing guidelines, not New York and/or Vermont's marketing guidelines.

Communications and Marketing Requirements

Communications and Marketing Definitions

Communications means activities and use of materials to provide information to current and prospective enrollees. This means that all activities and materials aimed at prospective and current enrollees, including their caregivers and other decision makers associated with a prospective or current enrollee, are “communications”.

Marketing is a subset of communications and includes activities and use of materials that are conducted by the Plan with the intent to draw a beneficiary's attention to a MA plan or plans and to influence a beneficiary's decision-making process when selecting a MA plan for enrollment or deciding to stay enrolled in a plan. Additionally, marketing contains information about the plan’s benefit structure, cost sharing, measuring or ranking standards, and rewards and incentives. Marketing activities may take place face-to-face, via telephone, mailings, electronic communications, or through various media channels such as TV, websites, or social media.

Communications and Marketing Requirements

Star Ratings

CMS rates MA plans based on "Star Ratings" that range from 1-5 stars. Stars for each plan show how well the plan performs in their service areas, such as detecting and preventing illness, ratings from patients, patient safety, and customer service. Plan sponsors must display their plans' ratings information to current and prospective enrollees by referring them to http://www.medicare.gov, by including it in their enrollment kits, making it available on websites, and upon request.

The following rules apply when referring to Star Ratings:

- References to individual Star Ratings measures must also include references to the contract's overall rating, with equal or greater prominence.
- Must not use an individual underlying category or measure to imply higher overall or summary Star Ratings.
- Any reference to a contract's Star Rating must make it clear that the rating is "___ out of 5 stars."
- Must clearly identify which Star Ratings contract year applies.
- May only market the Star Ratings in the service area in which the Star Rating is applicable.

Communications and Marketing Requirements

Marketing Materials

Marketing materials are made available on MVP's website or contact us for more information

To ensure that beneficiaries receive comprehensive plan information regarding their health care options, CMS requires MA Organizations to disclose certain plan information:

Summary of Benefits is a document that outlines the benefits from each plan from an MA Organization and is used for the beneficiary to compare different plan offerings. Plans must include the Summary of Benefits when providing an enrollment form and upon request.

Provider and Pharmacy Directories are directories of providers and pharmacies that participate in a MA plan's network and must be made available at the time of enrollment and annually afterward.

Evidence of Coverage is the member's contract with the Medicare Advantage plan. It gives details about the plan they are enrolled in and is made available at the time of enrollment and annually afterward.

Part D Formulary is a reference guide for a member's Part D plan and lists drugs covered by the Part D plan and is made available annually.

Annual Notice of Change (ANOC) is a document that highlights premium and benefit changes for a current MA enrollee's plan for the coming plan year. The ANOC must be provided to current plan enrollees no later than September 30th of each year.

Regulations and Requirements

Licensure/Certification

All representatives must be licensed in the state they are selling health insurance in – For MVP, our agents and brokers need to be licensed to sell in New York and/or Vermont. Representatives must be appointed to sell MVP's MA plans and complete MVP's product training annually.

CMS requires the successful completion of an annual MA certification training. Agents and brokers must be certified to receive compensation for MVP Health Care's MA sales. This certification is required to continue to receive commissions on sales from previous years.

For Medicare Products, the individual agent or broker that is selling the product or handling renewals must be licensed and certified. Licensure and certification cannot be held at a 'corporate' level to be used by each individual agent or broker.

Communications and Marketing Requirements

Intent and Content

Communication activities and materials are distinguished from marketing activities and materials based on both intent and content.

Intent – the purpose of marketing activities and materials is to draw a prospective or current enrollee's attention to a plan or group of plans to influence a beneficiary's decision when selecting and enrolling in a plan or deciding to stay in a plan.

Content - marketing activities and materials include:

- Information about benefits or benefits structure;
- Information about premiums and cost sharing;
- Comparisons to other Plans
- Rankings and measurements in reference to other Plans
- Information about Star Ratings

In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience of the activity or material, other information communicated by the activity or material, timing, and other context of the activity or material and is not limited to the stated intent.

