MVP Health Care Medicare Advantage Training

2024 Medicare Basics Certification Program

July 2023

Agenda

- Medicare Basics
  - Overview of Medicare
  - Eligibility Requirements
  - Options for Receiving Medicare
- Enrollment and Disenrollment Guidelines
- Communication and Marketing Requirements
- Agent and Broker Compensation

Medicare Basics:
Overview of Medicare

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 –**Medicare Advantage (MA)
- **Part D –**Prescription Drug Coverage

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 Parts and Covered Services

Part A

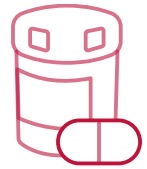
Covers hospital stays and inpatient services

Part B

Covers doctor visits, outpatient care, and preventive services

Part C

Refers to Medicare Advantage plans—and includes Part A and B,
and often Part D



Part D

Provides prescription drug coverage

Original Medicare

Medicare Advantage

Prescription Drug Coverage

Medicare Part A

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 Part B

Medicare Part B is also known as **Medical Insurance.**

Part B 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

Medicare Part C

Medicare Part C is also known as **Medicare Advantage (MA).**

MA plans are 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.

Must have the same or better benefits than Original Medicare.

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.

Medicare Part D

Medicare Part D is **prescription drug coverage.**

Part D provides coverage for basic and catastrophic non-Part B prescription drug costs.

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.

Medicare Basics: **Eligibility Requirements and Premiums**

Medicare Part A – Eligibility

To be eligible for Part A:

- 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 Part A – Premium Information

Most people don’t have to pay a monthly premium for Part A.

- *If they (or a spouse) paid Medicare taxes for **at least 40 quarters (10 years)** while they were working.*

Additional ways to 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 Part B – Eligibility & Premiums

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.

Monthly premiums are set each year by the Federal government and can be deducted directly from your Social Security check.

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 Part C- Eligibility and Premiums

Eligibility:

- 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.

Premiums:

- Each MA Plan has different premium amounts.
- Premiums are paid directly to the private insurer.
- MA plan premiums are in additional to Part A and Part B premiums.

Medicare Part D – Eligibility and Premiums

To be eligible for Part D, individuals can be enrolled in Part A ***or*** Part B.

Part D plans are provided through private insurance companies.

- Monthly premiums vary between plans

PDPs and MA-PDs can only offer equivalent or better coverage than the CMS Standard Medicare Part D benefit.

Creditable Coverage is prescription drug coverage that is at least equal to the benefits provided by the CMS Standard Medicare Part D benefit.

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.

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.

SPAPs help pay for Part D:

- Premium
- Deductible
- Copayments & coinsurance

New York: Elderly Pharmaceutical Insurance Coverage (EPIC)

Vermont: VPHARM

Not all states have a SPAP.

Part D – Cost Sharing Subsidies for Low-Income Individuals

LIS (low-income subsidy) or "Extra Help"

Medicare program to help people with limited income and resources pay for Medicare prescription drug costs:

- 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.

Section 1876 Cost Plans

Overview:
Section 1876 Cost Plans are Medicare plans offered by private insurers that contract with the federal government.

These plans are **not** Medicare Advantage plans.

May provide additional coverage and benefits to Original Medicare:

- Dental
- Vision
- Hearing

Beneficiaries keep their Medicare Part A and/or Part B coverage, but also have access to a network of providers through the Cost plan.

Cost plans pay for services outside their service area **only** if there is an emergency or urgently needed services.

- Routine services outside the plan's network area will get their Medicare covered services paid by Original Medicare

Section 1876 Cost Plans

Eligibility:

- Qualify for Medicare Part A and are enrolled in Part B; in some cases, you may only need to be enrolled in Part B.
- You're either a U.S. citizen or a lawful resident of the U.S.
- You live in the county where you'll be signing up for the Cost plan.

Premium Information:

- Members may have to pay a premium for a 1876 Cost Plan.

MVP does not offer any form of Cost Plan.

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

PACE is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.

PACE provides comprehensive medical and social services to certain frail, elderly people still living in the community.

An interdisciplinary team assesses an enrollee's needs, develops care plans, and delivers all services.

Enrollment in the PACE program is voluntary and enrollment continues as long as desired by the individual.

PACE Eligibility

If you have Medicaid, you won't pay a monthly premium for the long-term care portion of the PACE benefit.

If you don't qualify for Medicaid but you have Medicare, you'll pay:

- A monthly premium to cover the long-term care portion of the PACE benefit
- A premium for Medicare Part D drugs
- There's no deductible or copayment for any drug, service, or care approved by your health care team. If you don't have Medicare or Medicaid, you can pay for PACE yourself

A person enrolled in PACE is not eligible for a MA plan or a Medigap plan.

