1. Module 1: Overview: Medicare Program Basics

2. Navigation Instructions

3. Terms and Conditions

The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

4. Learning Objectives

After reviewing "Module 1: Medicare Program Basics" you will be able to explain:

- The different ways to get Medicare benefits
- Eligibility for Part A and Part B
- What is covered under Part A and Part B
- Original Medicare premiums
- Help for beneficiaries with limited income
- Original Medicare beneficiary protections
- Combining Original Medicare and Part D
- Medigap coverage

5. Training Roadmap: Module I

- Medicare Program Basics
- Original Medicare: Eligibility, Enrollment, Entitlement, and Premiums
- Help for Individuals with Limited Income
- Medicare Part A Benefits and Original Medicare Cost-Sharing
- Medicare Part B
- Original Medicare
- Medigap Coverage

6. Title Page – Medicare Program Basics

7. Medicare Basics

- Medicare is the Federal health insurance program for individuals who are aged (65 and over) and younger individuals who have certain serious health conditions or are disabled.
- Medicare eligibility does not take into consideration an individual's income. However,
    - individuals may pay higher premiums based on income, and
    - low-income individuals may be eligible for additional assistance.
- Individuals can receive their Medicare medical coverage:
    - directly from the Federal Government, which pays for services on a fee-for-service basis (this program is known as "Original Medicare" or "Fee-for-Service Medicare"); or
    - through a private health plan.
- Individuals must receive their Medicare Part D outpatient drug benefits through a private health plan (even if they get their medical coverage through Original Medicare).

8. Overview of Medicare Benefits and Coverage -- Parts A, B, C, and D

- Medicare coverage is often known by the part of Medicare law under which it is authorized or regulated.
    - Part A is referred to as "Hospital Insurance Benefits." Part A also covers other inpatient care, including skilled nursing facilities, rehabilitation facilities, and hospice.
    - Part B is referred to as "Supplementary Medical Insurance Benefits." Part B covers a broad range of outpatient services such as physician care, and drugs that are administered by physicians or other health care professionals (such as certain vaccines and intravenous medications).
    - Part C regulates and authorizes Medicare Advantage plans, which must cover Part A (except for hospice) and Part B benefits.
        - Individuals enrolled in a Part C plan still get hospice benefits, but they are paid for by Original Medicare.
    - Part D covers prescription drug benefits (for self-administered drugs, such as those picked up at a pharmacy and taken at home) and regulates Medicare prescription drug plans.

9. Overview of Medicare – Part E

There is also a lesser-known Part E of Medicare law that regulates other miscellaneous programs including:

- Medicare cost plans (which also cover Part A and Part B benefits)
    - Medicare cost plans are only offered in a limited number of states and are most frequently found in rural areas.
- Medicare supplemental insurance (Medigap Plans)
- The program for all-inclusive care for the elderly (PACE)

10. Different Ways to Get Medicare

There are different ways that beneficiaries can choose to receive their Medicare coverage.

- Original Medicare (Part A and Part B coverage)
    - Can be combined with a Medicare Supplement Plan and/or a Medicare Prescription Drug Plan.
- Medicare Advantage Plans (Medicare Part C health plans, with or without Part D benefits)
- Medicare Prescription Drug Plans
- Medicare Cost Plans
- PACE Plans
- Medicare-Medicaid Plans

11. Different Ways to Get Medicare – Brief Overview

WAYS TO GET MEDICARE COVERAGE[1]				
COVERAGE TYPE	**BENEFITS**			
	Part A and B benefits	**Some of the cost-sharing for Part A and B Benefits**	**Part D Benefits**	**Other benefits**
Original Medicare[3]	X			
Part C (Medicare Advantage)[4]	X	X	May cover depending on plan	X (most offer additional benefits)
Cost Plans [2,3]	X	X	May cover depending on plan	X (most offer additional benefits)
Medicare Prescription Drug Plans (PDPs)			X	
Original Medicare with a supplemental plan (Medigap)[3]	X (Original Medicare)	X (Medigap)		Some Medigap Plans cover foreign travel emergencies
PACE plans[2]	X	X	X	X (Adult day center, some meals, other benefits)
Medicare-Medicaid Plans[2]	X	X	X	X Integrates Medicaid benefits with Medicare benefits

[1] Brief overview. As detailed later, some ways can be combined and not all beneficiaries are eligible for all types of coverage.
[2] These types of plans are generally limited to certain geographic areas and are not available everywhere.
[3] These plans can be combined with coverage under a PDP.
[4] As discussed later, a few MA plan types (PFFS and MSAs) can be combined with coverage under a PDP.

12. Title Page – Original Medicare: Eligibility, Enrollment, Entitlement, and Premiums

13. Original Medicare

- Original Medicare covers only Part A and Part B benefits
    - Part A benefits include inpatient hospital, skilled nursing facility, hospice, and home health services.
    - Part B benefits include outpatient and professional services such as those provided by a doctor (or non-physician professional such as a nurse practitioner or physician assistant), clinical lab services, durable medical equipment, preventive services, and other outpatient medical services.
- Under Original Medicare, beneficiaries can receive covered services from any physician or facility that accepts Medicare, anywhere in the United States.
- No referrals are required under Original Medicare.

14. Eligibility for Part A and Part B

To be eligible for Medicare Part A and Part B, an individual must:

(1) Be age 65 or older, or be under age 65 with certain disabilities or health conditions, including:

- all who get disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board for 24 months.
- individuals with Amyotrophic Lateral Sclerosis (ALS), often referred to as Lou Gehrig's Disease or have an end-stage renal disease (ESRD).

(2) Be a U.S. resident; and

- be either a U.S. citizen, or
- be an alien who has been lawfully admitted for permanent residence and has been residing in the United States for 5 continuous years before the month of applying for Medicare.

15. Eligibility -- Individuals with ESRD

Individuals eligible based on end-stage renal disease (ESRD) generally lose eligibility 36 months after the month in which the individual receives a kidney transplant, unless the individual is eligible for Medicare on another basis, such as age or disability. However, such individuals may remain enrolled in Part B only but solely for coverage of immunosuppressive drugs if they have no other health care coverage that would cover the drugs.

16. Medicare Enrollment – Parts A and B

Some people are automatically enrolled in Parts A and B:

- Subject to the Part B exception below for Puerto Rico:
    - Individuals who are already getting benefits from Social Security or the Railroad Retirement Board (RRB) will automatically be enrolled in Part A and Part B starting the first day of the month they turn 65. (If their birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.) These individuals are also allowed to refuse Part B coverage. (See Medicare Part B for the potential consequences of refusing Part B).
    - Individuals with disabilities who are under age 65 are automatically enrolled in Parts A and B the month after they have received Social Security or Railroad Retirement disability benefits for 24 months. However, they have an opportunity to refuse Part B coverage.
    - Individuals with ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) get Part A and Part B automatically the month their Social Security disability benefits begin.
- Individuals living in Puerto Rico are not automatically enrolled in Part B. They must sign up for it.

17. Medicare Enrollment – Parts A and B

Other individuals will have to sign up if they want to be enrolled in Parts A and/or B.

- Individuals who are close to 65 but are not getting benefits from Social Security or the Railroad Retirement Board (RRB) may sign up for Parts A and B during their Part A/Part B **initial enrollment period**, which begins 3 months before their 65th birthday, including the month they turn 65 and ends 3 months after. (See Medicare Part B for the potential consequences of failing to sign up for Part B when first eligible).
- Individuals with end-stage renal disease (ESRD) may sign up for Medicare at any time. However, the date on which their Medicare coverage begins is usually the fourth month after dialysis treatments begin but may be earlier if certain conditions are met.
- Individuals eligible for Premium-free Part A can also sign up for Part A any time after they turn 65. Their Part A coverage starts 6 months back from when they signed up but cannot start earlier than the month they turned 65. If they have not signed up by the time they apply for Social Security, they will automatically be signed up (and coverage will be retroactive for 6 months).

18. Parts A and B After the Part A/Part B Initial Enrollment Period

- Individuals who do not enroll in Part B (or Part A if they have to buy it) when they are first eligible, can enroll during a Part A/Part B **General Enrollment Period (GEP)** each year from January 1 – March 31.
    - Coverage begins the first day of the month following the month in which the beneficiary enrolls.
- Individuals who have group health plan coverage based on their current employment or the employment of a spouse may enroll in Part A (if they have to buy it) and/or Part B anytime while covered under the group health plan or during a Part A/Part B **Special Enrollment Period** that occurs during the 8-month period immediately following the last month they have group coverage.

- Individuals who are eligible for premium-free Part A may sign up at any time.
- There are also Part A/Part B Special Enrollment periods that allow individuals to enroll after the Part A/Part B IEP due to issues such as emergencies or disasters in their area, release from incarceration, loss of Medicaid, health plan or employer error that caused them to miss the IEP or other exceptional conditions.

19. Medicare Part A Entitlement and Part B Enrollment

An individual is entitled to Part A if they are eligible for premium-free Part A or if the individual has enrolled in Part A and continues to pay the premium (or have the premium paid on their behalf).

For an individual to enroll in Part B and remain enrolled in Part B, the individual must pay the Part B premium (or have the premium paid on their behalf).

20. Other Ways to Get Medicare - Eligibility Overview

To get Medicare benefits other than through Original Medicare, beneficiaries must meet certain eligibility criteria.

Part C[1]	Part D	Cost Plans	Medicare-Medicaid Plans	PACE Plans
Individuals must: ○ be entitled to Part A and enrolled in Part B; and ○ reside in the MA plan's service area.	Individuals must: ○ be entitled to Part A and/or enrolled in Part B and ○ reside in the Part D plan's service area.	Individuals must: ○ be entitled to Part A and/or enrolled in Part B (if they are not entitled to Part A, they will not have coverage of Part A benefits under the cost plan); and ○ reside in the cost plan's service area.	Individuals must: ○ be eligible for both Medicare and Medicaid; ○ meet eligibility requirements specific to the state and ○ reside in the plan's service area.	Individuals must: ○ Be age 55 or older; ○ be certified as eligible for nursing home care by their state; ○ be able to live safely in a community setting at the time of enrollment; ○ reside in the PACE organization's service area; ○ Meet any additional program-specific eligibility conditions imposed under the plan's PACE Program Agreement

[1] Note that certain types of Part C plans such as Medical Saving Account plans and Special Needs Plans have additional eligibility requirements.

21. Medicare Premiums– Part A

Most individuals are entitled to Part A without paying a premium.

- For individuals ages 65 or older to be entitled to premium-free Part A, the individual or their spouse must have worked and paid Medicare taxes for at least 10 years; or
- All individuals eligible for Medicare due to a disability, End-Stage Renal Disease (ESRD), or Amyotrophic Lateral Sclerosis (ALS) are eligible for premium-free Part A.

For those individuals who do not automatically qualify for premium-free Part A coverage, the monthly Part A premium in 2024 is:

- $505, for individuals or their spouses who paid Medicare taxes for less than 30 quarters.
- $278, for individuals or their spouses who paid Medicare taxes for 30-39 quarters.

- Individuals who are not eligible for premium-free Part A and those who don't buy Part A when they are first eligible may pay a late penalty of up to 10% unless they enroll during a special enrollment period. (They will have to pay the higher premium for twice the number of years they could have had Part A but did not sign up.)

22. Medicare Premiums for Part B

Beneficiaries enrolled in Part B must pay a monthly premium.

- In 2024, the standard monthly premium for Part B is $174.70. Most people pay the standard monthly premium. However, some people pay more based on their income (as reported to the IRS two years prior in 2022).

23. Medicare Premiums for Part B and the IRMAA

- Individuals with incomes in 2022 over $103,000 or filing jointly with incomes over $206,000, pay more in 2024, up to $594.00 a month, based on the income-related monthly adjustment amount (IRMAA).

Individual tax return	Joint tax return	2024 Part B premium
< $103,000	<$206,000	$174.70
>$103,000 to $129,000	>$206,000 to $258,000	$244.60
>$129,000 to $161,000	>$258,000 to $322,000	$349.40
>$161,000 to $193,000	>$322,000 to $386,000	$454.20
>$193,000 and less than $500,000	>$386,000 and less than $750,000	$559.00
= or > $500,000	= or > $750,000	$594.00

* There are separate standards for beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses

24. Medicare Premiums for Part B: Payment Mechanisms and Penalties

- Part B premiums may be deducted from Social Security checks, Railroad Retirement checks, or Office of Personnel Management (civil service annuity) checks. If an individual does not get these checks, they will get a premium bill from Medicare every 3 months.
- Employers may pay monthly Part B premiums on behalf of retirees.
- For individuals who do not enroll in Part B when first eligible, the Part B premium is increased by 10% for each full 12-month period the beneficiary could have had Part B but did not enroll. This is known as a "late enrollment penalty."

Exception from Penalty: Individuals who have group health plan coverage based on their current employment or the employment of a spouse are not subject to the premium increase penalty if they enroll in Part B anytime while covered under the group health plan or during the special enrollment period that occurs during the 8-month period immediately following the last month they have group coverage. In addition, individuals enrolling during any other SEP are not subject to the penalty.

25. Medicare Premiums for Part B – Examples

Example: Mr. Klein is a Medicare-eligible retiree who did not enroll in Part B because he had health care coverage through his wife's employer. His wife is planning to retire soon. Mr. Klein can enroll in Part B at any time up until 8 months after the month in which his wife retires. If he fails to do this, he will be subject to a Part B penalty.

Example: Ms. Stein retired when she was 66 but did not enroll in Medicare Part B after her group coverage ended because she was healthy and thought her Part A benefit would cover catastrophic costs. Ms. Stein is now 72 and wants to get Part B because her doctor's bills, lab tests, and vaccines are becoming expensive. Ms. Stein will have to pay the monthly part B premium plus an additional 10 percent for each 12-month period since her group coverage ended. This obligation will continue if she has Part B unless she qualifies for extra help with her Medicare bills.

26. Title Page - Help for Individuals with Limited Income

27. Help for Individuals with Limited Income/Resources

- Beneficiaries may qualify for help to pay the Medicare Part A and Part B premium, the Part A and Part B deductibles and cost-sharing, and/or some Part D prescription drug costs.
- Beneficiaries may apply for the following programs through their State Medicaid office:
    - Medicare Savings Program: help paying for the Medicare Part A and Part B premiums and, in some cases, deductibles and cost-sharing.
        - The "Qualified Medicare Beneficiary" program is one type of Medicare Savings Program. Qualified Medicare Beneficiaries enrolled in Medicare Advantage plans also get help with their Medicare Advantage cost-sharing amounts.
    - Part D low-income subsidy (also known as "Extra Help"): help paying for prescription drug coverage. Persons interested in Part D help only may also call the Social Security

Administration (SSA) at 1-800-772-1213 or apply online at https://www.ssa.gov/medicare/part-d-extra-help. Extra help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa.
    - Medicaid: help with health care costs not covered by Medicare, such as custodial/long term care.

28. Help for Individuals with Limited Income/Resources

- Persons who do not qualify for the Part D low-income subsidy but are of limited means may qualify for help in paying Part D drug costs through a State's Pharmaceutical Assistance Program.
- Agents should encourage beneficiaries with limited income and resources to call or visit their Medicaid office and ask for information on Medicare Savings Programs. To get the phone number for the state, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227) or contact the State Health Insurance Assistance Program (SHIP).

29. Title Page - Medicare Part A Benefits and Original Medicare Cost-Sharing

30. Medicare Part A Benefits

- Part A provides coverage for:
    - Inpatient hospital care (including care provided by acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals)
    - Skilled nursing and rehabilitation care up to 100 days, but only after a three-day hospital stay (Medicare Advantage plans may waive the 3-day stay requirement)
    - Blood
    - Hospice care
    - Up to 100 days of home health care after an individual is in a hospital or skilled nursing facility (SNF) (Note that Part B covers home health care without the prior hospital or SNF stay if Part B conditions are met)
    - Inpatient psychiatric care (up to 190 lifetime days)

31. Medicare Part A – Original Medicare Cost-Sharing for Inpatient Hospital Care

In 2024, beneficiaries pay the following amounts for inpatient hospital care covered under Original Medicare:

- $1,632 deductible for each benefit period
    - A benefit period begins the day an individual is admitted to a hospital or skilled nursing facility (SNF) and ends when an individual has not received hospital or SNF care for 60 days in a row.
- Days 1–60: $0 after you pay your Part A deductible
- Days 61–90: $408 copayment per day of each benefit period
- Days 91-150: $800 copayment per each "lifetime reserve day" after day 90 for each benefit period

    - Lifetime reserve days are days a beneficiary may use after they have been in an inpatient hospital for 90 days. A beneficiary has 60 such days to use in their lifetime.
- Beyond lifetime reserve days: all costs

32. Medicare Part A – Original Medicare Cost-Sharing for Skilled Nursing and Rehabilitative Care

In 2024 beneficiaries pay the following amounts for skilled nursing and rehabilitative care covered under Original Medicare:

- Days 1-20: $0 for each benefit period (as defined by Medicare)
- Days 21-100: $204.00 copayment per day of each benefit period
- Days 101 and beyond: all costs

33. Title Page - Medicare Part B

34. Medicare Part B Benefits

Part B generally covers:

- Physician and other health care professional services
- Outpatient hospital services
- Clinical lab and diagnostic tests, such as X-rays, MRIs, CT scans
- Durable medical equipment
- Home health care that is not covered under Part A (because the individual was not in a hospital or SNF or has exceeded 100 days)
- Physical and occupational therapy
- Ambulatory surgical center services
- Chemotherapy provided on an outpatient basis

35. Other Part B Items and Services

- Ambulance services
- Chiropractic services – for limited situations
- Opioid use disorder treatment
- Certain preventive health services such as vaccines, mammograms, and smoking cessation counseling
- Diabetic supplies
- Kidney dialysis
- Outpatient mental health care (limits apply)
- Virtual check-ins (using video and audio technology)
- Continuous Positive Airway Pressure (CPAP) devices

36. Medicare Part B – Original Medicare Cost-Sharing

In 2024, beneficiaries pay the following amounts for Part B services covered under Original Medicare:

- A $240 annual deductible.
- After the deductible is satisfied, beneficiaries typically pay 20% of the Medicare-approved cost for Part B covered services.
- Beneficiaries have no cost-sharing for most preventive services.

37. Not Covered by Medicare Part A & B

- Most dental care (however, Original Medicare may pay for some dental services before, or as part of, certain related medical procedures (like before certain cardiac or organ transplant procedures).
- Cosmetic surgery
- Custodial/long term care
- Health care while traveling outside the US
- Hearing aids
- Outpatient prescription drugs (this is covered under Part D)
- Massage Therapy
- Eye exams for glasses
- Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care)
- Covered items or services provided by a doctor or other provider who has opted out of Medicare (except in the case of an emergency or urgent need)

38. Title Page - Original Medicare

39. Appeals Related to Original Medicare Part A and Part B Coverage and Payment Determinations

Beneficiaries receiving their Part A and/or Part B services through Original Medicare have a right to appeal Medicare coverage and payment decisions.