Communications and Marketing Requirements

Communications and Marketing – General Rules

- Plans/Part D sponsors cannot market for an upcoming plan year prior to October 1st. Plans/Part D Sponsors are permitted to concurrently market the current year with the prospective year starting on October 1st , provided marketing materials make it clear what plan year is being discussed.
- Plans/Part D sponsors may compare their Plan to another Plan/Part D sponsor, provided the information is accurate, not misleading, and can be supported by the MA organization making the comparison.
- Plans/Part D Sponsors may use the term "free" in conjunction with mandatory, supplemental, and preventative benefits provided at a zero-cost share for all enrollees.
- Plans/Part D Sponsors cannot use the term "free" to describe a $0 premium, any type of reduction in premium, reduction in deductibles or cost sharing, low-income subsidy, or cost sharing pertaining to dual eligible individuals.

Communications and Marketing Requirements

Communications and Marketing – Inappropriate/Prohibited Activities

- Plans/Part D sponsors may not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location.
- Plans/Part D sponsors may not target potential enrollees from higher income areas, state or imply that plans are only available to seniors rather than to all Medicare beneficiaries, or state or imply that plans are only available to Medicaid beneficiaries unless the plan is a Dual Eligible Special Needs Plan (D-SNP) or Medicare-Medicaid Plan (MMP).
    - *Only Special Needs Plans (SNPs) and MMPs may limit enrollments to individuals meeting eligibility requirements based on health and/or other status; such limitations must be consistent with the scope of their contracts with CMS.*

Communications and Marketing Requirements

Communications and Marketing – Inappropriate/Prohibited Activities

- Representatives must **not** practice discriminatory marketing or "cherry picking". Examples of cherry picking include but are not limited to steering members to health plans based on health issues, race, or age. It can also include targeting high income parts of a plan's service area, focusing sales campaigns only on healthy beneficiaries, and conducting health screenings of potential members.
- Providing cash or monetary rebates to potential members is prohibited. Charitable contributions made on behalf of a potential enrollee, gift certificates and gift cards that can readily be converted to cash are also prohibited.
- Representatives may not state that an MA plan is endorsed by CMS, Medicare, or the Department of Health and Human Services.
- Use absolute superlatives, such as "the best," "highest ranked," "rated number 1" or qualified superlatives such as "one of the best," "among the highest rank" are prohibited, unless they are substantiated with supporting data provided to CMS as a part of the marketing review processes

Communications and Marketing Requirements

Inappropriate/Prohibited Marketing Activities – Making Unsolicited Contact

Plan representatives may make unsolicited direct contact with potential enrollees using the following methods:

- Conventional mail and other print media (e.g., advertisements, direct mail)
- Email provided all emails contain an opt-out function

Plan representatives may not:

- Use door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence;
- Approach potential enrollees in common areas (e.g., parking lots, hallways, lobbies, sidewalks, etc.); or
- Use telephonic solicitation, including leaving electronic voicemail messages.
- Send direct messages from social media platforms

Note: when agents/brokers pre-schedule appointments with a potential enrollee and are a "no-show" they may leave information at potential enrollee's residence. If a potential enrollee provides permission to be contacted, the contact must be event-specific, and not treated as open-ended permission for future contacts.

Communications and Marketing Requirements

Prohibited Telephonic Activities

Plan Representatives may not conduct telephonic activities that include, but are not limited to, the following:

- Unsolicited calls about other business as a means of generating leads for Medicare plans.
- Calls based on referrals. If an individual would like to refer a friend or relative to an agent or Plan/Part D sponsor, the agent or Plan/Part D sponsor may provide contact information such as a business card that the individual could provide to a friend or relative.
- Calls to market plans or products to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling.
- Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call (there must be documentation of permission to be contacted).
- Calls to prospective enrollees to confirm receipt of mailed information.