Medigap

Medigap plans, also known as Medicare Supplement Insurance.

Sold by private insurance companies.

Work with Original Medicare to help pay some of the health care costs, or “gaps”, that Original Medicare doesn’t cover.

- Copayments & coinsurance
- Deductibles

Medigap coverage enhances Original Medicare’s benefits.

Medigap

Must have Part A and Part B.

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*

MVP does not offer Medigap plans

Medicare Basics: **Options for Receiving Medicare**

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)
- Medicare Advantage-Prescription Drug plan (MA-PD)
- Medicare Advantage (MA) plan or Cost Plan without a PDP
- Cost Plan with a stand-alone PDP
- Private Fee-for-Service
- MSA plan, with or without a PDP

Original Medicare

Medicare Part A and Part B only.

May be responsible for a deductible and 20% co-insurance for some covered medical services.

See any doctor in the U.S. that accepts Medicare.

Does not cover benefits such as dental care, vision exams, hearing aids, or international travel.

Prescription drugs are **not** covered.

- A separate Part D plan or creditable coverage is needed to avoid penalties

Has **no maximum out-of-pocket costs.**

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

Appeals and Grievances

Medicare beneficiaries have the right to file an appeal and grievance.

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.

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.

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.

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.

Private Fee-for-Service Plans (PFFS)

A Private Fee-For-Service (PFFS) plan is a Medicare Advantage (MA) health plan.

PFFS plans have no network.

Provide Medicare benefits, plus any additional benefits the company decides to provide.

Beneficiaries can see any provider who is eligible to receive payment from Medicare and agrees to accept payment from the PFFS Medicare Advantage Organization.

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.

Dual-Eligible Special Needs Plans (D-SNP)

Coordination-Only D-SNPs-provide Medicare-covered services and are required to coordinate the delivery of benefits with the Medicaid program, contract with state Medicaid programs, and notify states when enrollees are admitted to inpatient facilities.

Fully Integrated D-SNP (FIDE)-provide coverage of Medicare and Medicaid benefits under a single legal entity that holds both: an MA contract with CMS; and a contract with the state Medicaid agency that meets the requirements of a managed care organization

Highly Integrated D-SNPs (HIDE)-provide coverage of Medicaid benefits (through the DSNP or an affiliated Medicaid managed care plan), including coverage of LTSS, behavioral health benefits, or both

Medical Savings Account - MSA

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 gives the plan an amount of money each year that is deposited into a MSA account to be used for Medicare covered costs.

No monthly plan premium.

Do not offer Part D coverage.

Generally, do not have a network of health care providers.

Benefits and Beneficiary Protections

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

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

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.

Supplemental Benefits

A supplemental benefit is an item or service covered by a Medicare Advantage Plan that is not covered by Original Medicare.

Common supplemental benefits:

- Dental
- Vision
- Hearing aids
- Gym memberships

Supplemental Benefits

Most supplemental benefits must be primarily health-related. These benefits can either be:

- **Optional** - meaning that they are offered to everyone who is enrolled in a plan, and you can choose to purchase the benefits if you want to
- **Mandatory** - meaning that they are covered for everyone enrolled in a plan and you cannot decline the coverage (even if you do not need to use the service)

Out of Pocket Costs

Premium - The amount paid for health insurance every month.

Coinsurance - amount required to pay for the share of the cost for services. Coinsurance is usually a percentage.

Copayment - amount required to pay as the share of the cost for services. A copayment is usually a set amount, rather than a percentage.

Deductible –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.

Maximum Out of Pocket (MOOP) Limits

MA plans have an MOOP limit to help protect members from catastrophic medical expenses.

The MOOP max limits how much a member must pay in copays, coinsurance, and deductibles before the plan will pick up 100% of covered expenses.

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

Network Requirements

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 and Out of Network Providers

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: **Part D**

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 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.

For 2024, the Medicare Part D Standard Benefit is:

- Deductible - $545
- Coinsurance – 25% on all drugs after deductible is met, up to the Initial Coverage limit
- Initial Coverage Limit - $5,030 – 25% coinsurance on generic drugs and brand name drugs in coverage gap
- Out-Of-Pocket Cost Threshold - $8,000 - once this has been reached – **cost sharing for Part D drugs will be eliminated**

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 $5,030.

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 $8,000 annually. This is called True Out of Pocket, or TrOOP.**

Catastrophic Coverage Stage – After TrOOP reaches $8,000, beneficiaries are considered to be in the Catastrophic Coverage Stage. **Beginning in 2024, cost-sharing for Part D drugs will be eliminated for beneficiaries in the catastrophic phase of coverage**

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.