- Beneficiaries must file an appeal related to Part A or B services within 120 days of the date they get the Medicare Summary Notice (MSN) in the mail detailing their financial responsibility. The MSN will have instructions on where to send the appeal.
- Beneficiaries who believe their hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice services are ending too soon have a right to a fast appeal. Their provider will give them written notice before the end of their services. The notice tells them how to ask for a fast appeal. Beneficiaries must ask for a fast appeal no later than noon of the first day after the day before the termination date listed in their "Notice of Medicare Non-Coverage" or for hospital discharge determinations, no later than the day they are scheduled to be discharged.
- If a beneficiary disagrees with the appeal decision, they have 180 days after getting the decision notice to request a reconsideration by a Qualified Independent Contractor (QIC).

- Additional levels of appeal may also be available, depending on the amount of controversy.

40. Grievances under Original Medicare

Beneficiaries may also file complaints about their Medicare providers or the quality of care they received. For example, a beneficiary may have a complaint about:

- unprofessional conduct by a provider
- improper care
- unsafe conditions
- abuse by a provider
- long waiting times or unclean conditions

Instructions for filing grievances can be found at: https://www.medicare.gov/claims-appeals/how-to-file-a-complaint-grievance

41. Additional Beneficiary Protections under Original Medicare

- Medicare operates a 24-hour helpline at 1-800-Medicare. (TTY users should call **1-877-486-2048**.)
    - Beneficiaries can use this number to find out about their claim status, coverage and benefits, premium payments, or to ask other questions about Medicare.
- Beneficiaries can also get assistance with Medicare, including help filing an appeal or grievance, through their local State Health Insurance Assistance Program (SHIP).
    - Contact information for their SHIP can be found at https://www.shiptacenter.org/

42. Original Medicare and Part D Prescription Drug Coverage

- A beneficiary in Original Medicare may receive Part D prescription drug coverage through a stand-alone prescription drug plan (PDP).
- Generally, except for those dually eligible for Medicare and Medicaid, Medicare beneficiaries must actively select a Part D plan.
- Beneficiaries who enroll in Part D typically pay a monthly premium, annual deductible, and per-prescription cost-sharing.
- In selecting a Part D plan, beneficiaries should consider expected premiums and cost-sharing, formulary, and network pharmacies.

43. For More Information about Medicare

- Centers for Medicare & Medicaid Services (technical information) www.cms.gov
- Medicare (beneficiary audience) www.medicare.gov
- Medicare & You Handbook https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf
- Your Medicare Benefits handbook https://www.medicare.gov/Pubs/pdf/10116-your-medicare-benefits.pdf

44. Title Page: Medigap Coverage

45. Medigap (Medicare Supplement Insurance)

Medigap insurance:

- Works only with Original Medicare. It is illegal to sell a Medigap plan to someone already in a Medicare Advantage health plan.
- Is sold by private insurance companies to fill "gaps" in Original Medicare coverage, such as all or part of the deductibles or coinsurance amounts.
- Some Medigap policies cover limited benefits not covered by Part A or Part B of Original Medicare, such as extra days of coverage for inpatient hospital care or foreign travel emergency care. Generally, Medigap doesn't cover long-term care (like care in a nursing home), vision or dental services, hearing aids, eyeglasses, or private-duty nursing.

46. Further Information on Medigap (Medicare Supplement Insurance)

- Medigap policies are available in standardized benefit plans, identified by certain letters between A and N (however, different plans are offered in Massachusetts, Minnesota, and Wisconsin). States determine which standardized benefit plans may be offered in their state.
- Turning age 65 and signing up for Part B triggers a six-month Medigap open enrollment period when Medigap insurers must issue you a policy, regardless of any pre-existing conditions. This is called a guaranteed issue right.
- In certain limited instances, leaving a Medicare Advantage plan may trigger a guaranteed issue right.
- Issuance and sales of Medigap plans are regulated by States, which have varying laws. For example, some states have additional guaranteed issue rights, specific requirements around marketing Medigap plans, and requirements concerning commissions. Agents should familiarize themselves with their state's requirements for Medigap sales.

47. Medigap Coverage

All Medigap plans pay for some or all of the following costs:

- Part A coinsurance
- Coverage for 365 additional hospital days when Medicare coverage for hospitalization ends
- Part B coinsurance or copayment
- Blood (First 3 pints)
- Hospice care coinsurance or copayment

48. Beneficiaries with Medigap Plans with/without Drug Coverage

- Medigap plans H, I, and J offer non-Medicare drug coverage. These plans could no longer be sold as of January 1, 2006. However, some beneficiaries may have decided to keep their H, I, or J policy with the drug coverage they had before January 1, 2006.

- Individuals who are enrolled in Medigap plans may only obtain Medicare drug coverage (Part D) through a stand-alone prescription drug plan.
- To enroll in Part D, individuals who have Medigap plans H, I or J may:
    - keep their Medigap coverage with the drug portion of the coverage removed and enroll in a Part D PDP plan; or
    - drop their Medigap coverage and enroll in an MA-PD or other health plans with a PDP.
    - If their Medigap policy "creditable prescription drug coverage," the beneficiary may have to pay a late enrollment penalty. Having creditable coverage means that the Medigap policy's drug coverage pays, on average, at least as much as Medicare's standard drug coverage and gives the same value for your prescriptions as Part D.

49. Medigap rules for individuals who became eligible for Medicare after December 31, 2019

- Individuals who attained age 65 on or after January 1, 2020, or first become eligible for Medicare due to age, disability, or end-stage renal disease on or after January 1, 2020, may not purchase a Medigap plan that pays the Part B deductible (generally plans C, F or high deductible F, but the prohibition also applies in waiver states with non-standard packages).
- Individuals previously enrolled in plans that cover the Part B deductible may remain enrolled in those plans.
- Individuals who became eligible for Medicare before 2020 may enroll in plans that cover the Part B deductible.

50. Medigap Plans

Plans available to all beneficiaries									Plans available only to beneficiaries eligible before 2020	
Medigap Benefits	A	B	D	G[4]	K[3]	L[3]	M	N 2	C	F[1]
Part A Coinsurance and Hospital Benefits	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part B Coinsurance or Copayment	100%	100%	100%	100%	50%	75%	100%	100%[2]	100%	100%
Blood (First 3 pints)	100%	100%	100%	100%	50%	75%	100%	100%	100%	100%

Part A Hospice Care Coinsurance/ Copayment	100%	100%	100%	100%	50%	75%	100%	100%	100%	100%
Skilled Nursing Facility Care Coinsurance			100%	100%	50%	75%	100%	100%	100%	100%

1. There is a high-deductible version of Plan F offered in some states that is only available to individuals eligible for Medicare before January 1, 2020. In 2024, a policyholder pays $2,800 before the Medigap policy pays anything.
2. Plan N has a copayment of up to $20 for physician office visits and up to $50 for emergency room visits (waived in certain circumstances).
3. Plans K and L pay 100% after out-of-pocket limit is reached. In 2024 the out-of-pocket limits for Plan K and Plan L are $7,060 and $3,530, respectively.
4. There is a high deductible version of Plan G offered in some states. The deductible for 2024 is $2,800.

51. Medigap Plans, continued

Plans available to all beneficiaries									Plans available only to beneficiaries eligible before 2020	
Medigap Benefits	A	B	D	G[4]	K[3]	L[3]	M	N	C	F[1]
Medicare Part A Deductible		100%	100%	100%	50%	75%	50%	100%	100%	100%
Medicare Part B Deductible									100%	100%
Medicare Part B Excess Charges				100%						100%
Foreign Travel Emergency (up to plan limits)[2]			80%	80%			80%	80%	80%	80%

1. Plan F also has a high-deductible option in some states. In 2024, a policyholder pays $2,800 before the Medigap policy pays anything. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year.
2. The foreign travel benefit pays 80% of charges after a $250 deductible, up to a $50,000 lifetime maximum.

3. Plans K and L pay 100% after out-of-pocket limit is reached. In 2024 the out-of-pocket limits for Plan K and Plan L are $7060 and $3,530, respectively.
4. There is a high deductible version of Plan G offered in some states. The deductible for 2024 is $2,800.

52. For More Information about Medigap

- Centers for Medicare & Medicaid Services: http://www.cms.gov/Medigap/
- 2023 Medicare & You Handbook: https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf

1. Module 2: Part C and Other Medicare Health Plans

2. Navigation Instructions

3. Terms and Conditions

4. Learning Objectives

- After reviewing "Part 2: Medicare Health Plans" you will be able to:
  - Explain what types of Medicare health plans are available
  - Explain who is eligible for the different types of plans
  - Describe the different types of Special Needs Plans (SNPs)
  - Describe features of different Medicare health plan types
  - Describe the different types of benefits offered by Medicare Advantage plans
  - Explain how Medicare health plans work with prescription drug plans
  - Explain enrollee rights concerning their Medicare health plan

5. Training Roadmap: Module 2

- Medicare Advantage Plans
- MA Plan Types: Coordinated Care Plans
- Special Needs Plans
- MA Plan Types: Private Fee-for-Service (PFFS) Plans
- MA Plan Types: Medical Savings Account (MSA) Plans
- Medicare Advantage Employer/Union Plans
- Medicare Advantage: Eligibility, Costs, and Benefits
- Medicare Advantage Plans and Qualified Medicare Beneficiaries
- Medicare Advantage and Prescription Drugs
- Other Types of Medicare Health Plans
- Enrollee Protections: Appeals and Grievances

6. Title Page: Medicare Advantage Plans

7. Part C: Medicare Advantage Plans: Overview

Under the Medicare Advantage (MA) program, known as Medicare Part C, private companies offer health plans that cover all Medicare Part A and Part B benefits.

- Many also cover Part D prescription drug benefits (MA-PD plans)
- All MA plans have a maximum out-of-pocket limit (MOOP) for basic benefits
- Many MA plans also offer additional benefits that Medicare does not cover, known as supplemental benefits.
- The types of Medicare Advantage (MA) plans are:
    - Coordinated Care Plans. These plans have a network of preferred providers and include:
        - Health Maintenance Organizations (HMOs), some have a point-of-service (POS) benefit that allows beneficiaries to go out-of-network subject to limitations
        - Preferred Provider Organizations (PPOs), which may be local or regional
    - Private Fee-for-Service (PFFS) Plans
    - Medical Savings Account (MSA) Plans

8. Title Page: MA Plan Types Coordinated Care Plans

9. MA Plan Types Coordinated Care Plans – HMOs

- HMOs generally only cover services furnished by doctors and hospitals within the plan's network (known as participating providers). However, there are certain exceptions:
    - Emergency services furnished by out-of-network providers are covered.
    - When the enrollee is temporarily absent from the plan's service area, dialysis services are covered outside of the network**.**
    - Urgently needed services furnished by out-of-network providers are covered when the enrollee is temporarily outside of the service area or in rare circumstances when the network is not available.
    - If a needed specialist or a covered procedure is not available through participating providers, the HMO plan will authorize out-of-network services.
- HMO enrollees may need to select a primary care doctor and may need a referral for specialty care to be covered.
- Some HMOs offer a Point of Service (POS) option that allows enrollees to go to out-of-network doctors and hospitals without receiving prior approval for certain services.
    - Unlike a PPO, an HMO-POS plan may limit the services available out-of-network or may put a dollar cap on the amount of out-of-network coverage.
    - Cost-sharing is generally higher for services furnished by out-of-network providers than for services obtained from participating providers.

10. MA Plan Types Coordinated Care Plans – PPOs

Under a PPO, enrollees:

- may get care from any provider in the U.S. who accepts Medicare; they are not limited to participating providers.
- do not need a referral to see an out-of-network provider but are encouraged to contact the plan to be sure the service they wish to obtain out-of-network is medically necessary and will be covered.
- usually pay higher cost-sharing amounts to receive services from an out-of-network provider than from a participating provider.

Regional PPOs are PPOs that are offered throughout an entire region, made up of one or more states.

11. MA Plan Types Coordinated Care Plans – Special Needs Plans

- Special Needs Plans (SNPs) are a type of Medicare Advantage coordinated care plan (HMOs or PPOs) that are specially designed to serve a subset of Medicare beneficiaries.
- In addition to meeting all other MA eligibility criteria, beneficiaries must also meet criteria specific to the type of SNP in which they wish to enroll.
- All SNPs must implement an evidence-based model of care with appropriate networks of providers and specialists designed to meet the specialized needs of the plan's targeted enrollees.
- All SNP plans include prescription drug coverage.

12. Title Page: Special Needs Plans

13. Special Needs Plans –Types (1 of 2)

There are several types of Special Needs Plans

- Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to individuals with certain chronic or disabling chronic conditions, such as diabetes, certain cardiovascular disorders, cancer, certain chronic lung disorders, HIV, dementia, end-stage renal disease (ESRD) requiring dialysis, or certain other conditions.
    - Each C-SNP will specify the condition or conditions necessary to be eligible to enroll.
- Institutional SNPs (I-SNPs) are SNPs that 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 skilled nursing facility, a nursing facility (NF) as defined under Medicaid law, an intermediate care facility for the individuals with intellectual and developmental disabilities, a long-term care hospital, an inpatient psychiatric facility, or certain other facilities specified by CMS.
- Institutional Equivalent (IE) SNPs enroll MA eligible individuals who live in the community but require an institutional level of care (i.e., are determined by an impartial entity to need the level of services furnished by the types of facilities listed above). Eligibility for an IE-SNP may be limited to certain assisted living facilities.

14. Special Needs Plans –Types (2 of 2)

- Dual-eligible SNPs (D-SNPs) enroll certain categories (as determined by each state) of dual eligible beneficiaries.
- Dual eligible beneficiaries are those who qualify for both Medicare and Medicaid. They include beneficiaries enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or Medicaid assistance with Medicare premiums or cost-sharing.
- The categories of dual eligibles include the following:
  - Qualified Medicare Beneficiaries (QMBs) -- Medicaid helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs for these beneficiaries.
  - Specified Low-Income Medicare Beneficiaries (SLMBs): Medicaid helps pay Part B premiums for these beneficiaries.
  - Qualifying Individuals (QIs): Medicaid helps pay Part B premiums for these beneficiaries.
  - Qualified Disabled Working Individuals (QDWIs) -- Medicaid pays the Part A premium for certain disabled and working beneficiaries.
- Dual eligible individuals may also be eligible for full Medicaid benefits. Such individuals are known as full-benefit dual eligible (FBDEs).

15. D-SNPs

There are different types of D-SNPs, including:

- fully integrated dual-eligible (FIDE) D-SNPs, which provide dual-eligible enrollees coordinated access to Medicare and Medicaid benefits (including Medicaid primary care acute care, and long-term services and supports) under a single organization that has a Medicare Advantage and Medicaid managed care contract.
- highly integrated dual-eligible (HIDE) D-SNPs, which cover Medicaid benefits under a capitated contract between the State Medicaid agency and the MA organization, the MA organization's parent organization, or an affiliate. HIDE SNPS cover long-term services and support, or behavioral health services.
- coordination-only D-SNPs, which are not FIDE or HIDE D-SNPs and generally have certain obligations to notify the state Medicaid agency or its designee of hospital and skilled nursing facility admissions for certain high-risk full-benefit dual eligible individuals.

16. Title Page: MA Plan Types: Private Fee-for-Service (PFFS) Plans

17. MA Plan Types: Private Fee-for-Service (PFFS) Plans (1 of 2)

- Individuals enrolled in PFFS plans may receive covered services from any provider in the U.S. who is eligible to provide Medicare services and agrees to accept the plan's terms and conditions of payment. They are not limited to receiving services from a network of plan providers.
- Some PFFS plans contract with providers. If the PFFS plan has a network, enrollees may pay more if they see out-of-network providers.

- Except for emergencies, enrollees must inform providers before receiving services that they are a PFFS plan member (typically by showing their membership card), so the non-network providers can decide whether to accept the plan's terms and conditions.
- Non-network providers that accept Original Medicare may choose not to accept PFFS plan enrollees. Therefore, an enrollee needs to confirm that their provider of choice will accept a PFFS plan before enrolling in one.

18. MA Plan Types: Private Fee-for-Service Plans (2 of 2)

- Providers are prohibited from charging a PFFS enrollee more than the cost-sharing specified in the PFFS plan's terms and conditions of payment.
    - Cost-sharing may include balance billing up to 15% of the Medicare rate only if allowed in the plan's terms and conditions of payment.
        - Balance billing happens when a doctor is eligible to accept Medicare but is not a Medicare "participating" provider under Original Medicare. Under Original Medicare, these non-participating providers are allowed to balance bill beneficiaries up to 15% over the Medicare payment amount.
        - PFFS plans may choose whether or not to allow non-participating providers to balance bill their members.
- PFFS plans may choose to offer Part D benefits but are not required to do so.

19. Title Page – MA Plan Types: Medicare Savings Account Plans

20. MA Plan Types: Medical Savings Account (MSA) Plans

- A Medicare MSA is a high-deductible health plan that is combined with a special medical savings account.
    - Medicare contributes money to the beneficiary's medical savings account to assist with paying for Medicare covered services during the deductible phase.
    - The amount of the contribution varies by plan.
    - Money left in the account at the end of the year stays there. If the beneficiary remains enrolled in the plan the following year, Medicare will add any new deposits.
- If an MSA enrollee uses all the funds in their medical savings account, they must pay out-of-pocket until they reach their deductible.
- After the annual deductible is met, the plan pays 100% for covered services.
    - The maximum allowable deductible for MSA plans in 2024 is $16,000. However, most MSAs will have a substantially lower deductible.

21. MA Plan Types: MSA Plans

- There is no premium for an MSA, MSA plans cover Part A and Part B benefits, but beneficiaries must continue paying their Part B premium.
- MSAs do NOT cover Part D Medicare prescription drug benefits.
    - MSA enrollees must enroll in a stand-alone PDP if they want prescription drug benefits.
- MSA enrollees may receive covered services from any Medicare approved provider in the U.S. if the provider chooses to accept their plan.
- MSAs may not have a network or may have a full or partial network of providers.
- All non-network providers must accept the same amount that Original Medicare would pay them as payment in full. This is the amount the enrollee will pay the provider before the deductible is met.

22. Title Page: Medicare Advantage Employer/Union Plans

23. Employer/Union Plans

- Employers and unions may offer their retirees and their dependents:
    - Medicare Advantage individual plans (plans open to the public).
    - Medicare Advantage plans that are only available to individuals based on their employer, known as **Employer Group Waiver Plans or EGWPs**.
    - A Medicare Advantage plan through a direct contract between the employer or union and CMS, known as a direct contract plan.
- Employers with less than 20 employees (as calculated under Medicare secondary payor rules) may be able to offer Medicare Advantage plans to their active employees and their dependents.
- Any size employer can offer Medicare Advantage plans to its retirees and their dependents.
- EGWP and direct contract plans are different than other Medicare Advantage plans because eligibility to enroll is limited to certain active employees, retirees, and their dependents, and because a variety of regulatory requirements are waived as they apply to the plans.