Note: Calls are not considered unsolicited if the beneficiary provides consent or initiates contact with the plan. For example, returning phone calls or calling an individual who has completed a business reply card requesting contact is not considered unsolicited.

Communications and Marketing Requirements

Consequences of Engaging in Inappropriate or Prohibited Marketing Activities

All people marketing for MVP are contractually obligated to conform to all federal laws, rules, and regulations. This obedience guarantees beneficiaries do not receive misleading information. CMS or other federal agencies can impose criminal, civil, and/or monetary damages on specific individuals and/or MVP.
Some examples of consequences include:

- Termination of enrollment and/or marketing activities
- Termination of agent found to be engaging in inappropriate activities
- Suspension of payment to MVP
- Punitive damages to MVP and/or agent
- Forfeiture of agent's future commission

If any of the above penalties are directly attributed to the agent's actions, MVP could be found harmless, and all penalties could be directed to the individual agent. Any sanctions would remain in effect until CMS is satisfied that the deficiencies have been corrected and safeguards have been implemented to avoid future reoccurrences.

*Plans/Part D sponsors must report the termination of any agents/brokers to the State and CMS, and the reasons for the termination, if State law requires the reasons to be reported.

Communications and Marketing Requirements

Marketing/Sales Events and Appropriate Promotion

Marketing/Sales Events are designed to steer or attempt to steer potential enrollees, or the retention of current enrollees, toward a plan or limited set of plans. The following requirements apply to all marketing/sales events:

- Plans/Part D sponsors must submit talking points, if applicable, and presentations to CMS prior to use, including those to be used by agents/brokers;
- Sign in sheets must clearly be labeled as optional;
- Health screenings or other activities that may be perceived as, or used for, "cherry picking" are not permitted;
- Plans/Part D sponsors may not require attendees to provide contact information as a prerequisite for attending an event; and
- Contact information provided for raffles or drawings may only be used for that purpose.

Communications and Marketing Requirements

Sales Events – Do's

At sales events plan sponsors may:
•Accept and perform enrollments
•Provide a nominal gift to attendees with no obligation
•Give a sales presentation
•Distribute applications
•Collect applications
At sales events plan sponsors must:
•Announce all plan and product types that will be covered during the presentation at the beginning of that presentation
•Submit all sales scripts and presentations for approval to CMS prior to their use during the marketing/sales event
•Give appropriate notice for all cancelled events

Sales Events – Don'ts

At sales events plan sponsors may not :

- Provide or subsidize meals. Plan Sponsors may provide refreshments and light snacks.
- Solicit enrollment applications prior to the start of the Annual Election Period (Oct 15th)
- Require potential enrollees to submit personal information, such as contact information, as a prerequisite to attend plan marketing events
- Provide gifts over the $15 limit
- Give away items that are considered a health benefit, such as a free checkup
- Structuring marketing events to steer enrollees to particular providers, practitioners, or suppliers

Communications and Marketing Requirements

Personal/Individual Marketing Appointments

Personal/individual marketing appointments typically take place in the beneficiary's home; however, these appointments can also take place in other venues such as a library or coffee shop. Appointments must follow the Scope of Appointment guidance. All one-on-one appointments with beneficiaries are considered sales/marketing events.

The Plan representatives <u>may not</u> do the following:

- Discuss plan options that were NOT agreed to by the beneficiary
- Market non-health care related products, such as annuities or life insurance
- Ask a beneficiary for referrals
- Solicit/accept an enrollment application for a January 1st effective date prior to the start of the Annual Election Period, October 15th, unless the beneficiary is entitled to Special Election Period (SEP) or within their initial enrollment period.

Note: phone consultations can be considered a 1-1 appointment

Communications and Marketing Requirements

Scope of Appointment

When conducting marketing activities, a plan representative may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed to.

The plan representative must document the scope of the agreement before the appointment. Distinct lines of plan business include MA, PDP and Cost Plan products.

If a beneficiary requests to discuss other products, the plan representative must document a second scope of appointment for the additional product type to continue the marketing appointment.

