Basic Training Module 5
Medicare Part C – Advantage Plans
Study Guide

Print this study guide for your reference while proceeding through the module. Feel free to make notes as desired. At the end of the guide, there is space to write questions. If your questions are not answered in future modules, present them to the trainer at the final in-class module. Be sure to bring all study guides to class with you.

Coverage and Costs (3)

Medicare Advantage Plans (MAP) (3.1)

Medicare Path (3.2)

- Late 1990s—laws passed to provide more choices → Part C or Medicare Advantage
- One path at a time—Original Medicare or Medicare Advantage

Coverage (3.3)

- Medicare-approved plans
- Run by private insurance companies
- Several names—Part C, Medicare Advantage (MA), Health Plans, Medicare Advantage with Prescription Drugs (MAPD)
- Plans contracted with Centers for Medicare and Medicaid Services (CMS) to serve beneficiaries within a certain geographic area
- Plan must have network of providers and suppliers
- Beneficiaries in Advantage Plans still have Medicare
- Different membership card used for services

Coverage Continued (3.4)

- **Provides Part A and B Medicare-covered benefits to members**
- **Additional benefits may be offered that Medicare does not cover**
  - Vision
  - Hearing
  - Dental
  - Acupuncture
  - Transportation to medical facility or pharmacy
- **Most include prescription drug coverage**
- **Advantage Plans do not cover Hospice → Original Medicare will cover**
- **Rights, protections, and appeals provided**

Out-of-Pocket Costs (3.5)

- **Members will continue to pay monthly Medicare Part B premium.**
  - Certain plans may cover some or all the Part B premium, reducing the amount members pay
- **May pay monthly plan premium and deductible**
- **May have co-payments or co-insurances for services**
  - Amounts will vary if services provided inside or outside of plan's network
- **Financial Assistance module will explain low-income beneficiaries and balance-billing**

Capitation Rates (3.6)

- **Many Advantage Plans have $0 monthly premiums and low or $0 deductibles**
- **Medicare pays the plan monthly for each beneficiary's health care**
- **Payment known as "capitation rate"**
- **Rates range from $800 - $1200 per enrollee based on geographic area**
- **Explains how plans can offer coverage while charging little to no premium or deductible—already getting paid**

Star Ratings (3.7)

- **Based upon information provided from surveys by beneficiaries, providers, and other health care entities**
- **Based on quality of service, customer service, timeliness**
- **Scaled from 1 (lowest) to 5 (highest)**
- **Higher-ranked plans receive additional payments from Medicare**
  - Influences out-of-pocket costs
  - Reflected in supplemental benefits offered—hearing, dental, vision, reduced premiums

Eligibility Standards (4)

Part C Eligibility (4.2)

- **Available to most people with Medicare**
- **Must be entitled to Part A and enrolled in Part B**
- **Live in the plan's geographic service area**
- **Enroll in a plan (enrollment not automatic)**
- **Cannot have End-Stage Renal Disease (ESRD) at time of enrollment**

Eligibility with End-Stage Renal Disease (ESRD) (4.3)

- **Client develops ESRD while already enrolled in a plan → may stay in plan**
- **Plan leaves Medicare or no longer offers services in client's area → one-time right to join another plan**
- **Client may enroll → received a kidney transplant and no longer requires dialysis**
- **Client with ESRD already receiving benefits from employer group health plan → may enroll in Advantage Plan if offered through same insurance company**
- **Client may enroll in Special Needs Plan (SNP) that accepts those with ESRD if available in service area**

Enrollment (5)

Enrollment Periods (5.2)

- **SHINE Fact Sheet, Medicare Enrollment Periods, illustrates and explains various enrollment periods of Medicare**
  - Used throughout training and for quiz

Trial Right and Medigap (5.3)

- **Trial Right—for beneficiary age 65 or older who enrolls in Medicare Advantage for the very first time**
- **Advantage Plan may be dropped to switch back to Original Medicare anytime within the first 12 months of plan coverage**
- **Guaranteed issue of a Medigap Policy**