24. Title Page: Medicare Advantage Plans – Eligibility, Costs, and Benefits

25. Medicare Advantage Eligibility

To be eligible to enroll in a Medicare Advantage plan:

- A beneficiary must be entitled to Part A ***and*** enrolled in Part B.
- The beneficiary must permanently live in the MA plan's service area. (If a beneficiary spends six months or more outside of the plan's service area, they should only enroll in MA-PD plans with a visitor/traveler benefit.)
- Be a U.S. citizen or lawfully present in the United States on or before the enrollment effective date. (CMS makes this determination.)

- MA plans must generally enroll any eligible beneficiary who applies regardless of health status.
    - Special needs plans only enroll beneficiaries within their targeted populations.
    - Employer group waiver plans (EGWPs) or direct contract plans may only enroll Medicare beneficiaries who are active employees or retirees of the employer or union offering the plan and their dependents.

- An individual can sign up for Medicare through the Social Security Administration.

26.MSAs: Special Eligibility Rules

The following individuals are ***not*** eligible to enroll in an MSA:

- An individual who receives health benefits that cover all or part of the annual deductible under the MA MSA plan. Examples include, but are not limited to, primary health care coverage other than Medicare, Medicare hospice, certain supplemental insurance policies, and retirement health benefits.
- An individual who is enrolled in a Federal Employee Health Benefits plan or is eligible for health care benefits through the Veteran's Administration.
- Dual eligibles entitled to coverage of Medicare cost-sharing under Medicaid.
- An individual who cannot provide assurances that they will reside in the United States for at least 183 days during the year for which the election is effective.
- An individual who has already elected hospice.

27. Medicare Advantage Plans: Premiums and Cost-Sharing

- Medicare Advantage Plans may charge a premium. If the plan charges a premium, beneficiaries must generally continue paying their Part B premium in addition to paying the monthly plan premium to remain enrolled.
- Medicare Advantage plans may also require their members to pay for a portion of the covered services they receive. This is known as member cost-sharing. There are several potential types of cost-sharing:
    - Deductible: A set amount the member must pay for covered services before the health plan begins paying for those services.
    - Copayment: A fixed dollar amount per service the member must pay. For example, $20 for each visit to a primary care provider, or $30 for each visit to a specialist.
    - Coinsurance: A percentage of the cost of the service the member must pay. For example, 20% of the cost of durable medical equipment.

28. Maximum Out-of-Pocket Limits

- All Medicare Advantage plans must have a “maximum out-of-pocket” limit (known as the “MOOP”) for Part A and Part B benefits. That is, once the member pays a specified amount of cost-sharing, the health plan covers 100% of covered medical services. Each year CMS specifies a mandatory MOOP, which health plans cannot exceed, although they may have a lower MOOP.
    - Each plan’s MOOP will be specified in its summary of benefits and its evidence of coverage.
- For 2025, the maximum MOOP limit for Medicare Advantage coordinated care plans and private fee-for-service plans is $9,350, although most plans will have lower limits. PPOs must also have an aggregate MOOP for network and non-network providers of $14,000 in 2025. Again, it is likely that many will have lower limits.
- As previously noted, MSAs have a deductible that members must pay, then the plan pays 100% for covered services.

29. Part C: Medicare Advantage Plan Benefits

- All Medicare Advantage (MA) plans must cover all Part A and Part B benefits.
- Most Medicare Advantage plans also cover part of the Original Medicare cost-sharing for Part A and Part B benefits.
- Medicare Advantage plans may also cover extra benefits not covered by Original Medicare (known as "supplemental benefits"), such as:
    - Vision Services, including glasses
    - Hearing Aids
    - Routine Dental Services
- Supplemental benefits may be optional or mandatory.
    - Mandatory supplemental benefits are embedded in the Medicare Advantage plan and must be purchased as part of the plan. They can include reductions in cost-sharing for benefits under Original Medicare.
    - Optional supplemental benefits may be added to an MA plan at the option of the beneficiary.

30. Special Benefits Depending on Chronic Health Condition

Medicare Advantage plans may offer special benefits for individuals with certain chronic health conditions, such as diabetes, heart failure, COPD, or other conditions, that are not available to members of the same plan without the specified condition. There are two categories of such benefits: (1) those that are primarily health related and (2) those that are not (the latter generally address social determinants of health and are known as Special Supplemental Benefits for the Chronically Ill, or SSBCI).

- Primarily health related benefits for chronically ill enrollees may include items such as decreased cost-sharing for certain services, or supplemental benefits (e.g., at-home palliative care or transportation to medical appointments).
- SSBCI may include items such as groceries, meals beyond a limited basis, pest control, and non-medical transportation.

Consequently, it is useful for agents to know if their clients have conditions that may qualify them for these types of benefits if they are available in the clients' area.

31. Medicare Advantage Plans – Utilization Management

- Medicare Advantage plans may implement mechanisms to manage the utilization of covered services.
- Such mechanisms include requiring a referral or prior authorization to obtain a service.
    - PPOs may not require prior authorization for out-of-network services.
    - PFFS plans may not require prior authorization.
    - Non-network MSAs may not require prior authorization.
- Plans may also implement step therapy requirements for Part B or Part D drugs. Step therapy is when a plan requires a beneficiary to try less expensive options before "stepping up" to drugs that cost more.
- When an enrollee has enrolled in an MA plan after starting a course of treatment, there is a minimum 90-day transition period during which the MA organization may not disrupt or require

reauthorization for the active course of treatment for new plan enrollees, even if they are receiving the services from a non-network provider.

32. Title Page - Medicare Advantage Plans and Qualified Medicare Eligible Beneficiaries

33. MA Plans and Qualified Medicare Beneficiaries (QMBs)

As previously noted, QMBs are a type of dual eligible beneficiary. Special rules apply to QMBs enrolled in any type of MA plan:

- When a QMB enrolls in an MA plan, the beneficiary does not have to pay more cost-sharing than any minimal copayment that would apply under Medicaid.
- All providers (whether or not they are Medicaid participating, or in-network) are prohibited by law from balance billing QMBs for any Medicare cost-sharing amounts. Providers who balance bill are subject to sanctions.

34. Title Page - Medicare Advantage and Prescription Drugs

35. MA & Prescription Drugs

- An organization offering coordinated care MA plans must offer at least one MA plan with prescription drug coverage (known as an MA-PD plan) in every service area.
- MA PFFS plans have the option of offering prescription drug coverage but are not required to do so.
    - An individual enrolled in an MA PFFS plan that does not include a Part D benefit may enroll in a PDP, even if under the same MA contract, the organization offers another PFFS plan that includes a Part D benefit.
- MA MSA plans are prohibited from offering prescription drug coverage. If an MSA member wants prescription drug coverage, the member must enroll in a stand-alone PDP.
- If a beneficiary enrolls in an MA plan that includes Part D prescription drug coverage (an MA-PD plan), the beneficiary can only receive Part D drug coverage through that plan.
- If a beneficiary enrolls in an MA plan that is an HMO or PPO plan that does not include Part D coverage, the beneficiary cannot join a stand-alone Prescription Drug Plan (PDP). If the beneficiary wants to remain enrolled with the organization offering their MA plan, they must choose an MA-PD offered by the organization.
    - Enrollees in certain Employer/Union retiree group plans may have different options.

36. MA & Prescription Drugs – Example

Ms. Foley is enrolled in WeCare HMO's ruby plan, which does not include prescription drug coverage. She asks her agent about enrolling in a PDP because she likes WeCare HMO but wants drug coverage. Her agent advises her that to remain with WeCare HMO and receive drug coverage, she must enroll in WeCare's diamond plan, which is an MA-PD plan. She cannot enroll in a PDP if she is enrolled in WeCare HMO.

37. Title Page – Other types of Medicare Health Plans

38. Other Types of Medicare Health Plans

There are other types of Medicare health plans, which are NOT Part C or Medicare Advantage plans. The other types of Medicare health plans include:

- Medicare Cost Plans
- Programs of All-Inclusive Care for the Elderly (PACE) plans
- Medicare-Medicaid Plans (MMPs)
- Other Demonstration Plans
  - Other Medicare health plan demonstrations include state-specific demonstrations such as the Minnesota Senior Health Care Options (MSHO) program.

39. Medicare Cost Plans

Medicare Cost Plans are Medicare health plans that are not Medicare Advantage (Part C) plans and are not Original Medicare.

Cost plan enrollees can choose to receive Medicare-covered services:

- Under the plan's benefits by going to plan network providers
  - The plan's cost-sharing applies when the enrollee gets services from network providers.
- Under Original Medicare by going to non-network providers.
  - Original Medicare cost-sharing applies when the enrollee gets services from non-network providers. This amount is generally higher than the plan cost-sharing.

Medicare Cost Plans:

- may offer Part D prescription drug coverage as an optional benefit but are not required to do so.
- may offer other optional supplemental benefits.
- are available only in certain areas in the United States. In 2024 they were offered in 11 states including some counties in Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin, and Wyoming.

An individual may enroll in a cost plan and a PDP.

- This applies regardless of whether the cost plan offers Part D coverage.

The following individuals are eligible to enroll in a Medicare cost plan:

- Those with Medicare Parts A and Part B; or
- Those with only Part B. Enrollees with Part B only will not have Part A coverage under the plan unless they purchase it. The plan may adjust the enrollee premium for individuals with Part B only.

Premiums:

Enrollees must pay their Part B premiums and any plan premium.

40. PACE Plans

Programs of All-Inclusive Care for the Elderly (PACE):

- are Medicare plans for frail, elderly beneficiaries certified as needing a nursing home level of care but still living in the community (i.e., not in a nursing home).
- are available in most states but tend to have small service areas, and thus may only be available in a few counties.
- offer an adult day health center, where enrollees can get health care, meals, and other services.
- include comprehensive medical and social service delivery systems using an interdisciplinary team approach in the adult day health center, supplemented by in-home and referral services.

Eligibility for PACE: Participants must be

- age 55 or older.
- reside in the PACE organization's service area.
- be certified as eligible for nursing home care by their state.
- be able to live safely in a community setting at the time of enrollment.

Under a PACE Plan:

- There's no deductible or copayment for any drug, service, or care approved by the PACE team of health care professionals.
- Beneficiaries with Medicaid pay no premiums.
- Beneficiaries with only Medicare pay a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Part D (in addition to the Part B premium).

41. Medicare-Medicaid Plans (MMPs)

Medicare-Medicaid Plans (MMPs):

  - are established under demonstration authority; and
  - are available only in certain counties in Rhode Island, South Carolina, Texas, California, Illinois, Massachusetts, Michigan, New York, and Ohio.
- Only certain individuals eligible for both Medicare and Medicaid may enroll in MMPs.
  - Eligibility varies by state.
- MMPs financially integrate and provide both Medicare and Medicaid benefits.
  - In some states, MMPs may offer additional benefits.
- All MMPs include Part D benefits.
- MMPs are NOT Medicare Advantage plans.

42. Title Page-Enrollee Protections Appeals and Grievances

43. Enrollee Protections

Enrollees of a Medicare Advantage plan, Medicare Cost plan, PACE plan, or MMP have a right to:

- file complaints (sometimes called grievances), including complaints about the quality of their care.
- get a decision about health care payment or services, or prescription drug coverage.
- get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.

44. Enrollee Protections: Grievances

The grievance process is used for complaints about the operations of a plan or its network providers.

- Enrollees or their representatives may file a grievance if they experience problems with their health care services such as timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues also may include complaints that a covered health service, procedure, or item furnished during a course of treatment did not meet accepted standards for the delivery of health care.
- An enrollee or their representative may make the complaint orally, in writing, or via a CMS website at https://www.medicare.gov/MedicareComplaintForm/home.aspx.
- Plans must also provide a link to the Medicare.gov website where the enrollee can enter a complaint.

Example:

Mr. Russell went to an orthopedic surgeon after being referred by his primary care doctor. He sat in the waiting room for two hours after his appointment time before being called in to see the doctor. He called his MA plan to complain. The customer service representative told him that she could take his complaint, or he could file it through the plan's website. He opted to file it through the plan website. The plan investigated his complaint and responded to Mr. Russell.

45. Enrollee Protections: Coverage Decisions

- Coverage decisions are determinations made by a Medicare health plan concerning whether medical care or prescription drugs are covered, how they are covered, and the beneficiary's share of the cost.
- Examples of times when an enrollee may need a coverage decision include:
    - To get prior authorization for a provider to furnish a service.
    - To obtain payment for certain items or services, such as the type or level of services the enrollee thinks should be furnished.
    - To obtain payment for urgently needed services the enrollee received when they were temporarily out of the area.
    - To continue a service that the enrollee believes is medically necessary.
    - To obtain payment for a prescription drug.
    - To ask for an exception from a plan's formulary requirements (including step therapy requirements) or tiering structure for prescription drugs.

- An enrollee has a right to ask for prior authorization even when it is not required to find out if a service will be covered by the plan.

46. Enrollee Protections: Appeals

The appeals process is used to ask for a review of the plan's coverage or payment decisions.

- If an enrollee is not satisfied with the coverage decision, they, or in some cases their physician, can appeal the decision.
    - Physicians can appeal prior authorization denials on behalf of their patients.
- An appeal is a formal way to ask the plan to review or change a coverage decision.
- An appeal can also be filed if:
    - an enrollee believes a Medicare health plan did not pay for or authorize a service that should be covered. Where the plan did not pay, the enrollee must be financially liable in order to appeal.
    - an enrollee believes an authorized service such as a hospitalization or home health care is ending too soon.
    - an enrollee believes a plan has not authorized or paid for a Part D prescription drug that should be covered.

47. Enrollee Protections: Appeals

- Medicare health plans must provide enrollees with a written description of the appeal process.
- Medicare health plans offering a Part D benefit must:
    - provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a coverage determination or appeal a decision about coverage of a drug.
    - require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination concerning a drug.

48. Sources of Additional Information

- Medicare & You Handbook
  https://www.medicare.gov/medicare-and-you
- Detailed information on Medicare Advantage plan requirements
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending
- Information on Medicare Advantage enrollment and eligibility
  https://www.cms.gov/files/document/cy-2024-ma-enrollment-and-disenrollment-guidance.pdf

1. Module 3: Medicare Part D Prescription Drug Coverage

2. Navigation Instructions

3. Terms and Conditions

4. Learning Objectives

- After reviewing "Part 3 - Medicare Part D Prescription Drug Coverage" you will be able to explain:
    - What Part D plans are
    - Who is eligible to enroll in a Part D plan
    - Part D standard and alternate benefits
    - Part D management tools, covered drugs, and formulary requirements
    - Part D True Out-of-Pocket (TrOOP) costs and help for beneficiaries with limited income
    - Late enrollment penalties and premiums
    - New for 2025: The Medicare Prescription Payment Plan

5. Training Roadmap: Module 3

- Medicare Part D Basics and Eligibility
- Covered Drugs
- Part D Standard and Alternative Benefits
- "True Out-of-Pocket" Costs (TrOOP)
- Part D Premiums and Late Enrollment Penalties
- Part D Drug Management Tools and Formulary Requirements
- New for 2025: The Medicare Prescription Payment Plan
- Part D Enrollee Rights
- Part D Assistance Programs

6. Overview of Changes for 2025

As part of the Inflation Reduction Act, Congress made several changes to the Part D program that will be implemented for the first time in 2025 and are further addressed in this training. Those changes include:

- Eliminating the coverage gap phase from the standard Part D benefit structure
- Capping beneficiary out-of-pocket costs at $2000
- Adding a new program (the Medicare Prescription Payment Plan) that provides beneficiaries the option to pay their out-of-pocket Part D prescription drug costs in monthly amounts over the year, instead of paying at the point of service.

The legislation also imposed certain requirements on drug manufacturers that may reduce the cost of Part D drugs.

7. Title Page- Part D Basics and Eligibility

8. Medicare Part D Prescription Drug Program Basics

- Medicare Part D covers certain prescription drugs, diabetic supplies, and vaccines.
- Coverage of Medicare Part D benefits is provided only through private companies. There is no fee-for-service Part D benefit.
- The types of Medicare plans that include Part D benefits are:
    - Stand-alone Prescription Drug Plans (PDPs)
    - Medicare Advantage-Prescription Drug (MA-PD) Plans:
        - MA-PDs are MA health plans that also cover Part D prescription drugs.
    - Cost-PD Plans
        - Cost-PDs are Medicare cost plans that cover Part D prescription drugs as an optional supplemental benefit.
    - Medicare-Medicaid Plans
    - PACE plans

9. Medicare Part D Eligibility

To be eligible for Part D, individuals must be:

- entitled to Part A **and/or** enrolled under Part B (not including enrollment in Part B solely for coverage of immunosuppressive drugs); and
- a U.S. citizen or lawfully present in the United States on or before the enrollment effective date. (CMS makes this determination).

Individuals meeting the above criteria are generally eligible to obtain Part D benefits through any PDP offered in the area in which the individual permanently resides, depending on how they receive their Medicare benefits. PDPs must enroll any eligible beneficiary who applies regardless of health status.

- To obtain Part D benefits from other types of Medicare health plans, such as an MA-PD, Medicare-Medicaid Plan, or PACE Plan, the individual will have to meet the additional eligibility criteria for those plans. For example, to enroll in an MA-PD, individuals must be both entitled to Part A and enrolled in Part B.

10. Medicare Part D Prescription Drug Eligibility

Individuals' eligibility to enroll in a stand-alone PDP also depends on how they receive their medical benefits.

- Generally, only beneficiaries enrolled in Original Medicare, an MA MSA, a PFFS plan, or a Cost plan may enroll in a standalone PDP to receive Part D benefits.
    - Beneficiaries enrolled in a MA MSA may only obtain Part D benefits through a standalone PDP.
    - Beneficiaries enrolled in a Cost plan or MA PFFS plan may obtain Part D benefits through their plan (if offered) or through a standalone PDP.
- Beneficiaries enrolled in a MA HMO or PPO may only obtain Part D benefits through their HMO or PPO plan.
    - In some cases, employer group plan enrollees may have additional choices.
- Individuals enrolled in a Medicare-Medicaid Plan or PACE plan may only receive their Part D benefits through their plan.

11. Medicare Part D Eligibility: Examples

Ms. Fitzgerald meets an institutional equivalent level of care but is living in an assisted living facility. Because of her need for intensive case management, her broker has suggested either an institutional-equivalent Medicare Advantage special needs plan offered at her facility or a PACE plan. Ms. Fitzgerald asks whether she should also enroll in a PDP. Her agent correctly counsels her that all PACE plans and IE-SNP plans will include Part D benefits and if she enrolls in either, she will be ineligible to enroll in a freestanding PDP.

Mr. Bradley has Medicare FFS with a PDP. The PDP offers excellent low-cost coverage for the prescription drugs Mr. Bradley takes, and he would like to remain enrolled in it. However, Mr. Bradley is interested in enrolling in a Medicare Advantage plan to obtain additional coverage of the Medicare out-of-pocket amounts. To accommodate Mr. Bradley's wishes, his broker should help Mr. Bradley explore PFFS plans that do not include Part D and MSAs.