The documentation may be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement. Any technology (e.g., conference calls, fax machines, designated recording line, pre-paid envelopes, and email) can be used to document the scope of appointment.

Communications and Marketing Requirements

Scope of Appointment Cont.

Plans/Part D Sponsors are expected to include the following when documenting the Scope of Appointment:

- Product type (ex. MA, PDP) that the beneficiary has agreed to discuss during the appointment
- Date of appointment
- Beneficiary contact information
- Signature or verbal documentation of agreement (beneficiary or authorized representative)
- Agent information and signature
- A statement that beneficiaries are not obligated to enroll in a plan; their current or future Medicare enrollment status will not be impacted and clearly explain that the beneficiary is not automatically enrolled in the plan(s) discussed

Communications and Marketing Requirements

Personal/Individual Marketing Appointments

All agents and brokers will be required to record all individual marketing and sales Medicare Advantage and Part D **calls**

Communications and Marketing Requirements

Personal/Individual Marketing Appointments

TPMO (third-party marketing organization) Disclaimer

CMS now requires the following disclaimer from TPMOs

"We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."

TPMOs will be required to include this disclaimer:

- Verbally provided within the first minute of a phone call
- Electronically when communicating with a beneficiary through email, online chat, ir other electronic means of communication
- Prominently display the disclaimer on their website and marketing materials, including all print materials and television advertisements

Communications and Marketing Requirements

Educational Events

Educational events are designed to inform beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs. Educational events:

- Must be advertised as educational and hosted in a public venue by the Plan/Part D sponsor or an outside entity
- May include communication activities and distribution of communication materials
- May answer beneficiary-initiated questions
- May set up a future marketing appointment and distribute business cards and contact information for beneficiaries to initiate contact
- Must **not** include marketing or sales activities or distribution of marketing materials or enrollment forms – no materials or discussion about plan specific premiums or benefits
- Meals, snacks, or refreshments may be provided at educational events

Communications and Marketing Requirements

If a marketing event directly follows an educational event, the beneficiary must be made aware of the change and given the opportunity to leave prior to the marketing event beginning.

Communications and Marketing Requirements

Promotional Activities and Nominal Gifts

Promotional activities and nominal gifts are designed to attract the attention of prospective enrollees and encourage retention of current enrollees.
Promotional activities or nominal gifts offered by Plans:

- Must be offered to all people regardless of enrollment and without discrimination
- Must have only nominal value of no more than $15 and have an aggregate cap of $75 per year
- Must not be in the form of cash or other monetary rebates, even if their worth is $15 or less. Cash gifts include charitable contributions made on behalf of potential enrollees, and those gift certificates and gift cards that can be readily converted to cash, regardless of dollar amount.
- Must not be in the form of meals at marketing events. Snacks and light refreshments are permitted. Snacks cannot be bundled to create a "meal". Meals are permitted at educational events.

If a nominal gift is a chance to receive one large gift or a communal experience (concert, raffle, drawing), the total fair market value must not exceed the nominal per person value based on anticipated attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than $150 ($15 for each of the 10 anticipated attendees). Anticipated attendance must be based on venue size, response rate, and/or advertisement circulation.

Communications and Marketing Requirements

Cross-Selling Health and Non-Health Care Related Products

Cross-selling is defined as marketing non-health related products, such as life insurance and annuities, during a marketing event. It is also considered cross-selling to include enrollment applications for competing health-care related products, such as MA-PD or MA plans and Medigap products, or for other non-Medicare health plans, in mailings that combine Medicare plan information with other product information. CMS strictly prohibits cross-selling.

Communications and Marketing Requirements

Marketing during the Open Enrollment Period (OEP) – January 1st – March 31st

During the OEP, Plans/Part D sponsors may:

- Conduct marketing activities that focus on other enrollment opportunities including but not limited to:
    - Marketing to age-ins (who have not yet made an enrollment decision),
    - 5-star plans marketing the continuous enrollment SEP, and
    - Marketing to dual-eligible and LIS beneficiaries who, in general may make changes once per calendar quarter during the first nine months of the year.
- Send marketing materials when a beneficiary makes a proactive request, have one-on-one meetings with a sales agent at the beneficiary's request, and provide information on the OEP through the call center at the beneficiary's request
- Include educational information about OEP, excluding marketing, on the MA organization's website.