Advantage and Medigap (5.4)

- **Option 1—**
  - If beneficiary joined Advantage Plan when first eligible for Medicare at age 65 → may switch back to Original Medicare and select a Medigap Plan from any insurance company
- **Option 2—**
  - If beneficiary dropped a Medigap Plan when joining Advantage for the first time, then wanted to switch back to Original Medicare → may be able to get former Medigap Plan back if still available or buy a Medigap Plan A, B, C, F, G, K, or L
- **Option 3—**
  - If Advantage Plan leaves a service area or is terminated and there is no other plan accepting new enrollees or beneficiary doesn't want to enroll in another plan → guaranteed issue of Medigap Plan A, B, C, F, G, K, or L

Understanding Medicare Part C and D Enrollment Periods (5.5)

- **CMS Publication – *Understanding Medicare Part C & D Enrollment Periods***

Choosing a Plan (5.6)

- **Questions to ask**
  - Are prescription drugs covered?
  - Do my current doctors accept the plan?
  - Do I need to choose a primary care doctor?
  - Will I need a referral to see a specialist?
  - Am I limited to certain providers?
  - Do I live in the plan's service area?
  - Will I lose coverage if I travel outside of the plan's service area for long periods of time?
- **Traveling**
  - Travel outside of Advantage plan's service area continuously for more than 6 months—may be dis-enrolled
  - Some plans provide special benefits up to 12 months that allows client to stay in the plan if travel is in the U.S. or its territories.
  - Other plans may include limited "passport coverage" if travel is outside the area of coverage.
  - Important for beneficiary to know how plan will cover when traveling

Travel Fact Sheet (5.7)

- **"Medicare Coverage When on a Cruise or Traveling"**

Annual Notice of Change (ANOC) (5.8)

- **Also known as ANOC**
- **Must arrive by September 30, prior to Open Enrollment Period (OEP)**
- **Letter must include**
  - Summary of Benefits
  - Copy of formulary for upcoming year
  - Evidence of Coverage—optional inclusion
  - Changes to current plan coverage
    - Monthly premium
    - Co-payments or co-insurance

Consistent Poor Performer (5.9)

- **Advantage Plans must follow strict CMS operating standards and regulations**
- **Poor performance letter sent by CMS to beneficiary**
  - May be sent twice a year (February and October, during OEP)
    - October notice—overall star-rating of less than three stars out of five for at least 3 years
      - *Notifies beneficiary of one-time opportunity to move into a higher rated plan*
    - February notice—specifically sent to beneficiaries who enrolled in consistently poor performing plans during OEP

New Members (5.10)

- **Enrollment letter**
- **Membership materials**
  - Identification card
  - Customer service information
- **Evidence of Coverage sent by January 31**
  - Plan's service area
  - Benefits
  - Formulary
  - How to get information
  - Financial assistance for prescription drugs
  - How to file an appeal

Types of Plans (6)

Types of Advantage Plans (6.2)

- **6 types of plans: Health Maintenance Organization (HMO), Health Maintenance Organization with Point of Service (HMO-POS), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS), Medical Savings Account (MSA), Special Needs Plan (SNP)**

HMO—Health Maintenance Organization (6.3)

- **HMO**
  - Covers all Part A and Part B services through specific network of providers
  - Beneficiary must choose a Primary Care Physician (PCP) and get referrals for specialists
  - Plan sets co-payment or co-insurance amounts
  - "Network"—specific doctors and hospitals who contract with the plan
    - Beneficiary must get care from those in the network
  - Care outside of network
    - Beneficiary may be required to pay directly for services
    - HMO nor Original Medicare will pay for services
- **HMO-POS—HMO with Point-of-Service Option**
  - Can go out-of-network for certain services at a higher cost
- **Emergencies covered if beneficiary out of network**
- **Most plans offer drug coverage**
  - Cannot add a stand-alone drug plan to an HMO