12. Title Page- Covered Drugs

13. Covered Part D Drugs

Part D plans cover:

- Prescription drugs
- Biologics
    - Biologics are drugs made from natural sources (human, animal, or microorganism) that are not chemically synthesized, examples include allergy shots and gene therapies.
- Insulin
- Medical supplies associated with the injection of insulin (e.g., syringes, needles, alcohol swabs, and gauze) or delivering insulin into the body (e.g., an inhalation chamber)
- Vaccines not covered by Part B

14. Drugs Excluded from Part D Coverage

The following are excluded from the definition of a Part D covered drug:

- Drugs for weight loss or gain, fertility, cosmetic purposes, symptomatic relief of cough and colds
- Vitamins- Prescription vitamins and minerals with the exceptions of prenatal vitamins and fluoride preparations for certain uncommon Vitamin D analogs (Vitamins D2 and D3 are excluded from Part D coverage).
- Medical foods formulated to be consumed or administered enterally under the supervision of a physician that are not regulated as drugs under section 505 of the Federal Food, Drug, and Cosmetic Act
- Erectile dysfunction drugs (when used for sexual dysfunction)
- Non-prescription drugs
- Some off-label use drugs
- Drugs covered under Part A and B (even if an individual does not have such coverage)

Part D plans are permitted to offer supplemental benefits that cover drugs that otherwise meet the definition of a Part D prescription drug but are explicitly excluded from coverage, such as certain prescribed weight loss drugs.

15. Formularies

- Part D plans generally do not cover all drugs available in each category of Part D covered drugs because in some cases several similar drugs are available to treat the same medical condition.
- Part D plans include the Part D drugs they will cover on a list known as a "formulary."
    - Formularies are developed by pharmacists, doctors, and other experts.
- Part D plan formularies must include:
    - At least two drugs in each therapeutic category.
    - Generic and brand-name drugs.

16. Tiering

A common feature of Part D benefit structures and formularies is cost-sharing tiers.

- Tiered cost-sharing means grouping Part D drugs into different cost-sharing levels within a Part D sponsor's formulary. Many plans group drugs into 3 or 4 tiers with lower tiers requiring less beneficiary cost-sharing than higher tiers, for example:
    - Tier 1: Generic drugs
    - Tier 2: Preferred brand-name drugs
    - Tier 3: Non-preferred brand-name drugs
    - Tier 4: High-cost drugs or "specialty drugs"
- Thus, in evaluating whether a Part D plan should be recommended to a beneficiary, it is important to confirm not only that the beneficiary's drugs are on the formulary, but to also evaluate which cost-sharing tier the drugs fall into.

17. Title Page- Part D Standard and Alternative Benefits

18. Part D Plan Benefits

- All Part D plans must cover at least the Part D standard benefit or meet the requirements for "alternative benefits."
    - Benefit structures that are not standard but instead are actuarially equivalent, are known as "alternative" coverage.
- The standard benefit structure includes several coverage "phases" including:
    - a deductible
    - an initial coverage phase between the deductible and the annual out-of-pocket threshold
    - a catastrophic coverage phase that applies after the beneficiary reaches the annual out-of-pocket threshold
- The standard benefit includes coverage of drugs in six protected categories. These six protected classes include: anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants.

19. Part D Benefits: Alternative Coverage

- Alternative coverage is prescription drug coverage that is not standard drug coverage but is at least actuarially equivalent to standard drug coverage.
- Actuarial equivalent means that the value of Part D benefits must be at least the same as the standard coverage. Alternative coverage must also:
    - not have an annual deductible that exceeds the annual deductible under the standard benefit.
    - impose cost-sharing no greater than the standard benefit once the annual out-of-pocket threshold is met.
- Alternative benefits may also be structured with some or all of the coverage phases that are part of standard benefits.
- Some Part D plans may offer enhanced coverage for an additional monthly premium (known as enhanced alternative benefits).
    - Coverage enhancements may include, for example, a reduction of the deductible; coverage of excluded drugs, and/or a decrease in the beneficiary coinsurance amounts.

20. Standard Part D Benefits for 2025

For 2024, the standard benefit requires the beneficiary to pay:

- a $590 deductible
- 25% of prescription drug costs during the initial coverage phase.

Once beneficiary out-of-pocket costs reach a total of $2,000, the beneficiary is through the initial coverage phase and reaches catastrophic coverage.

- The out-of-pocket costs that count toward reaching the catastrophic limit are known as "true out-of-pocket" costs or TrOOP. In some instances, amounts not directly paid by the beneficiary count toward TrOOP. After reaching the annual out-of-pocket threshold, the beneficiary pays nothing.

21. Part D Plan Benefits: The Standard Benefit Plan for 2025 (Illustrated)

Medicare Module 3 – Part D Standard Benefit Enrollee Cost Sharing

Catastrophic Coverage Enrollee pays $0
$2000 (out-of-pocket threshold)
Initial Coverage Enrollee Pays 25% of prescription drug costs
$590 (deductible)
Deductible Enrollee pays 100%

22. Applicable Measures to Determine Coverage Phases

It is important to note that there are different financial measures to determine when a new coverage phase is met.

- Progression through the deductible is determined by the total gross covered prescription drug costs, which refers to spending on covered Part D drugs by beneficiaries or on their behalf by any third party as well as the Part D sponsor.
- Progression through the initial coverage phase is determined by accumulated true out-of-pocket cost (TrOOP) spending.

23. Special Cost-Sharing for Insulin and Vaccines

- There is no cost sharing for Part D adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), even in the deductible phase. This includes, but is not limited to vaccines for:
    - Shingles vaccines
    - Tdap vaccines (tetanus, diphtheria, and pertussis/whooping cough)
    - Hepatitis A
- The cost-sharing for a one-month supply of a covered insulin product cannot be more than $35 in any coverage phase.

24. Title Page- True Out-of-Pocket Costs (TrOOP)

25. "True Out-of-Pocket" Costs (TrOOP)

Part D True Out-of-Pocket costs or "TrOOP" are out-of-pocket costs that count towards the annual out-of-pocket threshold to move into the catastrophic coverage phase.

- TrOOP is calculated on an annual basis.
- Generally, TrOOP includes beneficiary payments for Part D prescription drugs, including:
    - The annual deductible and cost-sharing above the deductible up to the annual out-of-pocket threshold.
- Generally, for drug costs to count toward TrOOP, drugs must be on the plan's formulary and be purchased at the Part D plan's participating network pharmacy.

The following also count towards TrOOP:

- Amounts paid or borne by the AIDS Drug Assistance Program and the Indian Health Service.
- Amounts paid by or through qualified State Pharmaceutical Assistance Programs (SPAPs), most charities, health savings accounts, flexible spending accounts, and medical savings accounts.
- Supplemental Part D coverage provided by enhanced alternative Part D plans and other health insurance.
    - This includes supplemental coverage provided by Employer Group Waiver Plans as well as Medicare plan reductions in cost sharing for enrolled beneficiaries, such as reductions by Medicare-Medicaid Plans and D-SNPs.
- a Medicare Prescription Payment Plan participant's TrOOP-eligible costs that are paid by their Part D plan under the Medicare Prescription Payment Plan.

What is Excluded?

Some costs <u>do not</u> count toward TrOOP costs including:

- costs for drugs not on a Part D plan's formulary, unless the beneficiary requests and receives a formulary exception under which the plan covers the drug
- costs for over-the-counter (OTC) and other non-Part D drugs
- costs for covered Part D drugs obtained out-of-network (unless the plan's out-of-network coverage policy applies)
- costs paid for or reimbursed to an enrollee by insurance, a group health plan, most government-funded health programs, or another third party including:
    - Medicaid, State Children's Health Insurance Program (CHIP), Federally Qualified Health Centers, Rural Health Clinics, Patient Assistance Programs (PAPs) outside the Part D benefit, TRICARE, Federal Employees Health Benefits Program (FEHBP), Black Lung Funds, and health reimbursement arrangements (HRAs)
- costs for drugs purchased outside the United States
- any manufacturer payments made under the new (for 2025) Discount Program.

26. Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), Examples

Example 1: Mr. Bingham takes several formulary drugs which have a total cost of $2000 per year. He uses a Health Reimbursement Arrangement (HRA) funded by his employer to pay his deductible and cost-sharing. No costs that Mr. Bingham pays for with HRA funds count toward TrOOP.

Example 2: Ms. Howard has acid reflux. To address it, she has been taking a formulary drug provided by a network pharmacy and an over-the-counter medication. Only the amount Ms. Howard pays for the formulary drug counts toward TrOOP.

27. Part D Pharmacy Networks

- Part D coverage is generally provided through contracted pharmacies (network pharmacies) in the Part D plan's service area, except that PFFS plans are not required to use a pharmacy network but may voluntarily choose to have one.
- Network pharmacies include retail pharmacies, long term care pharmacies, and may also include mail-order pharmacies.
- Within their networks, Part D plans may designate some pharmacies as preferred pharmacies that offer lower levels of cost-sharing ("preferred cost-sharing") than apply at other network pharmacies ("standard cost-sharing").
- Enrollees are generally required to fill prescriptions for covered drugs at network pharmacies.
- Under certain circumstances, enrollees may fill prescriptions for covered drugs at out-of-network (non-network) pharmacies, but possibly at a higher cost to enrollees. For example:
    - If the enrollee has an illness or loses a drug while traveling outside the service area; or
    - If circumstances result in limited drug access through an in-network pharmacy.

28. Title Page - Part D Premiums and Late Enrollment Penalties

29. Part D Premiums

- Part D plans may charge a premium.
    - Typically, a higher premium means lower out-of-pocket costs for the plan.
- Part D enrollees have three options for paying their Part D premium.
    - An automatic electronic monthly mechanism, such as withdrawal from their checking or savings bank account or automatic charge against their credit or debit card.
    - Direct monthly billing from the plan.
    - Automatic deduction from their monthly Social Security Administration (SSA) benefit check.
        - Typically, it takes 2-3 months for SSA withholding to begin or end.
        - When withholding begins, it will be for the 2-3 months of premiums owed.
- Generally, the beneficiary must stay with the premium payment option they choose for the entire year.
- If an enrollee does not choose an option, the beneficiary will be billed by the Part D plan monthly.

30. Part D Late Enrollment Penalty

- Non-Medicare insurers are required to notify beneficiaries annually whether or not the prescription drug coverage they have is creditable (coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay).
- Beneficiaries may have to pay a monthly premium penalty to join a Part D plan if:
    - they do not have creditable drug coverage and do not enroll when first eligible for Part D.
    - there have been at least 63 continuous days following a beneficiary's initial enrollment period for Part D during which the beneficiary did not have either Part D or other creditable drug coverage.
- The penalty will be 1% of the national average beneficiary premium for each month the beneficiary did not have Part D or creditable coverage.
- In general, the penalty is in effect for as long as the beneficiary has Medicare prescription drug coverage.
- Beneficiaries who qualify for the low-income subsidy are not subject to the late enrollment penalty.

31. Late Enrollment Penalty Examples

Mr. Russell did not sign up for Part D when he first became eligible because, as an active employee, he had creditable coverage through his employer. Mr. Russell retired 6 months ago. His employer does not offer retiree coverage and he has not signed up for Part D. It is the Annual Election Period and Mr. Russell seeks to enroll in a Part D plan effective January 1. He is not eligible for a low-income subsidy. Mr. Russell will pay a premium penalty of 1% for each month he was without creditable coverage.

Ms. Smith did not sign up for Part D when she first became eligible and has not had creditable coverage. She has been paying out of pocket for her drugs for the past 3 years but can no longer afford them. She now wishes to enroll in a Part D plan. Her agent asks Ms. Smith about her income and determines that Ms. Smith is likely to qualify for a low-income subsidy. The agent helps Ms. Smith apply for a low-income subsidy and advises her that if her application is approved, she will avoid what would otherwise be a substantial late enrollment penalty.

32. Title Page – Part D Drug Management Tools and Formulary Requirements

33. Part D Drug Management Tools

In addition to formularies and cost-sharing tiers, Part D plans use a variety of prescription drug benefit management tools including:

- Step therapy: Requires enrollees to try one or more similar lower-cost drugs before other costlier drugs are covered, if necessary.
- Prior authorization: Requires the doctor to contact the plan and request authorization before the plan will cover the prescription drug. The doctor must show the plan that the drug is medically necessary for it to be covered.
- Quantity limits: For safety and cost reasons, Part D sponsors may limit the amount of certain prescription drugs they cover over a specified time period.

- Substitution: Part D sponsors may substitute generic drugs for brand name drugs if the generic drugs have the same or lower cost-sharing and certain conditions are met.
- Comprehensive Addiction and Recovery Act (CARA) programs: Plans may impose certain limitations on the prescribers or pharmacies a beneficiary can use to manage utilization for beneficiaries who are at risk of misusing or abusing frequently abused drugs, such as opioids.

34. Transition Requirements

- Part D sponsors must provide coverage of at least a one-month fill (unless a lower amount was prescribed) of non-formulary drugs to the following individuals prescribed a non-formulary drug, including Part D drugs that are on a sponsor's formulary, but require prior authorization, step therapy, or are subject to a quantity limit that is not safety-based:
    - beneficiaries initially enrolling in Part D,
    - beneficiaries switching plans, and
    - current enrollees affected by formulary changes (other than allowable substitutes of a generic drug for a brand name drug)
    - current enrollees experiencing a level of care change, if the Part D sponsor is notified of the change before or at the time of the request for the fill

35. Transition Requirements

- Beneficiaries eligible for transition fills must receive coverage of at least a one-month fill (unless a lower amount was prescribed) of their non-formulary drugs during the first 90 days after their enrollment, the plan switch, or the formulary change.
- To the extent that a current enrollee in a long-term care setting is outside their 90-day transition period, the sponsor must still provide a one-month supply of nonformulary Part D drugs while an exception or prior authorization request is being processed.
- During the transition period:
    - the Part D plan does not apply prior authorization, non-safety-based quantity limits, or step therapy rules.
    - the enrollee and their physician can request an exception to the Part D plan's formulary to continue coverage of the non-formulary drug or can transition to a formulary drug.

36. New for 2025: The Medicare Prescription Payment Plan (1 of 3)

Beginning in 2025, Part D sponsors are required to provide all Part D enrollees the option to pay their cost-sharing amounts (including any deductibles, copayments, or coinsurance) in monthly amounts spread out over the plan year, instead of paying them in full at the point of service (e.g., the pharmacy).

- Part D enrollees can opt into the Medicare Prescription Payment Plan ("the program") at the beginning of the year or any point during the year.
- Part D enrollees who choose to participate in the program pay nothing at the point of service for a Part D covered drug but are billed each month by their Part D plan.
- Monthly payments do not start until the beneficiary opts into the program and first incurs out-of-pocket costs for covered Part D drugs.

- The amount that the Part D sponsor bills the enrollee for a month under the program cannot exceed a maximum monthly cap, calculated based on each enrollee's costs and the point in the plan year in which they enrolled in the program. The monthly cap varies from month to month.
- Opting into the program will not impact how a Part D enrollee moves through the phases of the Part D benefit (i.e., deductible, initial coverage period, and catastrophic coverage) or what counts towards their true out-of-pocket (TrOOP) costs.

37. The Medicare Prescription Payment Plan (2 of 3)

- The program is intended to allow beneficiaries to spread out their cost-sharing obligations throughout a plan year.
- While this program is available to any Part D enrollee, those incurring high out-of-pocket costs earlier in the plan year are generally more likely to benefit.
- Part D enrollees with low-to-moderate recurring out-of-pocket drug costs (e.g., maintenance drugs whose annual costs are not expected to exceed the out-of-pocket threshold) are not likely to benefit from the Medicare Prescription Payment Plan because their costs are already distributed evenly throughout the year.

38. The Medicare Prescription Payment Plan (3 of 3)

- Enrollees can opt out of the program at any time. However, they will continue to be billed monthly for any cost-sharing amounts still owed.
- Failure to pay the monthly billed amount will result in disenrollment from the program (but not the plan) after a specified grace period. However, the Part D sponsor will continue to bill amounts owed under the program in monthly amounts. The sponsor may also offer the beneficiary the option to repay the full outstanding amount in a lump sum.
- Once a beneficiary leaves the program, they must resume paying their out-of-pocket cost sharing at the point-of-service.

39. Title Page- Part D Enrollee Rights

40. Enrollee Rights: Requesting Coverage Determinations and Appealing Decisions

- Part D Plan Sponsors must provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a determination of whether the plan will cover a drug (a coverage determination) or appeal a coverage decision.
    - Enrollees may appeal coverage determinations, decisions on exceptions, or requests concerning tiering or formularies.
- Plan Sponsors must also require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination.

Enrollee Rights: Requesting Exceptions for Drugs

- Enrollees have the right to request coverage of a drug that is not on the Part D plan's formulary or to request exceptions from plan rules such as prior authorization, step therapy, or quantity limits. Such requests are known as formulary exception requests.

- Enrollees also have a right to request coverage of formulary drugs at a less costly formulary tier. This is known as a tiering exception.
- Exception requests must be accompanied by a supporting statement by a physician or other prescriber explaining why the exception is necessary.
- A standard form is available on Part D plan websites for enrollees to request a coverage determination, including a formulary or tiering exception. A physician or other prescriber may also request a tiering or formulary exception.

Enrollee Rights: Filing Grievances

- Beneficiaries may also file complaints about their Part D plan or their pharmacies. These complaints are known as grievances.
- Grievances include complaints about issues such as pharmacy wait times, a plan's failure to mail a beneficiary requested material, or the length of hold time on the plan customer service line.
- Grievances do not include complaints about a Part D sponsor's refusal to cover a drug or approve an exception request. Beneficiaries must resolve such issues through the appeals process.

41. Title Page- Part D Assistance Programs

42. Help for Individuals with Limited Income and Limited Resources

If a beneficiary has limited income and resources, they may qualify for a low-income subsidy (LIS) to cover all or part of the Part D plan premium and cost-sharing. To qualify for the LIS in 2024:

- Beneficiary income may not exceed 150% of the Federal Poverty Level (FPL). The 150% FPL varies geographically. In addition, beneficiary resources may not exceed the published limit. The resources counted toward the limit include bank accounts, stocks, bonds, and other liquid resources that beneficiaries can readily convert to cash within 20 days and real estate that is not the beneficiary's primary residence.
- Based on 2024 FPL's, income limits are as follows:
    - 48 states and DC $22,590 (individual)/$30,660 (couple)
    - Alaska $28,215 (individual)/$38,310 (couple)
    - Hawaii $25,965 (individual)/$35,250 (couple)
- CMS publishes the resource limits for each year in the late fall of the previous year. For 2024, beneficiaries' resources may not exceed $15,720 (individual)/$31,360 (couple). These limits are increased by $1500 per person if the beneficiary notifies the Social Security Administration that they expect to use some of their resources for burial expenses.