Medicare contracted Brand Name Drugs will have a 70% manufacturer's discount while in the coverage gap.

2024 Inflation Reduction Act

Catastrophic Coverage - cost-sharing for Part D drugs will be eliminated for beneficiaries in the catastrophic phase of coverage.

Vaccines - Part D plans must not apply the deductible to an adult vaccine recommended by the Advisory Committee on Immunization Practices and must charge no cost-sharing at any point in the benefit for such vaccines.

Insulin - Part D plans must not apply the deductible to any Part D covered insulin product and must charge no more than $35 per month's supply of a covered insulin product in the initial coverage phase and the coverage gap phase.

Low-Income Subsidy -will be expanded so that beneficiaries who earn between 135 and 150 percent of the federal poverty level and meet statutory resource limit requirements will receive the full LIS subsidies that were prior to 2024 only available to beneficiaries earning less than 135 percent of the federal poverty level.

Pharmacy Networks

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 an emergency situation when an in-network pharmacy is not available.

Medicare Basics: **Other Plan Types**

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.

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

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.

MA organizations have the option to accept enrollment requests using an online enrollment form as well as enrollment via telephone.

Enrollment Procedures

Short Enrollment Form

CMS has developed a model short enrollment form and a model plan selection form.

This allows 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.

Simplified (Opt-In) Enrollment Mechanism

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.

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

Recording

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

Pre-Enrollment Checklist

Plans must include the Standardized Pre-Enrollment Checklist:

Understanding the Benefits:

- Review full list of benefits found in the Evidence of Coverage (EOC)
- Review Provider Directory
- Review Pharmacy Directory
- Review Part D Formulary

Pre-Enrollment Checklist

Plans must include the Standardized Pre-Enrollment Checklist

Understanding Important Rules:

Continue to pay Part B premium in addition to plan premium.

Benefits, premiums, copayments, coinsurance may change in the new plan year.

You may see providers outside of our network (non-contracted providers), however, you may pay a higher co-payment or co-insurance for services received by non-contracted providers.

Out-of-network services for non-contracted providers are limited for HMO-POS plans. PPO members can utilize non-contracted providers.

Urgent and emergent services are covered worldwide across all plans.

Effect on your current coverage—your current health care coverage will end once your new Medicare coverage starts.

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.

Processing Enrollment Requests – Notifications

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

The packet includes important materials like:

- Formulary (if the plan sends it)
- Member Handbook
- 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.

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: **Part C and D Enrollment Periods**

Initial Coverage Election Period (ICEP)

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.

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.

MA Open Enrollment Periods (MA-OP)

Newly Eligible MA-OP

- Available for three months following the MA plan start date
- Switch to a different MA Plan
- Drop to Original Medicare and join a Part D plan
- Can use **once** during the three-month timeframe

Annual MA-OP

- January 1st-March 31st
- Switch to a different MA Plan
- Drop to Original Medicare and join a Part D plan
- Can use **once** during the three-month timeframe

MA Open Enrollment Periods (MA-OP)

What MA Plans May Do

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

MA Open Enrollment Periods (MA-OP)

What MA Plans May NOT Do

- 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

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.

Special Enrollment Period (SEP)

You can only join a Medicare Advantage Plan (Part C) or Medicare drug plan (Part D) during certain times.

Medicare provides a Special Enrollment Period (SEP) for enrolling when certain events happen in your life.

SEPs can happen throughout the year, outside of the Annual Enrollment Period.

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

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.

Dual-eligible/LIS Status SEP

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 SEP begins the month the individual becomes eligible and exists as long as they receive Medicaid benefits or LIS.

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
- 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.

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.

Additional Common SEPs

- Eligible for SPAP
- Lose SPAP eligibility
- Change in permanent residence
- Leaving employer group coverage

Section 1876 Cost Plan Open Enrollment

The general requirements for open enrollment are that the cost plan:

- Hold an annual open enrollment period of at least 30 or more consecutive days for Medicare beneficiaries.
- Publicize its upcoming enrollment period in appropriate media throughout the service area
  - (this requirement does not apply for Cost Plans that are continuously open for enrollment).
- Enroll Medicare beneficiaries on a first come, first serve basis.

Enrollment and Disenrollment: **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.

Voluntary Disenrollment

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.

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

Communication and Marketing Requirements: **Agent and Broker Responsibilities**

HIPAA Privacy

HIPAA – The Health Insurance Portability and Accountability Act

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 by keeping all potential and current member's protected health information private and confidential.

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.

Communication and Marketing Requirements: **Communication and Marketing Overview**

Communication Definition

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 Definition

Marketing is a subset of communications.

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.