Communications and Marketing Requirements

Marketing during the Open Enrollment Period (OEP) – January 1st – March 31st

During the OEP, Plans/Part D Sponsors may not:

- Send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the OEP
- Specifically target beneficiaries who are in the OEP because they made a choice during Annual Enrollment Period (AEP) - purchase of mailing lists or other means of identification to target these beneficiaries is prohibited
- Engage in or promote agent/broker activities that intend to target the OEP as an opportunity to make further sales
- Call or otherwise contact former enrollees who have selected a new plan during the AEP

Communications and Marketing Requirements

Marketing during the Open Enrollment Period (OEP) – January 1st – March 31st

Plans/Part D sponsors are prohibited from knowingly targeting or sending unsolicited marketing materials to any MA enrollee or Part D enrollee during the continuous Open Enrollment Period (OEP) (January 1 to March 31). “Knowingly” takes into account the intended recipient as well as the content of the message.

Communications and Marketing Requirements

Referrals and Soliciting Leads from Members

The following guidelines apply to referral programs under which a plan sponsor solicits leads from new members for new enrollees:

- A plan sponsor can ask for referrals from active members, including names and addresses, but cannot request phone numbers. Plan sponsors may use member provided referral names and mailing addresses to solicit potential new members by mail only.
- Any solicitation for leads, including letters sent from plan sponsors to members cannot announce that a gift will be offered for a referral.
- Plan sponsors may not use cash promotions as part of a referral program.
- Plan sponsors may offer thank you gifts provided that they're each individually worth $15 or less.

- MAY ask for referrals from enrollees/members – names, mailing addresses, email address ONLY – all emails MUST have opt-out feature in every communication
- MAY solicit potential new members by conventional mail & email

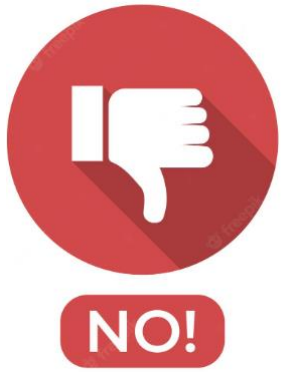
Communications and Marketing Requirements

Marketing in the Health Care Setting

Plans may not conduct marketing activities in healthcare settings except in common areas.

Hospital or nursing home cafeterias, community or recreational rooms, conference rooms, common entryways, vestibules, and waiting rooms.

Plans are prohibited from marketing to Medicare beneficiaries in areas where patients primarily receive health care services or are waiting to receive health care services.



Waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas, and pharmacy counter areas

Communications and Marketing Requirements

Marketing in the Health Care Setting

If a pharmacy counter area 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/Part D Sponsors are only permitted to schedule appointments with beneficiaries residing in long-term care facilities including nursing homes, assisted living facilities, and board and care homes upon request by the beneficiary. If a resident did not request an appointment, any visit by an agent or broker is considered unsolicited door-to-door marketing.

Communications and Marketing Requirements

Agent/Broker Compensation – Compensation Eligibility

All compensation requirements contained in this section apply to independent agents/brokers. Agents/brokers employed by a Plan/Part D Sponsor are exempt from compensation requirements. Referral fees, however, apply to everyone. All other marketing and sales requirements must be met.

Communications and Marketing Requirements

Agent/Broker Compensation – Compensation Eligibility

- Plans must ensure that all agents and brokers selling Medicare products are trained and tested annually on Medicare rules, regulations, and on details specific to the plan products that they sell. Training and testing must take place prior to the agent or broker selling the product. Agents and brokers must obtain a passing score of at least eighty-five percent on the test. Agents and Brokers are not eligible for compensation unless they complete and pass the required training and testing.
- Plans may not pay compensation to agents and brokers not meeting licensure and appointment requirements or those that have been terminated for cause.