43. Individuals with Limited Income 2025- Low-Income Subsidy (LIS)

- For 2025, individuals who qualify for full LIS and are Full Benefit Dual Eligibles (FBDEs) with income at or below 100% of the Federal Poverty Level (FPL) and resources below the applicable threshold have a $0 deductible and cost-sharing of:
    - Maximum cost-sharing up to the out-of-pocket threshold of:
        - $1.60 for generic drugs

        - $4.80 for other drugs
- For 2025, individuals who qualify for full LIS and are FBDEs with (income over 100% of FPL and resources below the applicable threshold) have a $0 deductible and cost-sharing of:
    - Maximum cost-sharing up to the out-of-pocket threshold of:
        - $4.90 for generic drugs
        - $12.15 for other drugs
- For 2025, individuals who qualify for LIS but are not FBDEs have a $0 deductible and cost-sharing of:
    - Maximum cost-sharing up to the out-of-pocket threshold of:
        - $4.90 for generic drugs
        - $12.15 for other drugs

44. Other Help for Low-Income – Pharmaceutical Assistance Programs

- Some pharmaceutical manufacturers operate programs that assist low-income individuals in obtaining drugs at reduced or no costs.
- Some states have assistance programs designed specifically for their residents.
    - Some programs are "qualified" State Pharmaceutical Assistance Programs or SPAPs that count towards TrOOP and some do not count towards TrOOP.
    - Becoming familiar with your state's programs may allow you to help a beneficiary address cost-sharing for prescriptions.

45. Encourage Individuals with Limited Income/Resources to Apply to the State Medicaid Office

- Beneficiaries with limited income and resources should be encouraged to apply for the low-income subsidy (LIS) – also called extra help – through the State Medicaid office or the Social Security Administration (SSA). Beneficiaries may apply at any time.
    - If beneficiaries apply to the State Medicaid office for Part D help, the State Medicaid office also will check for eligibility for other low-income assistance programs.
    - They may also call SSA at 1-800-772-1213 (TTY users can call 1-800-325-0778) or apply online at https://secure.ssa.gov/i1020/start for help with Part D costs.
- After SSA or the State approves an application for extra help, it is effective on the first day of the month in which the individual applied.

46. Certain Individuals Automatically Qualify for Extra Help

Individuals automatically qualify for Extra Help if they have Medicare and meet any of these conditions:

- They have full Medicaid coverage
- They get help from their state Medicaid program paying their Part B premiums (in a Medicare Savings Program)
- They get Supplemental Security Income (SSI) benefits

Medicare mails these individuals a purple letter to let them know they automatically qualify. They should keep this letter for their records. They do not need to apply for Extra Help if they get this letter.

47. Title Page-Part D and Other Coverage

48. Employer/Union Coverage of Drugs

- Employer or Union Coverage: Employers/unions will notify their employees of whether their non-Medicare prescription drug coverage is "creditable" (coverage that, on average, covers at least as much as Medicare's standard Part D covers) via an annual statement.
    - If coverage is creditable and the beneficiary keeps it, the beneficiary will not incur a premium penalty if later they lose or drop the employer coverage and join a Part D plan.
    - If coverage is not creditable, the beneficiary will need to enroll in Medicare Part D during their initial eligibility period to avoid the late enrollment penalty.
- If a beneficiary has creditable drug coverage through TriCare, the VA, or the FEHBP, they can compare that coverage with available Part D plans to decide whether to enroll in Part D.
- The beneficiary should check with the employer or union benefits administrator before making changes to their employer/union coverage.
    - If a beneficiary drops employer/union prescription drug coverage, they may not be able to get it back and may also lose health coverage.
- There will be no late enrollment penalty if the beneficiary retires or otherwise loses employer/union creditable coverage and joins a Medicare Part D plan or otherwise obtains creditable drug coverage within 63 days.

49. Medicaid Drug Coverage

- When a Medicaid beneficiary becomes eligible for Medicare, then Medicare, instead of Medicaid, covers the Part D drugs once the beneficiary is enrolled in a Part D plan.
- If Medicaid beneficiaries don't choose a plan, Medicare will select one for them.

50. For Additional Information

Medicare's site on Part D prescription drug coverage for beneficiaries.
http://www.medicare.gov/part-d/index.html

The Medicare and You Handbook
https://www.medicare.gov/medicare-and-you/medicare-and-you.html

Your Guide to Medicare Prescription Drug Coverage
https://es.medicare.gov/publications/11109-Medicare-Drug-Coverage-Guide.pdf

1. Module 4: Communications and Marketing Rules for Medicare Advantage and Part D Plans

2. Navigation Instructions

3. Terms and Conditions

4. Learning Objectives

- After reviewing "Module 4: Communications and Marketing Rules for Medicare Advantage and Part D Plans" you will be able to explain:
    - What are communications
    - What activities constitute marketing and what materials are marketing materials
    - The special rules for marketing Medicare health plans and Part D plans
    - Rules for making marketing appointments
    - Prohibited marketing and communications practices
    - Permitted promotional and marketing activities
    - The difference between educational and marketing events
    - Rules regarding agent compensation
    - Plan enforcement of the marketing rules and potential penalties

5. Training Roadmap: Module 4

- New rules for agent compensation and sharing of contact information
- New rules concerning incentives to agents and other TPMOs
- Applicability of rules concerning marketing and communications
- Marketing Representatives: agents/brokers and third-party marketing organizations
- Key terms and general background information
- Regulation of communications activities and materials
- Marketing communications – contacting beneficiaries
- Rules related to sales and educational events
- Marketing at individual appointments
- Use of social media to market
- Required practices
- Accessing and using certain plan materials
- Plan ratings and call recordings
- Prohibited activities
- Marketing during the open enrollment period
- Marketing in healthcare settings
- Plan oversight and enforcement of marketing requirements
- Prohibition on incentives, referral fees, and agent/broker compensation

6. New for Marketing of 2025 Products

- Compensation to independent agents/brokers will include amounts for administrative services. All Plan Sponsors that pay compensation to independent agents/brokers must pay the specified fair market value amount. No additional payments may be made to independent agents/brokers tied to enrollment, related to enrollment in a Medicare or Part D plan or product, or for services conducted as a part of the relationship associated with the enrollment.
- Beneficiary information collected by a third-party marketing organization (TPMO), including an agent/broker for purposes of marketing or enrolling the beneficiary into a Medicare health plan or Part D plan may only be shared with another TPMO when prior written consent is given by the beneficiary. The consent must list each entity receiving the data.
- Plan sponsors must ensure that no provision of a contract with an agent or other TPMO has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary.

7. Title Page – Applicability of Rules Concerning Marketing and Communications

8. Medicare Marketing and Communications Rules

The Medicare marketing and communications rules apply to the following types of Medicare health plans and Part D plans:

- Medicare Advantage (MA) only plans
- Medicare Advantage Prescription Drug (MA-PD) plans
- Prescription Drug Plans (PDPs)
- Section 1876 Cost plans
- Medicare-Medicaid Plans (MMPs)
    - For MMPs, marketing requirements may be modified by state-specific requirements. Each state in which MMPs are offered has state-specific marketing guidelines and CMS-approved model documents. Those guidelines and documents can be accessed at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html

9. Applicability of Medicare Communications and Marketing Rules to Marketing Representatives

Plan marketing representatives are subject to the same requirements related to marketing and communications as the plans. Plans are responsible for ensuring compliance with Medicare rules by their marketing representatives, such as the need for annual training.

Plan marketing representatives include:

- individuals employed by a plan
- individuals or entities under contract to the plan through a direct or downstream contract.
    - This would include brokers and agents (contracting directly with the plan or through an agency or other entity), Field marketing organizations (FMOs), agencies, general agents (GAs), or other Third-Party Marketing Organizations (TPMO).

10. Applicability of Medicare Communications and Marketing Rules when Marketing to Employer/Union Groups

Marketing representatives and Plans must follow all marketing rules and guidelines when marketing employer group health plans except the following:

- the prohibition against unsolicited contacts
- the prohibition against cross-selling other products
- the requirement to obtain prior documentation of the scope of an appointment
- the prohibition against providing meals at marketing events
- the pre-enrollment checklist requirement
- marketing representative compensation requirements

- the requirement that a marketing representative must pass an annual test, although the requirement for annual training does apply

Plans offering employer group health plans are not required to submit marketing materials specific only to those employer plans to CMS at the time of use. However, CMS may request and review copies if employee complaints occur or for any other reason to ensure the information accurately and adequately informs beneficiaries about their rights and obligations under the plan.

11. Title Page – Marketing Representatives: Agents/Brokers and Third-Party Marketing Organizations

12. Third-Party Marketing Organizations and "Marketing Representatives"

- Third-Party Marketing Organizations (TPMOs) are organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA or Part D plan or plans to making an enrollment decision). TPMOs may directly contract with the Plan Sponsor, may be a downstream contractor of a Plan Sponsor, or may be a related entity of the Plan Sponsor (referred to as first tier, downstream, or related entities or FDRs). However, they may also be entities that are not FDRs but provide services to a Plan Sponsor or a Plan Sponsor's FDR.
    - Independent agents and brokers are those that are not directly employed by a plan and those that market for more than one plan.
    - Agents and brokers employed by the plan are not TPMOs.
- In this training, we refer to TPMOs and employed agents and brokers as "Marketing Representatives."

TPMOs: Example
Amazing Agency contracts through an FMO to market and enroll members in 10 different Medicare Advantage organizations. Amazing Agency has contracted with Internet Innovations to advertise the agency, its products, and provide sales leads to the agency. The FMO, Amazing Agency, and Internet Innovations are all TPMOs.

13. Requirements to Act as Agents and Brokers

- Plan Sponsors must contract with or employ agents and brokers that are licensed by the state if they conduct the relevant activities in that state.
- Agents and brokers must be appointed by the plan if required under State law.
- MA and Part D plans are required by law to ensure that all employed and contracted agents and brokers complete training at least annually that includes all content specified by CMS.

- They also must pass a written test each year that demonstrates thorough familiarity with both the Medicare program and the products they are selling.
- Agents/brokers marketing only employer/union group plans are not required to be tested. However, plans may choose to require testing.

14. Title Page – Key Terms and General Background Information

15. Marketing and Communication – In General

- ***Communications*** are materials and activities that provide information to current and prospective enrollees on Medicare Health Plans and Part D Plans.
- ***Marketing*** is a subset of communications. Marketing is distinguished from communications-only material and activity based on intent and content.
- Marketing activities and materials are generally subject to a higher degree of regulation and oversight.

16. What is Marketing?

To be considered marketing, the material or activity must include both marketing intent and marketing content.

- **Marketing 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 plan choice, including a decision to remain enrolled in their current plan.
- **Marketing Content** – Marketing activities and materials include or address content regarding any of the following:
    - Information about benefits or benefit structure
    - Information about premiums or cost-sharing
    - Rankings, such as comparisons to other Plan(s)/Part D sponsor(s)
    - Measurement standards, such as Star Ratings
    - Plan rewards and incentives programs (programs offered by Medicare health plans to qualifying individuals to voluntarily perform specified target activities in exchange for reward items)
    - Mentioning a broad category of widely available benefits, such as dental, vision, hearing or premium reduction is marketing content.

17. What are Communication-Only Materials and Activities?

Communication-only activities and material provide information to current and prospective enrollees that:

- contains no marketing content; or
- includes marketing content but does not have marketing intent. For example,
    - CMS designates certain materials that have marketing content, such as the Evidence of Coverage, as a communication-only material, while the summary of benefits and an annual notice of change are designated by CMS as marketing materials.
    - A targeted letter sent to a plan's members may be intended to encourage those members to receive certain preventive services they have not yet received and refer to the cost-sharing for those services. While it contains marketing content, it would not meet the marketing intent standard.

18. Title Page – Regulation of Communications Activities and Materials

19. Regulation of Communications-Only Materials

- **Material Content** -- While CMS does not generally require communications-only materials to be submitted to CMS for review and approval; it may review such materials and does require certain disclaimers to be used in those materials. CMS also prohibits the use of certain claims or language in communications materials.
    - CMS does require certain designated communication materials critical to beneficiaries' understanding or accessing their benefits to be reviewed (e.g., the Evidence of Coverage.
    - CMS may require prior review of communication materials that, based on feedback such as complaints or data gathered through reviews, warrant additional oversight to ensure accuracy.

What are Examples of Communication Only Materials

- A flyer that says, "Healthy Choice Medicare plan has been serving beneficiaries for 30 years, call to find out if we are right for you!"
- A newsletter sent to members of Healthy Choice Medicare plan reminding them that preventive health care services have a $0 copay and that it is important to get such services, such as flu shots, to stay healthy.
- A television advertisement from a large agency that announces, "We can connect you with a Medicare Advantage plan designed to meet your needs" (as discussed later in this training, such an ad would require the TPMO disclaimer).
- Materials specifically designated by CMS as communications because they do not meet the "intent" standard, such as the formulary, or provider directory.

20. Regulation of Communications-Only Activities

- **Contact** – CMS regulates how marketing representatives can contact potential enrollees. For example, agents may not make cold calls even if they limit their conversation to communications content.
- **Other Content** – CMS regulates what marketing representatives may say to enrollees and potential enrollees.

21. Regulation of Marketing Materials and Activities in General

CMS regulates marketing activities in a variety of ways, including:

- **Setting** – CMS has rules regarding marketing in a health care setting versus marketing in other settings and marketing at educational versus marketing events.
- **Who may market** – CMS requires marketing representatives to comply with state laws concerning licensure; CMS places strict limits on marketing by health care providers.
- **Timing** – CMS regulates when marketing representatives can begin marketing the next year's plans.
- **Contact**– CMS regulates how marketing representatives can contact potential enrollees.
- **Content** – CMS may require that certain disclaimers or other information be included in marketing materials. CMS also prohibits the use of certain claims or language.
- **Review and Approval** – CMS requires that all marketing materials be submitted to CMS for approval and/or review.
    - Materials developed for use with employer/union group members do not have to be submitted to CMS.

22. What are Examples of Marketing Activities?

Examples of marketing activities include:

- Talking to a Medicare beneficiary about how a particular plan offers a higher level of coverage for the services the beneficiary uses most often.
- Handing out health plan brochures and a summary of benefits at an event.
- Calling current clients who are Medicare beneficiaries to discuss upcoming premium and benefit changes to their plans and encourage them to remain enrolled in those plans.
- Passing out plan-specific benefits information and agent business cards after a health management seminar.
- Accepting enrollment forms and performing enrollment at marketing/sales events.

What are Examples of Marketing Materials?
Examples of marketing materials include the following if they contain marketing content:

- General audience materials such as direct mailings, newspaper ads, or websites that promote specific plans and discuss their star ratings.
- Marketing representative scripts or outlines for telemarketing, enrollment, or other presentations that discuss plan benefits.
- Brochures that promote enrollment in a plan and discuss the plan's reward programs for receiving preventive care services.
- Presentation materials such as slides and charts explaining the benefits of enrolling in a particular plan.
- Social media posts (e.g., Facebook, Twitter [now X], YouTube, etc.) that mention a plan's star rating, note its low premium, or promote its benefits.

23. Rules that apply to all Communications (including Marketing) Materials and Activities

Plans and their marketing representatives may not:

- mislead, confuse, or provide materially inaccurate information to beneficiaries.
- target enrollees based on income levels (except in the case of Dual Eligible SNPs).
- target enrollees based on health status (except in the case of a chronic care SNP).
- state or imply that the plans are only available to seniors, rather than all eligible Medicare beneficiaries (e.g., younger disabled individuals).

24. Title Page- Marketing and Communications – Contacting Beneficiaries

25. Unsolicited Contacts

- Marketing representatives are prohibited from making unsolicited contact with beneficiaries, including through:
  - door-to-door solicitation, including leaving leaflets, flyers, or door hangers at a residence or on someone's car. Contact is unsolicited door-to-door contact unless an appointment, at the beneficiary's home at the applicable date and time, was previously scheduled.
  - approaching beneficiaries in common areas such as parking lots, hallways, lobbies, sidewalks, stores, or parks.
  - telephone calls without a scope of appointment or not meeting the plan business exception.
  - text messages and other forms of electronic direct messaging (e.g., through social media platforms, like Facebook instant messaging).
  - voicemail messages after unplanned calls.
- The prohibition on making unsolicited contact does not extend to e-mail, conventional mail, and other print media such as advertisements.

26. Unsolicited Contacts

- Marketing representatives may not make unsolicited calls about other businesses as a means of generating leads for Medicare plans (e.g., bait and switch strategies).
- Marketing representatives may not make unsolicited contact based on referrals or leads provided by enrollees or other sources. However, they may leave business cards with beneficiaries for distribution to friends they are referring.
- Enrollees who are voluntarily disenrolling may not be contacted for sales purposes or be asked to consent to sales contacts.
- Marketing representatives may not make calls to beneficiaries who attended a marketing event unless the beneficiary gave express permission at the event for a follow-up call (there must be documentation of permission to be contacted).
- May not contact a lead provided by another TPMO unless the beneficiary gave explicit written consent to share their information with the agent and receive a marketing call.

Unsolicited Contacts Example

Example 1: Agent Jackson is involved in a health fair that offers a raffle. After the fair, Agent Jackson takes the telephone numbers on the raffle entries and calls each individual to see if they would be interested in discussing MA plans. Agent Jackson has violated the prohibition on unsolicited contacts.

Example 2: Agent Miller sells life insurance in addition to MA plans. Agent Miller calls a lead provided to him by another client to talk to her about life insurance. During the conversation, Agent Miller asked the beneficiary if she would like to learn more about Medicare Advantage plans. Agent Miller has violated the prohibition against making unsolicited calls about other business as a means of generating leads for Medicare plans.

Example 3: Agent Lopez's aunt tells him that her neighbor was recently telling her that she was having trouble understanding her Medicare choices and wanted to know if it made sense to enroll in an MA plan. His aunt offers the neighbor's telephone number, but Agent Lopez gives his aunt his card and says that the neighbor should call him. Agent Lopez has wisely avoided making an unsolicited call based on a referral.

27. Permitted Contacts

Marketing representatives may:

- initiate electronic contact through e-mail. However, they must provide an opt-out process to no longer receive electronic communications.
- return calls or messages from individuals who initiate contact and request information.
- call beneficiaries who have expressly given permission for the contact, for example by filling out a business reply card or asking a plan customer service representative to have an agent contact them. However, business reply cards and requests to contact are only valid for twelve months following the beneficiary's signature date or the date of the beneficiary's initial request for information.
- call beneficiaries to confirm an appointment that has already been agreed to by a beneficiary.
- call beneficiaries who submit enrollment applications to conduct business related to enrollment.