PPO—Preferred Provider Organization (6.4)

- **Beneficiary may see any doctor or provider who accepts Medicare and the plan**
- **Referral not needed to see a specialist or an out-of-network provider**
- **Must cover all services received out-of-network, but beneficiary will pay more for those services**
- **Most plans offer drug coverage**
  - Cannot add a stand-alone drug plan to a PPO

PFFS—Private Fee-for-Service (6.5)

- **Beneficiary may go to any provider who accepts the plan's terms and conditions of payment**
- **Plan may fluctuate how much it pays providers and how much a beneficiary must pay when receiving care**
- **Some plans contract with a network of providers who will always treat new patients enrolled in the plan**
- **Out-of-network doctors, hospitals and other providers can decide not to treat beneficiary <u>even</u> if beneficiary has been seen before**
- **For each service received, beneficiary must make sure provider agrees to treatment under the plan and will accept plan's payment terms**
- **Beneficiary may get a separate stand-alone drug plan**

SNP—Special Needs Plan (6.6)

- **Limited membership to specific groups of people who must meet strict eligibility standards**
- **What plan provides**
  - Focused care management
  - Special expertise of providers
  - Benefits tailored to enrollee conditions
- **Must include prescription drug coverage**
- **Only available in certain areas of the state**
- **Three types of SNPs**
  - Certain chronic or disabling conditions
    - Diabetes or Heart Disease
      - Additional providers available
      - Special education or counseling
      - Nutrition and exercise programs
  - Dual eligible—beneficiary has Medicare and Medicaid
    - Help accessing community resources
    - Coordination of care
  - Certain situations
    - Short-term—nursing care at home
    - Long-term—SNF, rehab hospital, or nursing home

MSA— Medical Savings Account (6.7)

- Combines a high-deductible health insurance plan with a Medical Savings Account
- High Deductible, meaning you'll pay most of your healthcare costs out of pocket until you reach the deductible
- No Drug Coverage
- Unused money in your MSA rolls over to the next year
- Requires you to manage your healthcare costs carefully, especially due to the high deductible

SNP—Qualifiers (6.8)

- Alcohol and other drug dependencies
- Autoimmune disorders
- Cancer
- Cardiovascular disorders
- Chronic Heart Failure
- Dementia
- Diabetes
- End-stage Liver Disease
- End-Stage Renal Disease (ESRD) requiring dialysis
- Severe hematologic blood disorders
- Chronic lung disorders
- Disabling mental health conditions
- Neurologic disorders and strokes
- CMS Publication 12026 – *Understanding Medicare Advantage Plans*

Rights and Protections (7)

Rights and Protections (7.1)

- CMS Publication – *Medicare Rights & Protections*

Plan Marketing Guidelines (7.2)

- **Healthcare and prescription drug plans begin marketing to general public October 1 each year**
- **Plans must: Use CMS-approved materials and events**
  - TV commercials
  - Mailings such as flyers
  - Ads or articles in local newspapers about outreach presentations
  - Use only state-licensed, certified, or registered individuals to market plans
  - Comply with the "Do Not Call" Registry

Plan Marketing (7.3)

- **Plans may NOT:**
  - Solicit door-to-door unless invited
  - Send unsolicited email
  - Enroll by telephone unless the beneficiary calls specifically to enroll
  - Offer cash payment as an incentive to enroll
  - Misrepresent or use high pressure sales tactics
- **Where to report infractions for investigation**
  - CMS
  - FLOIR – Florida Office of Insurance Regulation

Appeals Process (7.4)

- **Advantage Plans must provide meaningful procedures for grievance resolutions**
- **SHINE's Specialty Training - "Complaints and Appeals" → Liaison**

Module 5 Quiz (7.5)

Conclusion (8)

The Next Module (8.2)

- **Password: _____**

Questions for Training Instructor