To influence a beneficiary's decision-making process when selecting a MA plan for enrollment or deciding to stay enrolled in a plan.

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.

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.

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:

- Detecting and preventing illness
- Ratings from patients
- Patient safety
- Customer service.

Plan sponsors must display their plans’ ratings information to current and prospective enrollees by referring them to http://www.medicare.gov or by including it in their enrollment kits, making it available on websites, and upon request.

Rules 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.

Marketing Materials

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.

Communication and Marketing Requirements: **Standards for Communication and Marketing**

Inappropriate/Prohibited Activities

Communication and Marketing Activities

- Conducting health screenings at marketing events
- Providing cash or monetary rebates
- Unsolicited contact with beneficiaries
- Comparing plan to other plans (requirement and restriction)
  - Unless the information is accurate and not misleading
- Displaying names or logos or both of provider co-branding partners (requirement and restrictions)
- Failure to record all sales and enrollment-related telephonic contact

Potential Consequences

Potential Consequences of Engaging in Inappropriate or Prohibited Communication and 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.

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.

Potential Consequences

Potential Consequences of Engaging in Inappropriate or Prohibited Communication and Marketing Activities

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.

Marketing/Sales Events

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
- Contact information provided for raffles or drawings may only be used for that purpose

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

Communication and Marketing Requirements: **Personal/Individual Marketing Appointments**

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.

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

Personal/Individual Marketing Appointments

The Plan representatives may not 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.

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.

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.

Scope of Appointment

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

TPMO Disclaimer

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, or other electronic means of communication
- Prominently display the disclaimer on their website and marketing materials, including all print materials and television advertisements

Individual Sales Appointments – Do's

Comply with Medicare marketing guidelines.

Submit talking points and presentation to CMS prior to use.

Complete and execute a Scope of Appointment prior to presenting the product.

Individual Sales Appointments – Don’ts

Not discuss options that were NOT agreed to by the beneficiary.

Not market non-health care related products, such as annuities or life insurance.

Not ask the prospect for a referral.

Communication and Marketing Requirements: **Educational Events**

Educational Events

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

- 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.

Educational Events

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.

Communication and Marketing Requirements: **Nominal Gifts**

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

- 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.

Promotional Activities and Nominal Gifts

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.

Communication and Marketing Requirements: **Cross-Selling**

Cross-Selling

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.

Communication and Marketing Requirements: **Unsolicited Contact**

Plan Representatives – Do's

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 – Don’ts

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).
- 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.

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.

Referrals and Soliciting Leads

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.

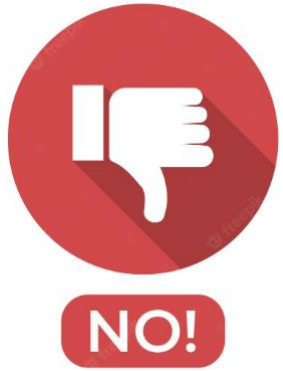
Communication and Marketing Requirements: **Marketing in a Healthcare Facility**

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 (can interact if individual approaches agent, agent cannot approach in waiting room)

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

Activities in Health Care Settings

Examples Include

- Hospitals
- Skilled nursing facilities
- Doctor's offices

Agents May

Interact with prospects while onsite in common areas (cafeterias, conference rooms, common entryways, and waiting rooms)

- Participate in facility events
- Leave plan materials in common areas
- Conduct sales presentations or obtain SOAs in common areas
- Schedule an appointment with a prospect residing in LTC facility (Resident must have requested an appointment)

Activities in Health Care Settings

Pharmacy counter area

If 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.

Long-term care facilities

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.

Communication and Marketing Requirements: **Activities in the Community**

Activities in the Community

Examples Include

- Shopping center or public library
- Parked MVP vehicle in an approved location
- Local gym

Examples of Events:

- Flu-shot clinic at a local senior center
- Health fair to encourage healthy lifestyle practices
- New to Medicare event at senior housing community room

Activities in the Community

Agents May:

- Set up a table or kiosk and provide information.
- Advertise event as educational, if applicable.
- Serve meals, snacks, or refreshments.
- Leave plan communication material and BRCs and SOAs
- Provide giveaways with the plan name/number but no benefit information.
- Answer questions and obtain SOAs for future appointments.
- Include communication activities and distribute communication materials.
- Perform sales activities immediately following the event (beneficiary must be made aware of transition).

Communication and Marketing Requirements: **Agent and Broker Compensation**

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.

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.

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
- Referral/finder's fees

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.

Agent/Broker Compensation

- 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

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.

“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.

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.

Rapid Disenrollment

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.

Test Your Knowledge!

Congratulations – you've completed MVP's 2024 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 2024 certification training and for being a valuable partner.