28. Permitted Contacts

Marketing representatives may:

- call current enrollees of the parent organization, including those in non-Medicare health plan products, to discuss plan business, for example, they may:
    - contact individuals enrolled in one of the MA organization's commercial health plans when the individual is aging into Medicare.
    - contact the MA organization's Medicaid plan enrollees to discuss Medicare products.
    - contact current MA enrollees to promote other Medicare plan types or to discuss plan options/benefits.
    - contact the MA organization's Medigap enrollees regarding MA, PDP, or cost plan options.
    - call current enrollees of a plan to discuss/inform them about general plan information such as Annual Enrollment Period dates, availability of flu shots, upcoming plan changes, educational events, and other important plan information.
    - call a beneficiary whom the marketing representative enrolled in a plan to discuss plan business, as well as discuss the availability of other plan options/types within the same parent organization.
- However, if the Plan Sponsor or its marketing representatives reach out to beneficiaries regarding plan business, the Plan Sponsor must provide notice to all beneficiaries whom the plan contacts at least once annually, in writing, of the individual's ability to opt out of future calls regarding plan business.

29. Title Page- Rules Related to Sales and Educational Events

30. Marketing/Sales and Educational Events

- Marketing/sales events are events designed to steer potential enrollees toward a plan or limited set of plans or to encourage current enrollees to remain in their plans.
- Educational events are events designed to inform potential enrollees about Medicare, including MA, Part D, or other Medicare programs, and do not include marketing materials or activities.
    - Educational events may be held in public venues.
    - Educational events may be put on by providers or other groups and/or sponsored by one or more health plans.
- Marketing events are prohibited from taking place within 12 hours of an educational event in the same location. The same location is defined as the entire building or adjacent buildings.
- Advertisements and invitations (in any form of media) that are used to invite beneficiaries to a marketing or educational event must include the following statement: "For accommodation of persons with special needs at meetings call <insert phone and TTY number>."

31. Marketing /Sales Events, Required and Permitted Activity

- Plans must submit presentations that include marketing content to CMS before use at a sales event.

- At marketing/sales events agents may:
  - discuss plan-specific information such as premiums and benefits.
  - discuss plan star ratings.
  - discuss the merits of a plan
  - distribute and collect enrollment applications.
  - distribute plan-specific advertisements, explanatory information, and general information about Medicare.
  - provide refreshments and light snacks of nominal value as long as they are not bundled and provided as if a meal.

32. Marketing/Sales Events, Prohibited Activity

At marketing/sales events agents may not:

- require beneficiaries to provide contact information as a prerequisite for attending the event.
  - This includes requiring an email address or other contact information as a condition to RSVP for an event online or through the mail.
  - Sign-in sheets must be labeled as optional.
- conduct health screenings or other activities that could give the impression of "cherry-picking."
- provide meals or multiple snacks/refreshments bundled and provided as if a meal, regardless of value.
- use information collected for raffles and drawings for other purposes.

33. Educational Events, Required and Permitted Activity

Educational events must be explicitly advertised as "educational." At educational events, marketing representatives may:

- engage in communications activities and distribute communication materials.
- use a banner with the plan sponsor name and/or logo displayed.
- distribute promotional items, including those with the plan name, logo, and toll-free number and/or website. These items must be free of marketing content and be provided consistently with gift/promotional item rules (e.g., provided to all without obligation and be under $15 retail value).
- provide an objective presentation to educate beneficiaries about the different ways they can get their Medicare benefits.
- have a health care provider make an educational presentation on wellness or another health care related topic.

Educational Events, Permitted Activities

At educational events, marketing representatives may:

- answer beneficiary-initiated questions about Medicare health or drug plans.
- make available opportunities to provide voluntarily and receive beneficiary contact information, including Business Reply Cards, but not including Scope of Appointment forms.

- distribute business cards and agent/agency or plan contact information so that beneficiaries can initiate contact.
- provide meals, refreshments, or snacks as long as they comply with the gift/promotional item requirements, including the nominal value requirement.

Educational Events, Prohibited Activities
When an event has been advertised as "educational," marketing representatives may NOT:

- conduct sales or marketing presentations.
- discuss, display, or distribute plan-specific premiums, benefits, or other marketing content or marketing materials.
- engage in marketing activities.
- distribute or collect enrollment applications.
- set up future personal marketing appointments.
- make available or obtain completed Scope of Appointment (SOA) forms.

34. Gifts and Promotional Items

Section 1128A (a) (5) of the Social Security Act prohibits offering or giving anything of value to a Medicare or Medicaid beneficiary that is likely to influence the beneficiary to order or receive from a particular provider, practitioner, or supplier any item or service covered under Medicare or Medicaid. There is a nominal value ($15) exception to this rule.

- Marketing representatives may provide gifts, prizes, or promotional items to beneficiaries as part of an event or for marketing purposes as long as the nominal value exception is met and the gift is provided regardless of enrollment and without discrimination.
- Gifts are of nominal value if an individual item is worth $15 or less based on the retail purchase price of the item (it does not matter if the plan or representative pays less for the item).
- When more than one gift is offered on one occasion, the combined value of all items must not exceed $15.
- Multiple gifts given to a beneficiary on different occasions may not exceed $75 aggregate, per person, per year.

35. Gifts and Promotional Items

Gifts or prizes must not be in the form of cash or cash equivalents or other monetary rewards or rebates even if their worth is less than $15.

- Cash equivalents include:
  - gift certificates or cards that can be readily converted to cash.
  - general gift cards that are not restricted to specific retail chains or to specific items and categories, such as VISA gift cards.
  - gift cards for retailers or online vendors that sell a wide variety of consumer products (e.g., Walmart, Target, and Amazon).

    - debit cards.
- A gift card that can be used for a more limited selection of items or food, would not be considered a cash equivalent (e.g., Starbucks or a Shell Gas gift card).
- Rebates would include, for example, a discount on the first month's premium or on a copayment.
- Gifts or prizes may not be charitable contributions.

36. Promotional Activities: Drawings, Prizes, Giveaways

- Plan sponsors must include a disclaimer on all materials promoting a prize, drawing, communal experience (e.g., a concert), or any promise of a gift that there is no obligation to enroll in the plan.

37. Title Page –Marketing at Individual Appointments

38. Individual Marketing Appointments

- Personal/Individual marketing appointments are those tailored to an individual or small group (e.g., husband and wife). They are not defined by the location.
- During a personal/individual appointment, representatives may market only health care related products identified in a scope of appointment.
    - Health care related products include Medicare health plans, Medigap plans, and dental plans, but not accident-only plans.
    - Non-health care products (such as accident-only policies, life insurance policies, or annuities) may not be marketed during a Medicare health or drug plan appointment.

39. Required Practices: Scope of Appointment

- At least 48 hours before any marketing appointment, marketing representatives must coordinate with the beneficiary to identify the types of product(s) that will be discussed, obtain agreement from the beneficiary, and document that agreement (known as a "scope of appointment" or "SOA").
    - Types of products include MA, PDP, Cost plans, and Medicare-Medicaid Plans.
- There are two exceptions to the 48-hour rule:
    - Where the SOA is completed during the last 4 days of the relevant election period.
    - Where there is an unscheduled, in-person meeting initiated by a beneficiary. This includes when a beneficiary unexpectedly walks into a marketing representative's office or unexpectedly attends a sales appointment properly set up for another individual.
- A new SOA is required if the beneficiary requests information regarding a different plan type than previously agreed upon.
- An SOA is valid for twelve (12) months from the date of the beneficiary's signature.

40. Required Practices: Scope of Appointment

- A scope of appointment may be in writing, in the form of a signed agreement (including electronic signature) by the beneficiary, or a recorded oral agreement. Any technology (e.g., conference calls, fax machines, designated recording lines, pre-paid envelopes, and e-mail) can be used to document the scope of appointment.
- A Plan Sponsor or agent may not agree to the scope of appointment on behalf of the beneficiary.

Scope of Appointment: Documentation

Plan Sponsors and their TPMOs are expected to include the following documentation in the SOA:

- Product type (e.g., MA, MMP, cost plan, or PDP) that the beneficiary has agreed to discuss during the appointment,
- Date of appointment,
- Beneficiary and agent contact information (e.g., name, address, telephone number),
- Written or recorded verbal documentation of beneficiary or appointed/authorized representative agreement,
- 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 explaining that the beneficiary will not be automatically enrolled in any plan.

41. Individual Marketing Appointments, Permitted Activities

During individual appointments, marketing representatives may:

- distribute plan materials such as an enrollment kit or marketing materials.
- provide educational information.
- discuss benefits, premiums, and cost-sharing.
- distribute and accept plan applications.
- review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns.
- talk about plan rewards and incentives programs.
- provide and collect enrollment forms, provided that prior to enrollment all issues required to be discussed have been discussed.

Individual Marketing Appointments, Prohibited Activities

During individual appointments, marketing representatives may not:

- discuss plan options that were not agreed upon by the beneficiary and documented in a scope of appointment, business reply card, or request to receive additional information (which are only valid for twelve months following the date of the beneficiary's signature date or the date of the beneficiary's initial request for information).
- market non-health care related products.

- solicit/accept an enrollment request for a January 1st effective date before the start of the Annual Election Period on October 15 unless the beneficiary is entitled to another enrollment period (for example, an initial enrollment period or special enrollment period).

42. Use of Social Media to Market

- Plan Sponsors and their TPMOs must submit to CMS any social media (e.g., Facebook, Twitter [now X], YouTube, LinkedIn, TikTok, Scan Code, or QR Code) posts that meet the definition of marketing, specifically those that contain marketing content such as benefits, premiums, cost-sharing, or Star Ratings. This includes such posts by agents.
- Social media posts are generally subject to marketing/communications content requirements, such as prohibitions on using certain language and any requirements to include disclaimers.
- Re-publication (or re-post) of an individual's post, content or comment that promotes a Plan's/Part D Sponsor's product from social media sites is considered a product endorsement/testimonial and must adhere to the guidance on testimonials.

43. Title Page-Required Practices

44. Required Practices: Marketing and Discussion Topics

Marketing representatives must:

- provide to prospective enrollees only CMS-approved/submitted marketing materials or CMS created marketing materials.
- use only CMS-approved/submitted talking points and presentations if they are marketing.
- ensure that, before an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether the beneficiary's current providers are in the plan's network), prescription drug coverage and costs (including whether the beneficiary's current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.

45. Required Practices: HIPAA and Confidentiality of Beneficiary Information

Marketing representatives are business associates of the health plans they sell. As such, they must comply with Federal and state law regarding the confidentiality of individually identifiable health information (known as protected health information or PHI) and any confidentiality obligations in their business associate contracts with plans.

- PHI includes any information about an individual's health care coverage, payment for health care, or health care condition.
- HIPAA regulates both the use and disclosure of PHI. Marketing representatives may only use and disclose PHI on behalf of the plans they represent.

- If a marketing representative subcontracts with another individual or entity that may obtain, use, or disclose PHI on their behalf, they must enter into a business associate agreement with the individual or entity requiring the same protections to the PHI.
- Plan Sponsors must obtain a HIPAA compliant authorization from an enrollee before the Plan Sponsor may use (or may request a marketing representative to use on their behalf) information about the enrollee to market non-health related items or services. The authorization must explicitly allow marketing uses.

46. Required Practices: Consent to Share Beneficiary Information

Beginning October 1, 2024:

- Personal beneficiary information collected by a TPMO (including agents/brokers) for marketing or enrolling them into an MA, Cost, or Part D plan may only be shared with another TPMO when prior written consent to share the information and be contacted for marketing or enrollment purposes is given by the beneficiary.
- The beneficiary's prior written consent must be obtained through a clear and conspicuous disclosure that lists each entity that would receive the data and allows the beneficiary to consent or reject to the sharing of their data with each individual TPMO.

47. Required Practices: Use of TPMO Marketing Disclaimer

- Independent agents/brokers and other third-party marketing organizations must use the TPMO marketing disclaimer if they sell plans on behalf of more than one Plan Sponsor.
- If the TPMO does not sell for all Plan Sponsors available in the service area, the disclaimer consists of the following statement: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov or 1–800–MEDICARE, or your local State Health Insurance Program to get information on all your options.''
- If the TPMO sells for all Plan Sponsors in the service area, the disclaimer consists of the statement: "Currently, we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program for help with plan choices.''
- The disclaimer must be:
    a. verbally conveyed within the first minute of a sales call.
    b. electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
    c. prominently displayed on TPMO websites.
    d. included in any TPMO marketing materials, including print materials and television advertising.

48. Required Practices: Special Rules Related to Lead Generation

- TPMOs conducting lead generating activities, either directly or indirectly for a Plan Sponsor, must, when applicable, disclose to the beneficiary that their information will be provided to a licensed agent for future contact. This disclosure must be provided:
    - verbally when communicating with a beneficiary through telephone;
    - in writing when communicating with a beneficiary through mail or other paper; or
    - electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.
- If the lead generating TPMO transfers a beneficiary to an agent, the TPMO must disclose to the beneficiary that they are being transferred to a licensed agent who can enroll them into a new plan.
- Plan Sponsors, Agents/Brokers, FMOs, or agencies that obtain leads from such entities should ensure that these requirements have been met in generating the leads and include this obligation in any contracts with the lead generating TPMO.
- As previously noted in this module, beginning October 1, 2024, beneficiary information collected by a TPMO for marketing or enrolling may only be shared with another TPMO when prior written consent is given by the beneficiary.

49. Title Page- Accessing and Using Certain Plan Materials

50. Certain Plan Materials: Accessing and Using

Plans are required to post certain documents in a downloadable format on their website. Beneficiaries and marketing representatives may access the following materials, as applicable to the plan, through each plan's website:

- Evidence of Coverage
- Summary of Benefits
- Annual Notice of Change
- Provider Directory, searchable by specified elements such as name, location, cultural and linguistic capabilities, and specialty
- Pharmacy Directory
- Formulary

Such documents are important tools to be used by marketing representatives in determining issues such as:

- Whether a beneficiary's providers or pharmacies are in the plan network
- Whether the drugs a beneficiary takes are on the plan's formulary
- Whether the plan covers other benefits that are important to a beneficiary
- Whether or the extent to which the plan covers out-of-network services

Many plans provide their provider/pharmacy directories and formularies in a searchable format. Plans will also provide these materials to beneficiaries after they enroll.

51. Required Materials with an Enrollment Form

- When a beneficiary is provided with enrollment instructions/form, they must also receive:
    - plan ratings information
    - the summary of benefits
    - the pre-enrollment checklist
    - the multi-language insert (or at the plan option after September 30, 2024, the Notice of Availability)
- The beneficiary must also receive the multi-language insert when provided with any other CMS required material (for example, Evidence of Coverage, Annual Notice of Change, or Summary of Benefits).
- For Dual Eligible Special Needs Plans, if Medicaid benefits are not included in the summary of benefits, a separate document including the Medicaid benefits must be included with the enrollment form.
- When a beneficiary enrolls in a plan online, the plan sponsor must make these materials available electronically, (e.g., via website links) to the potential enrollee before the completion and submission of the enrollment request.
- For telephonic enrollments, the contents of the pre-enrollment checklist must be reviewed with the prospective enrollee before the completion of the enrollment. In addition, the beneficiary must be told verbally where the summary of benefits and star rating documents may be accessed.

52. Title Page- Plan Ratings and Call Recordings

53. Plan Ratings: Background

- CMS releases star ratings that allow beneficiaries to compare MA plans and Part D plans. These ratings include topics such as whether members got various screening tests, vaccines, and other check-ups to help them stay healthy, and how members rate the plan on topics such as access to care and customer service.
- Marketing representatives and beneficiaries who have access to the Internet may obtain plan rating information at http://www.medicare.gov.
    - Click on the “Find Health & Drug Plans” button.
- The Star Ratings information document must also be prominently posted on each plan’s website.

54. Plan Ratings – Required Practices

- Plan Sponsors must provide the plan’s overall performance ratings to beneficiaries in the standard Plan Ratings information document.
- New Plans/Part D Sponsors that do not have any Star Ratings information are not required to provide Star Ratings information until the next contract year.
- Plan Sponsors and their marketing representatives may only reference or mention a plan’s rating on an individual measure in conjunction with the plan’s overall performance rating (MA-PD), the contract’s highest rating, Part C summary rating (MA-only), or Part D summary rating (PDPs), with equal or greater prominence.

- Plan Sponsors and their marketing representatives may only market the Star Ratings in the service area in which the Star Rating is applicable.

55. Required Practices: Plan Ratings - Prohibitions

Plan Sponsors and their marketing representatives may not:

- use a plan's star rating in an individual category or measure to imply a higher overall plan rating than is actually the case.
    - For example, a plan that received a 5-star rating in customer service promotes itself as "rated 5 stars by our enrollees," when its overall plan rating is only 4 -stars.
- use the plan's star ratings in a manner that misleads beneficiaries into enrolling in plans based on inaccurate information.
- use updated star ratings until CMS releases star ratings on the Medicare Plan Finder.
- continue to use an old star rating after **21** days from the release of a new star rating.

56. Required Practices: Recording Calls with Beneficiaries

Independent agents/brokers and other third-party marketing organizations must record all sales, marketing, and enrollment calls with beneficiaries in their entirety. This includes recording the audio portion of calls occurring via web-based technology.

57. Title Page- Prohibited Activities

58. Prohibited Practices: Marketing and Communications

Marketing representatives must NOT:

- market any non-healthcare-related products (such as annuities and life insurance) during any MA or Part D sales activity or any other marketing activity for existing enrollees. This is considered cross-selling.
- use or disclose the enrollee's protected health information (PHI) for marketing purposes, including sending any non-plan or non-health related information or otherwise contacting them for purposes unrelated to plan benefits administration or CMS contract execution, without first obtaining HIPAA required authorization from the enrollee.
- market that the Plan Sponsor will not disenroll individuals due to failure to pay premiums.
- display the names or logos or both of provider co-branding partners on marketing materials, unless the materials indicate via a disclaimer or in the body that "Other providers are available in the network.
- fail to record all sales and enrollment related telephonic contact.

59. Prohibited Practices: Marketing and Communications

Marketing representatives must NOT:

- use a Medicare beneficiary to endorse a plan unless the beneficiary was an enrollee of the plan when the endorsement was created.
- solicit enrollment applications for the following contract year before the start of the annual election period on October 15.
- use marketing materials that have not been submitted by the plan for review and/or approval by CMS.
- charge beneficiaries marketing fees.
- engage in bait and switch strategies such as making unsolicited outbound calls to beneficiaries about other lines of business (e.g., calling Medicare beneficiaries about Affordable Care Act plans) as a means of generating leads for Medicare plans.

60. Prohibited Practices: Discriminatory Activity, Superlatives, and Comparisons

Marketing representatives must NOT:

- engage in any discriminatory activity such as attempting to recruit Medicare beneficiaries from higher-income areas without making comparable efforts to enroll Medicare beneficiaries from lower-income areas.
- encourage individuals to enroll based on their health status unless the plan is a special needs plan that focuses on the beneficiary's particular condition.
- conduct health screening or other activities that could give an impression of "cherry-picking".
- use unsubstantiated superlatives e.g., best, highest rated, best value, etc. Superlatives may only be used if the sources of documentation or data supportive of the superlative are also referenced in the material. Such supportive documentation or data must reflect data, reports, studies, or other documentation that applies to the current or prior contract year. (Including data older than the prior contract year is permitted provided the current and prior contract year data are specifically identified).
- make explicit comparisons between plans, unless they can support them, such comparisons are factually based, and the comparisons are not misleading.