If Plans use licensed agents and/or brokers as customer service representatives, they cannot act as both a customer service representative and a sales/marketing agent and/or broker.

Communications and Marketing Requirements

Agent/Broker Compensation – Definition of Compensation

Compensation includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and referral/finder's fees.

Compensation **does not** include:

- The payment of fees to comply with State appointment laws
- Training
- Certification
- Testing costs
- Reimbursement for mileage to, and from, appointments with beneficiaries
- Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials

Annually, CMS releases it's Fair Market Value (FMV) cut-offs for Agent/Broker compensation. These cut-offs are the maximum a plan can pay for initial and renewal compensation.

Communications and Marketing Requirements

Compensation Types

Initial Compensation is paid for the beneficiary's first year of enrollment and when a beneficiary enrolls in an "unlike plan type," like from an MA-PD to a Cost plan, if the beneficiary is currently in a renewal year. Initial compensation may be paid at or below the fair market value (FMV) cut-off amounts published by CMS annually.

Renewal Compensation is paid following the initial year compensation, or when a beneficiary enrollees in a new, "like plan type." (MA-PD to MA-PD). A new "like plan type" may be a change from one plan to another plan within the same Parent Organization or between different Parent Organizations. Renewal compensation may be paid up to fifty (50) percent of the current FMV.

Referral/Finder's Fees are paid to all agents and brokers and may not exceed $100 ($25 for PDPs) for an agent or broker to recommend or enroll a beneficiary into a Plan/Part D Sponsor that meets beneficiaries' healthcare needs. Referral/finder's fees paid to all agents and brokers must be part of total compensation not to exceed FMV for that contract year.

Communications and Marketing Requirements

Agent/Broker Compensation – Definition of “like plan type” and “unlike plan type”

Like Plan Type - (i) PDP replaced with another PDP. (ii) MA or MA-PD replaced with another MA or MA-PD. (iii) Cost plan replaced with another cost plan.

Unlike Plan Type - (i) An MA or, MA-PD plan to a PDP or Section 1876 Cost Plan. (ii) A PDP to a Section 1876 Cost Plan or an MA or MA-PD plan. (iii) A Section 1876 Cost Plan to an MA or MA-PD plan or PDP.

Communications and Marketing Requirements

Agent/Broker Compensation – Guidance on Compensation Payments

- The compensation year is **January 1st through December 31st**, regardless of the month the beneficiary enrolls in their plan.
- Initial compensation is paid either the full amount, or is pro-rated, depending on the beneficiary enrollment date.
- Payment must be pro-rated for mid-year renewals.
- Recoupment of compensation must occur for the months a member is not in a plan.

Communications and Marketing Requirements

Agent/Broker Compensation – Guidance on Compensation Payments - continued

Rapid disenrollment means the member disenrolled from the plan within the first three months of enrollment. Additionally, rapid disenrollment compensation recovery applies when a beneficiary uses OEP to make an enrollment change. Rapid disenrollment compensation recovery does not apply when a beneficiary enrolls in a plan effective October 1, November 1, or December 1, and uses the Annual Election Period to make changes to their current plan for an effective date of January 1 of the following year. If a beneficiary enrolls for October 1, November 1 or December 1 and disenrolls from the plan unrelated to the AEP, the Plan/Part D Sponsor should recover compensation based on the rapid disenrollment. Rapid disenrollment compensation recovery does not apply when CMS determines that recoupment is not in the best interests of the Medicare program.

Knowledge Check

Test Your Knowledge!

Congratulations – you've completed MVP's 2023 Medicare Basics Training for **Agents/Brokers**

You must take the knowledge check and score an **85% or better** to pass - you will be allowed multiple attempts to pass. You will receive a score upon completion of the exam. MVP Health Care will also receive a copy of your score upon your completion.

Thank you.

We appreciate you for completing this 2023 certification training and for being a valuable partner.