61. Prohibited Practices: Misleading Marketing Practices

Marketing representatives must NOT engage in marketing practices that may mislead or confuse beneficiaries, such as:

- providing false or misleading information about the plan, including benefits, provider rules, and other plan information, such as claiming that a PFFS plan is the same as Original Medicare or a Medigap plan.
- claiming that Medicare, CMS, or any government agency endorses or recommends the plan.
- using the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card in a misleading way. (Use of the Medicare card image is permitted only with authorization from CMS).

- advertising benefits that are not available to beneficiaries in the service area where the marketing appears, unless the advertisement is in local media that serves the service area(s) where the benefits are available and reaching beneficiaries who reside in other service areas is unavoidable.
- marketing products or plans, benefits, or costs, unless the Plan Sponsor's(s') name or marketing name(s) of the Plan Sponsor(s) offering the products or plans, benefits, or costs are identified in the marketing material.
- including information about savings to beneficiaries that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary.

62. Prohibited Practices: Misleading Marketing Practices

Marketing representatives must NOT:

- use the term "free" to describe a zero-dollar premium.
- use the term "free" in conjunction with any reduction in premiums, deductibles, or cost-share, including Part B premium buy-down, low-income subsidy, or dual eligibility.
- lead beneficiaries to believe that the broker or agent works for Medicare, CMS, or any government agency.
- imply that a plan operates as a supplement to Medicare.

63. Prohibited Practices: Targeting Dual Eligibles

Unless they are promoting a D-SNP, Marketing representatives must NOT:

- imply that the plan is available only to or designed for dual eligible individuals (unless the plan is comparable to a D-SNP plan, such as an MMP, as determined by the Secretary).
- claim that the Plan has a relationship with the state Medicaid agency, unless the MA plan (or its parent organization) has contracted with the state to coordinate Medicaid services, and the contract is specific to that MA plan (not for a separate D-SNP or MMP).
- market a non-dual eligible special needs plan as if it were a dual-eligible special needs plan.
- target their marketing efforts for the Plan exclusively to dual eligible individuals (unless the plan is comparable to a D-SNP plan, such as an MMP, as determined by the Secretary).

64. Open Enrollment Period – Marketing Prohibitions

The Medicare Advantage Open Enrollment Period (MA-OEP) is a period during which an individual enrolled in an MA or MA-PD plan can make a one-time change to another MA plan, elect Original Medicare, or can change Part D coverage. For individuals enrolled in an MA plan on January 1, the MA-OEP is the first 3 months of the calendar year. For individuals enrolling during their initial coverage election coverage period (ICEP), the MA-OEP is the first three months after they enroll in an MA or MA-PD plan. The MA-OEP is further described in Module 5.

During the MA Open Enrollment Period (OEP), marketing representatives 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 chose an MA or MA-PD plan during the Annual Enrollment Period (AEP) by the purchase of mailing lists or other means of identification.
- engage in or promote 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.

65. Promoting Health Plans During the Open Enrollment Period

However, during the OEP, marketing representatives may conduct marketing activities that focus on other enrollment opportunities, including but not limited to:

- marketing to individuals turning 65 (who have not yet made an enrollment decision).
- marketing by 5-star plans regarding their continuous enrollment SEP.
- marketing aligned D-SNPs (such as FIDE-SNPs and HIDE SNPs) to full-benefit dual-eligible beneficiaries who have a once-per month SEP to enroll in an aligned D-SNP.

In addition, during the OEP marketing representatives may:

- send marketing materials when a beneficiary makes a proactive request.
- at the beneficiary's request, have one-on-one meetings with a sales agent.
- at the beneficiary's request, provide information on the OEP through the Plan's call center.

MAOs may also include information about the OEP on their websites.

66. Soliciting Referrals from Beneficiaries

Inducements (such as gifts) for referrals are regulated under fraud and abuse laws (such as the anti-kickback statute or beneficiary inducement statute). However, typically there are nominal value exceptions under those laws. Marketing representatives should consult with their plans to determine whether the plans impose requirements around gifts in exchange for beneficiary referrals.

67. Title Page-Marketing in Healthcare Settings

68. Marketing Activities: Marketing in a Healthcare Setting

Marketing representatives must <u>NOT</u>:

- engage in marketing activities or provide marketing materials in areas where patients receive healthcare services, for example:
    - Exam rooms, dialysis center treatment areas, hospital patient rooms, pharmacy counter areas, and other treatment areas where patients interact with a provider and their clinical team and receive treatment.

Marketing representatives <u>may</u>:

- engage in marketing activities (i.e., conduct sales presentations and distribute and accept enrollment applications) in common areas of healthcare settings, for example:
    - In a cafeteria, community or recreational room, waiting room, common entryway, vestibule, or conference room
    - At a retail pharmacy, in areas away from the pharmacy counter
- provide communication materials to be distributed and displayed in the healthcare setting.

69. Marketing Activities: Marketing in a Long-term Care Facility

- Long-term care facilities include, for example, nursing homes, assisted living facilities, and board and care homes.
- Plan Sponsors/marketing representatives may schedule an appointment with a beneficiary in a long-term care facility ONLY upon request of the beneficiary (or authorized representative).
- Plan Sponsors/marketing representatives may not visit individuals in a long-term care facility without an appointment.
- MA institutional special needs plans (I-SNPs) may use staff operating in a social worker capacity to provide information, including marketing materials concerning I-SNPs, to residents. Such information must not include an enrollment form and the social worker may not accept or collect a scope of appointment or enrollment form on behalf of the plan sponsor.
- Marketing representatives may set up in common areas of a long-term care facility and allow residents to approach them.

70. Title Page- Plan Oversight and Enforcement

71. Oversight and Corrective Action

- Plan Sponsors must establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS.
- Plans are required to implement a strategy to prevent prohibited marketing practices from occurring, detect prohibited marketing tactics at their early stages, and take immediate corrective action to respond to non-compliant marketing activities.
- Plans must take disciplinary and/or corrective action in the event of verified misconduct. Examples of such disciplinary action include:
    - Withholding or withdrawing commissions
    - Retraining
    - Suspension of marketing
    - Termination
    - Other consequences outlined in the contract with the plan

72. Reporting to, and Cooperating with, States and CMS

- Plans must comply with requests from a State insurance or other department in connection with investigations of plan marketing representatives who are licensed by the department.
- Plans must report to States the termination of any agent or broker, including the reasons for the termination if required under State law. Plans must also report to CMS any for-cause agent/broker terminations.
- Plans must report to CMS all enrollments made by unlicensed agents or brokers.
- Upon CMS' request, the plan must provide CMS with information necessary for it to conduct oversight of marketing activities.

73. Reporting and Disclosure Obligations of Marketing Representatives

Plan Sponsors must require third-party marketing organizations, including independent agents and brokers, to:

- Disclose to the Plan Sponsor any subcontracted relationships used for marketing, lead generation, and enrollment.
- Report to plan sponsors monthly any staff disciplinary actions or violations of any requirements that apply to the Plan Sponsor associated with beneficiary interaction with the plan.

74. Title Page-Prohibitions on Incentives, Referral Fees, and Agent/Broker Compensation

75. Prohibitions on Incentives

Beginning with contract year 2025, Plan Sponsors must ensure that no provision of a contract with an agent, broker, or other TPMO has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary.

This obligation would apply not only to direct contracts with Plan Sponsors but also to contracts between TPMOs.

76. Referral Fees

- Plan Sponsors and their subcontractors may pay individuals or entities for referrals (including recommendations, provision of information, or other means of referring beneficiaries) for potential enrollment into a plan. The payment may not exceed $100 for a referral into an MA or MA-PD, MMP, or 1876 Cost plan and $25 for a referral into a PDP plan.
- The limitations on referral fees for potential enrollment into a plan apply to all agents and brokers (including employed and captive agents) as well as any other individual or entities.

77. Agent/Broker Compensation: Compensation Defined

Compensation includes monetary or non-monetary compensation of any kind relating to the sale, renewal, or services related to a plan or product offered by a Plan Sponsor, including but not limited to:

- Commissions
- Bonuses
- Gifts
- Prizes or awards

Beginning with sales of 2025 plans, compensation also includes:

- payment of fees to comply with State appointment laws, training, certification, and testing costs.
- reimbursement for mileage for appointments with beneficiaries.
- reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.
- any other payments made to an agent or broker that are tied to enrollment, related to an enrollment in a MA, Medicare Cost or Part D plan or product, or for services conducted as a part of the relationship associated with the enrollment into an MA, Medicare Cost or Part D plan or product.

78. Agent/Broker Compensation: Applicability of Rules

- Compensation structures for independent agents must comply with CMS guidance.
    - Independent agents are those who sell for multiple plans and are not employed by the plan sponsor.
    - Compensation rules do not generally apply to marketing representatives who are plan employees, to "captive" agents who market for only one plan, or when independent agents are marketing only to employer/union groups.
    - Compensation to independent agents who market to and enroll beneficiaries is covered by the rules whether it is paid directly by a plan or paid by an agency, Field Marketing Organization (FMO), or other Third-Party Marketing Organization (TPMO).
- The limitations on referral fees for potential enrollment into a plan apply to all agents and brokers (including employed and captive agents) as well as any other individual or entities.

79. Agent/Broker Compensation: When Compensation May Not Be Paid

Plan Sponsors may not pay agents:

- when they have not been trained and tested.
- when they do not meet state licensure/appointment requirements.

- When a Plan Sponsor and/or a contracted independent agent terminates an agent contract, any future payment for an existing business will be governed by the terms of the contract that specify the agent's payment, subject to the limits in the CMS regulation.

- However, to continue receiving renewal fees, agents must remain trained, tested, licensed, and appointed (to the extent required under state law), regardless of whether they are actively selling.

80. Agent/Broker Compensation: Applicable Amounts

- Applicable compensation amounts depend on whether enrollment is an initial year enrollment or a renewal year enrollment.
    - CMS provides reports to the plan that specify whether enrollment is initial or renewal.
- Renewal year enrollments include plan changes between "like plans."
    - A "like plan type" enrollment includes:
        - A PDP to another PDP
        - An MA, MA-PD, or MMP to another MA, MA-PD, or MMP
        - A Section 1876 Cost Plan to another Section 1876 Cost Plan
    - An "unlike plan type" enrollment includes:
        - An MA or MA-PD plan to a PDP or Section 1876 Cost Plan
        - A PDP to a Section 1876 Cost Plan or an MA (or MA-PD) plan
        - A Section 1876 Cost Plan to an MA (or MA-PD) plan or PDP

81. Agent/Broker Compensation: Applicable Amounts

- For enrollments in two plans at once (for example, enrollment in an MA-only plan like a MSA and a stand-alone PDP or a cost plan and a PDP), the compensation rules apply independently to each plan. This is known as "dual plan" enrollment.
- However, when dual plans are replaced by an enrollment in a single plan, compensation is paid based on the MA or cost plan movement (e.g., movement from an MA-only PFFS plan and PDP to an MA-PD plan would be compensated at the renewal compensation amount for the MA to MA-PD "like plan type" move).

82. Agent/Broker Compensation: Compensation Amounts

- Plan Sponsors are not required to pay compensation for enrollments. However, if they do, they must follow these rules.
- Beginning with sales of 2025 plans, compensation for initial year enrollments must be the fair market value (FMV) published annually by CMS.
- Beginning with sales of 2025 plans, compensation for renewal year enrollments must be 50 percent of the FMV cut-off.
- Referral or finders' fees paid to independent, captive, or employed agents/brokers may not exceed $25 for PDPs or $100 for all other types of plans.
- Payments for administrative services are included in the compensation amount. Thus, agents may not receive additional compensation for such services.

83. Agent/Broker Compensation: Rules

- Compensation is paid on a calendar year basis. Thus, regardless of the month of a beneficiary's initial year enrollment, the renewal year begins on January 1 of the subsequent year, NOT on the beneficiary's enrollment anniversary date.
- Plan Sponsors have the flexibility to make compensation payments annually, quarterly, monthly, or by a different schedule. However, they must pay compensation payments during the year of enrollment.
- Compensation (with some limited exceptions) may only be paid for the months the beneficiary is enrolled in the plan.
    - If a plan pays compensation in advance, it must recoup amounts paid for months a beneficiary is not enrolled.
    - If a beneficiary enrolls mid-year, compensation must be prorated.

84. Agent/Broker Compensation: Exception to Pro Rata Payment Rule

- A plan may choose to pay for an entire initial enrollment year, despite less than 12 months of enrollment, for a beneficiary who has never been enrolled in a plan before or where a beneficiary moves from an employer group plan to a non-employer group plan.
- However, if the plan pays a full initial compensation and the enrollee disenrolls during the contract year, the plan must recoup a pro-rated amount for all months the enrollee is not enrolled.

Example: Ms. Franklin turns 65 in June and is eligible for Medicare for the first time. An agent helped her enroll in an MAPD with a June 1 effective date. The contract between the plan and the agent specifies that the plan will pay the agent for the entire year at the initial rate for a beneficiary who has never been enrolled in a plan before. The plan makes the full year payment to the agent. However, Ms. Franklin disenrolls from the plan effective October 1. The plan must recoup payment for the eight months of the year in which Ms. Franklin was not enrolled.

85. Agent/Broker Compensation: Rapid Disenrollment

- If a beneficiary disenrolls within the first 3 months of enrollment (referred to as "rapid disenrollment"), the entire compensation amount paid for the enrollment must be recouped, except under certain circumstances.
    - plans do not have to recoup any compensation paid including when a beneficiary disenrolls in the first 3 months because the beneficiary:
        - Enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1.
        - Became dually eligible for both Medicare and Medicaid
        - Qualified for another plan based on special needs
        - Became LIS eligible
        - Lost Medicare entitlement
        - Moved out of the service area
        - Failed to pay the plan premium
        - Changed enrollment to a plan with a 5-star rating or disenrolled from a LPI (low performing) plan to move into a plan with three or more stars

- Moved into or out of an institution
- Gained/dropped employer/union sponsored coverage
- Changed plans due to an auto, facilitated, or passive enrollment
- Died.
- Was enrolled in a plan that terminated, non-renewed, or CMS imposed sanctions on the plan.

86. Compensation: Rapid Disenrollment, continued

Rapid disenrollment applies when an enrollee moves from one parent organization to another parent organization, (e.g., from Superior Health Plan to Healthy Living Plan) or when an enrollee moves from one plan to another plan within the same parent organization (e.g., from Superior Health Plan's gold plan to its silver plan).

Example of rapid disenrollment: An Agent assisted Ms. Howard in enrolling in a Medicare Advantage HMO plan during the Annual Enrollment Period. After enrolling, she realized her podiatrist was not in the network. In February she switched to a PPO offered by the same organization so that she would have coverage for out-of-network services. The plan must recoup all compensation payments paid to the Agent for Ms. Howard's enrollment.

87. For More Information

- Medicare Marketing Guidelines: http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html
- CMS Marketing Website: http://www.cms.gov/ManagedCareMarketing/
- Medicare Beneficiary Website: www.medicare.gov

1. Module 5: Enrollment Guidance Medicare Advantage and Part D Plans

2. Navigation

3. Terms and Conditions

4. Learning Objectives

- After reviewing "Part 5: Enrollment Guidance - Medicare Advantage and Part D Plans" you will be able to explain:
    - When beneficiaries can enroll or change plans
    - Who can complete an enrollment form
    - What information must be discussed with a beneficiary before accepting an enrollment
    - Post-enrollment requirements
    - Enrollee protections
    - The disenrollment process

5. Training Roadmap: Module 5

- Enrollment and Election Periods
- Election Periods: MA Open Enrollment Period
- Special Enrollment/Election Periods (SEPs)
- Open Enrollment for Institutionalized Individuals
- Enrollment Requests
- Beneficiary information, acknowledgements, and enrollee discrimination prohibitions
- Post-enrollment activities and rules
- Disenrollment

6. Title Page – Enrollment and Election Periods

7. Enrollment/Election Periods – Overview

- Beneficiaries may only enroll in or change plans at certain fixed times each year or under certain limited circumstances.
    - If the application is not received during those fixed times of the year or does not include information supporting a permissible election period, such as an attestation of eligibility to enroll, plans must contact the beneficiary to decide if enrollment is permissible.
- MA and Part D Enrollment/Election periods are:
    - MA Initial Coverage Election Period (ICEP)
    - Part D Initial Enrollment Period (IEP)
    - MA and Part D Annual Election Period (AEP)
    - MA and Part D Special Enrollment/Election Periods (SEP)
    - Open Enrollment Period for Institutionalized Individuals (OEPI)
    - MA Open Enrollment Period (MA-OEP)

8. Roadmap to Election Periods

- Certain election periods have fixed calendar dates and are available to all beneficiaries while others depend on an individual's circumstances.
- Fixed annual election periods:
    - Annual election period (October 15 – December 7)
    - Medicare Advantage Open Enrollment Period (MA-OEP) (January 1 – March 31)
- Election periods with dates and conditions based on individual circumstances:
    - Initial enrollment/election periods when a beneficiary is first eligible for Medicare
        - New beneficiaries who enroll in Medicare Advantage also have an MA-OEP that starts the month of entitlement to Part A and Part B
    - Special enrollment/election periods (SEPs) when special circumstances arise
    - Continuous open enrollment for institutionalized individuals (OEPI)

9. MA and Part D Enrollment/Election Periods – Brief Summary

Enrollment Period	MA Options	PDP Options
MA Initial Coverage Election Period (ICEP) / Part D Initial Enrollment Period (IEP)	Enroll	Enroll
Annual Election Period (AEP) (Oct. 15-Dec. 7)	Enroll, disenroll, or change plans	Enroll, disenroll, or change plans
MA Open Enrollment Period (OEP) (Jan. 1 – March 31 and for individuals choosing an MA plan during their ICEP, the month of entitlement to Part A and Part B through the last day of the 3rd month of entitlement)	Disenroll from an MA or MA-PD plan and return to Original Medicare, Change MA plans, change Part D option under MA plan (change from MA to MA-PD or MA-PD to MA)	After disenrolling from an MA or MA-PD plan, may enroll in a PDP
Special Election Period (SEP)	Under most SEPs beneficiaries can enroll, disenroll, or change plans. However, under some SEPs beneficiary options are limited.	Under most SEPs beneficiaries can enroll, disenroll, or change plans. However, under some SEPs beneficiary options are limited.
Open Enrollment Period for Institutionalized Individuals (OEPI)	Enroll, disenroll, or change plans	Enroll in a PDP, disenroll from a PDP, and enroll in another PDP or MAPD

10. Election Periods – MA Initial Coverage Election Period (ICEP)

- The MA ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan.
- The ICEP begins three months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of:
    - The last day of the second month after the month in which they are first entitled to Part A and enrolled in Part B, or
    - The last day of the individual's Part B initial enrollment period.

        - The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B and ends 3 months after the month of eligibility.
- During the ICEP:
    - An eligible individual may enroll in an MA plan.
    - An individual may also choose an MA-PD when the Part D IEP (i.e., an initial enrollment period for Part D) and MA ICEP occur at the same time.
- The individual can make one enrollment choice under the ICEP. Once enrollment is effective, the ICEP is used. (Note, however, that individuals choosing an MA plan during their ICEP have an MA-OEP following their election through the last day of the 3rd month of entitlement, during which they can disenroll to Original Medicare or change plans.)
- The ICEP for an MA enrollment election will frequently relate to either the individual's 65th birthday or the 25th month of disability, but it must always relate to the individual's entitlement to both Medicare Part A and Part B.

11. Election Periods – Part D Initial Enrollment Period (IEP)

- The Part D IEP begins 3 months before the month an individual is first entitled to Part A OR enrolled in Part B and ends 3 months after the month of eligibility.
- Individuals eligible for Medicare before age 65 (for example, because of disability) will have another IEP when attaining age 65.
- During the Part D IEP, beneficiaries may make one Part D enrollment choice, including enrollment in an MA-PD plan if they are eligible for MA.
- Generally, individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B.

Election Periods – Part D IEP example

Mr. Crosby will turn 65 on August 10, 2024. He will continue working. He plans to sign up for his Medicare Part A benefits, effective August 1, 2024, but has decided not to enroll in Part B, since he will still have employer group coverage. He will be eligible for Part D since he will have Part A. Even though he will not enroll in Part B, his Part B IEP is still the 3 months before, the month of, and the 3 months following his 65th birthday – that is, May 2024 through November 2024. Hence, his IEP for Part D is also from May 2024 through November 2024.

12. Election Periods – Annual Election Period: Overview

- The Annual Election Period (AEP) takes place from October 15 to December 7 each year and is available to all MA and Part D eligible beneficiaries.
- During the Annual Election Period beneficiaries may:
    - add or drop drug coverage;
    - enroll in an MA plan, MA-PD, or PDP;
    - change MA, MA-PD, or PDP; or
    - return to Original Medicare.

- No action is needed if the beneficiary keeps their current health and/or drug plan. However, they should check for any benefit changes under the plan to confirm that staying enrolled is in their best interest.
- Beneficiaries may make more than one enrollment choice during the Annual Election Period, but the last one made before the end of the Annual Election Period, as determined by the date the plan or marketing representative receives the completed enrollment form, will be the election that takes effect.

13. Election Periods – Annual Election Period, Timeframe for Submitting Enrollment Forms

- Marketing representatives may not solicit or accept enrollment forms before October 15 for enrollments under the Annual Election Period.
- If a beneficiary sends an unsolicited AEP paper enrollment request to the plan on or after October 1 but before the Annual Election Period begins, the plan will process the application beginning on the first day of the election period (October 15).
- A beneficiary will receive an acknowledgment letter when the plan sponsor receives an early enrollment form to enroll during the AEP.
- Paper AEP enrollment requests received before the start of the AEP for which there is an indication of sales agent or broker involvement in the submission of the request (i.e., the name or contact information of a sales agent or broker) must be investigated by the Plan Sponsor for compliance.
- Marketing representatives are permitted to simultaneously market plans for the current and prospective years starting on October 1, provided marketing materials indicate what plan year is being discussed.
    - Current year plans should only be presented to beneficiaries with a valid election period that would result in an effective date before the next year.

14. Title Page –Election Periods MA Open Enrollment Period

15. Election Periods – MA Open Enrollment Period (MA OEP)

- For individuals enrolled in an MA plan on January 1 (including those renewing and those whose AEP election first becomes effective January 1) - The MA OEP takes place from January 1 – March 31 of each year.
- For new Medicare beneficiaries who are enrolled in an MA plan during their ICEP- the MA OEP begins the month of entitlement to Part A and Part B and ends the last day of the 3rd month of entitlement.
    - The limitation to one election or change during the ICEP does not prevent a new enrollee from changing during the MA-OEP.
- During the MA OEP:

- An MA–PD enrollee may switch to: (1) another MA–PD plan; (2) an MA-only plan; or (3) Original Medicare with or without a PDP.
- An MA-only enrollee may switch to: (1) another MA-only plan; (2) an MA–PD plan; or (3) Original Medicare with or without a PDP.

16. Election Periods – MA OEP

- Beneficiaries may only change plans once during the MA OEP.
- MSA enrollees may not use the MA OEP to disenroll from the MSA.
- As eligibility to use the MA OEP is available only for MA enrollees, the ability to make changes to Part D coverage is limited to any individual who is enrolled in an MA or MA-PD plan before they change.
- As a reminder - Marketing representatives may not do targeted marketing related to the OEP, for example, marketing that mentions the OEP or that targets individuals known to be MA enrollees.

Election Periods – MA OEP: Example
Ms. Hildalgo has been a long-time enrollee of an MA-PD offered by GreenPlan. She did not make an enrollment election during the AEP and thus remained enrolled in her GreenPlan MA-PD for the subsequent year. Ms. Hildalgo did not read the plan documents she received on October 15th disclosing substantial changes to her GreenPlan benefits. After receiving services in January, those changes became evident, and Ms. Hildalgo was no longer happy with her plan. She called her agent to complain. Her agent correctly advised her that she had until March 31st to change to another MA-PD, MA plan, or Original Medicare with or without a PDP.

17. Title Page – Special Enrollment/Election Periods (SEPs)

18. Election Periods – SEPs

- MA eligible and Part D eligible beneficiaries who experience certain qualifying events or wish to enroll in a 5-star plan are provided a special period to change their election, known as a Special Election Period or "SEP."
- Timeframes for SEPs vary.
- The SEP generally ends when the individual makes an allowed change to their enrollment, or the time expires, whichever comes first.
- Where appropriate, SEPs allowing changes to MA coverage are coordinated with those allowing changes in Part D coverage.
- During a SEP, individuals who disenroll from a MA plan and enroll in Original Medicare may have guaranteed Medigap issue rights. MA plans will notify such beneficiaries of these rights.

19. Election Periods – SEPs, Limitations

- Under Part D SEPs, qualifying beneficiaries generally have one opportunity to drop, add, or change their Part D coverage.
- Under MA SEPs, qualifying beneficiaries generally have one opportunity to change their MA coverage. (Except for MSA plan enrollees.)
    - But, if a beneficiary disenrolls from their MA plan and returns to Original Medicare, they may subsequently select a new MA plan, as long as they do so before the SEP expires.

20. Election Periods – SEPs

Some (but not all) situations resulting in an SEP include:

- Change in residence
- Involuntary loss of creditable drug coverage
- Gaining or losing eligibility for Medicaid or the Part D low-income subsidy
- Changing into or out of employer coverage
- Dropping a Medigap policy after enrolling for the first time in an MA plan, if an individual is still in a "trial period" and has guaranteed enrollment
- Being enrolled into a plan by CMS or a State (i.e., through passive enrollment, auto-enrollment, facilitated enrollment, and reassignment)

21. Typical SEPs – Change in Residence

Beneficiaries who move out of their existing plan's service area, or who have new options available to them as a result of a permanent move have a SEP allowing them to enroll in a MA or Part D plan.

The SEP begins either the month before the permanent move, if the plan is notified in advance, or the month the beneficiary provides notice of the move. It continues for two months following the month it begins or the month of the move, whichever is later.

A beneficiary using this SEP may choose an effective date up to 3 months after the month in which the enrollment form is received by the plan, but it may not be earlier than the date of the permanent move.

22. Typical SEPs – Employer/Union Group Coverage Change

Certain individuals experiencing or making changes in employer group coverage have a SEP allowing them to enroll in or disenroll from an MA or Part D plan. Those beneficiaries include:

- Individuals leaving employer-sponsored coverage (including COBRA coverage).
- Individuals who elect into or out of employer-sponsored MA or PDP plans.
- Beneficiaries disenrolling from an MA or PDP plan to enroll in employer/union sponsored coverage that includes medical and/or drug coverage.

The SEP begins when the employer/union plan would otherwise allow the individual to make changes to their coverage and ends 2 months after the month the employer or union-sponsored coverage ends.

The individual may choose the effective date of enrollment or disenrollment, up to 3 months after the month in which the individual completes an enrollment or disenrollment request. However, the effective date may not be earlier than the first of the month following the month in which the request was made. The effective date also may not be earlier than the first day of the individual's entitlement to Medicare.

23. Typical SEPs – Beneficiaries enrolled in a plan by CMS or the State

Individuals who are enrolled into a plan by CMS or a State (i.e., through passive enrollment, auto-enrollment, facilitated enrollment, and reassignment) have an SEP to disenroll from their assigned plan or enroll into a different plan.

During the SEP, beneficiaries may make an election within three months of the effective date of the assignment, or notification of the assignment, whichever is later.

24. Typical SEPs – Limitations for At-Risk and Potential At-Risk Beneficiaries

- An "at-risk" individual is a Part D eligible individual who is determined to be at-risk for misuse or abuse of a frequently abused drug per the requirements for drug management programs under CMS regulations.
- A "potential at-risk beneficiary is a Part D eligible individual who is identified as being potentially at-risk for misuse or abuse of a frequently abused drug per the requirements for drug management programs under CMS' regulations.
- Once an individual is identified by the Plan Sponsor as a "potential at-risk" or "at-risk" beneficiary and the Plan Sponsor has sent written notice to the individual, they cannot use the dual eligible or LIS SEP to change plans while this risk designation is in place. The notice to the individual explains that this SEP is no longer available.
- The enrollment limitation for a "potential at-risk" or an "at-risk" individual will not apply to other Part D enrollment periods, including the AEP or other SEPs.
- Note that individuals may appeal their designation of at-risk or potential at-risk.

25. Typical SEPs – Change in Medicaid or LIS Status

- Beneficiaries who are entitled to Medicare Part A and/or Part B who have a change in their Medicaid or LIS status, including the gain or loss of eligibility or a change in the level of assistance they receive are eligible for a SEP. During the SEP:
    - Beneficiaries entitled to Part A and Part B can enroll in or disenroll from an MA and/or Part D plan once.
    - Those entitled only to Part B can only do so for PDPs
- The SEP begins the later of the change or notification of the change and continues for 3 months.

26. Other Common SEPs

Medigap SEP -- Any Medicare beneficiary who dropped a Medigap policy when they enrolled for the first time in an MA plan has a SEP during the first 12 months of their enrollment in the MA plan during which they can elect to disenroll from their first MA plan to Original Medicare. They will also have a guaranteed eligibility period to rejoin a Medigap plan.

Part D SEP for Dual Eligibles and Beneficiaries with LIS -- Individuals who have Medicare Part A and/or Part B and receive any type of assistance from Medicaid (dual eligibles) and individuals who qualify for a low-income subsidy but who do not receive Medicaid benefits have a SEP that allows them to make a one-time per month election into a standalone PDP.

Severe or Disabling Chronic Conditions SEP -- Beneficiaries who have severe or disabling chronic conditions and wish to enroll in a SNP designed to serve individuals with their specific condition have a SEP during which they can enroll in a chronic condition SNP (C-SNP) designed to serve individuals with their condition. The SEP lasts as long as the individual has the qualifying condition and ends once the individual enrolls in a C-SNP.

Loss of Special Needs SEP -- Beneficiaries enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status have a SEP that begins the month the individual's special needs status changes and ends when they make an enrollment request or three calendar months after the effective date of involuntary disenrollment from the SNP, whichever is earlier.

5-Star Plan SEP - Beneficiaries who live in the service area of a 5-star plan have a SEP during which they can disenroll from an MA plan, PDP, or Cost plan or leave Original Medicare to enroll in a 5-star MA plan, PDP, or a Cost plan. The 5-Star Plan SEP is available each year beginning on December 8 and may be used once through November 30 of the following year.

Low Performing Plan SEP -- Beneficiaries enrolled in a plan that has been identified with the low performing icon have a SEP that exists as long as the beneficiary is enrolled in the low performing MA plan.

Aligned Enrollment SEP -- Full-benefit dual eligible beneficiaries have a SEP allowing them to make a one-time-per-month election into a fully integrated dual eligible special needs plan, a highly integrated dual eligible special needs plan, or an applicable integrated plan. This SEP is only available to facilitate aligned enrollment.

Significant Changes in Provider Network SEP -- CMS will establish a SEP, on a case-by-case basis, when it determines that changes to an MA plan's provider network are significant based on the affect, or potential to affect, on current plan enrollees, for example, the loss of a large provider group from the plan's network. The SEP begins the month enrollees are notified of eligibility for the SEP and continues for an additional two calendar months thereafter.

27. Common SEPs – Examples

Example 1: Mr. Brown is moving from his home to an assisted living facility a mile away. An IE-SNP is available only to residents of the Assisted Living Facility. Since Mr. Brown will have a new plan option available to him as a result of his change in residence, he will have a SEP if he wishes to enroll in the IE-SNP.

Example 2: Ms. Turner is eligible for Part A but did not enroll in Part B when she was first eligible because she had insurance through her employer. She did not enroll in Part D because she had creditable coverage. Ms. Turner is turning 68 and would like to retire in June. Her employer group insurance will end on her retirement effective date. If Ms. Turner enrolls in Part B, she can use the SEP for individuals changing employer group coverage to enroll in an MA plan or MA-PD. The SEP will last until August 31st.

28. Title Page – Open Enrollment Period for Institutionalized Individuals

29. MA Open Enrollment Period for Institutionalized (OEPI) Individuals/Part D SEP for Institutionalized Individuals

- The OEPI is available for individuals who move into, reside in, or move out of an institution. For example, a skilled nursing facility, nursing facility, rehabilitation hospital, intermediate care facility for individuals with intellectual disabilities (ICF/IID), psychiatric hospital or unit, or long-term care hospital.
- The OEPI is NOT available for individuals who are institutional-equivalent, that is, who meet the institutional level of care but do not reside in one of the facilities listed above. For example, the OEPI does not apply to individuals in assisted living facilities.
- The OEPI is a continuous open enrollment period as long as an individual is in an institution.
- The OEPI ends two months after the month the individual moves out of the institution.
- Beneficiaries eligible for the OEPI can:
    - make an unlimited number of MA enrollment requests and may disenroll from their MA plan.
    - enroll in or disenroll from a Part D plan.
    - return to Original Medicare.
- Note that an MA organization is not required to accept requests to enroll in its plan during the OEPI. If it is open for these enrollment requests, the organization must accept all OEPI requests to enroll in the plan.

OEPI examples

Example 1: Mr. Weir has been residing in a nursing home for the past three months. He is unhappy with his current Medicare Advantage plan. Mr. Weir can use the OEPI to change his enrollment at any time.

Example 2: Ms. Osbourne meets an institutional level of care as determined by using a state assessment tool. However, Ms. Osbourne has been residing in an assisted living community for the past 6 months and plans to remain there as long as she can. She would like to enroll in an institutional-equivalent special needs plan (IE-SNP) offered at her community. Ms. Osbourne cannot use the OEPI to enroll and will have to wait for another valid enrollment period.

30. Cost Plan Enrollment Periods

- Generally, Cost plans must establish an annual open enrollment period of at least 30 days.
- Most Cost plans allow enrollment year-round.
- For Cost plans that offer an optional supplemental Part D benefit, beneficiaries may select this benefit only during valid Part D enrollment periods. Cost plans must accept Part D enrollments during these periods.
- A beneficiary who is enrolled in an MA plan must have a valid MA disenrollment period to switch to a Cost plan.

31. Title Page – Enrollment Requests

32. Format of Enrollment Requests

- Plan sponsors must accept enrollment requests, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms defined by CMS.
- All plans must make available and accept a CMS-approved paper enrollment form appropriate to the plan type (MA, PDP, MA-PDP, MSA, or PFFS).
- Plans may also accept enrollments electronically or telephonically.
- Most enrollments must be completed using the standard enrollment form regardless of the format of the request.
- However, a short enrollment form/process may be used in certain circumstances.
    - A short form or plan selection form may be used when an individual changes between plans offered by the same parent organization (but not for MSAs); or
    - A simplified process known as the “opt-in” process may be used when an individual new to Medicare who is already a member of the organization’s non-Medicare coverage (e.g., commercial or Medicaid) wishes to enroll in an MA plan.

33. Formats of Enrollment Requests – Electronic Enrollment

- Plan sponsors may develop and offer electronic enrollment mechanisms made available via an electronic device or a secure internet website.
- Similar to the non-electronic enrollment format, individuals must be provided with all required pre-enrollment information (see module 4 discussion of the Pre-Enrollment Checklist).
- Enrollment via the internet:

- CMS offers an online enrollment center through www.medicare.gov
  - CMS online enrollment is disabled for MA and Part D plans with a low performer icon (LPI), which means the plan received less than 3 stars for three consecutive years.
- MA and Part D plans may offer online enrollment on the plan sponsor's, a broker/agency's, or a third party's secure website. All online enrollment mechanisms must be CMS-approved.

34. Formats of Enrollment Requests – Telephone

- Plan Sponsors may accept telephonic enrollments where the following requirements are met:
  - Plans may accept telephonic enrollments on incoming calls only from individuals with whom the plan sponsor does not have an existing business relationship.
  - Plans may also accept enrollment requests during communications initiated by the plan when, during outreach to provide information about their Medicare plan offerings to individuals with whom they have an existing business relationship, the individual expresses a desire to enroll in one of the organization's plans.
  - All telephonic enrollment and marketing calls must be recorded.
  - If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual's authority under state law to complete the request, in addition to the required contact information.

35. Formats of Enrollment Requests – Telephone

- Plan Sponsors must ensure that the telephonic enrollment is effectuated entirely by the beneficiary or authorized representative.
- Individuals must be advised that they are completing an enrollment request.
- Calls must include a statement of the individual's agreement to be recorded.
- Telephonic enrollments must include all required elements necessary to complete an enrollment
  - If the criteria for using a short enrollment form are met, the shorter list of required elements would apply.
  - The "Beneficiary Signature and/or Authorized Representative Signature" element for a telephone request is satisfied with a verbal attestation of intent to enroll.
- CMS also offers telephone enrollment through 1-800-Medicare (1-800-633-4227) TTY 1-877-486-2048.

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36. MA Opt-in Enrollment Requests

- MAOs may conduct outreach to individuals enrolled in its non-Medicare lines of business who are nearing Medicare eligibility or recently Medicare enrolled and offer them the opportunity to enroll in their plan.
- The opt-in mechanism is a simplified enrollment method that allows a Medicare Advantage Organization (MAO) to 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. The

organization is required to obtain any data necessary from the individual that it doesn't have from its data sharing.

- MAOs may only offer simplified opt-in enrollment to individuals who:
    - Are in their ICEP based on their initial enrollment in Medicare;
    - Are enrolled in any type of non-Medicare plan under the same organization (or an entity under the same parent organization as the MA organization); and
    - Do not have a break in coverage between the non-Medicare plan and the MA plan.
- MAOs may offer simplified opt-in enrollment via paper, telephone, or electronically.

Opt-in Enrollment example

Mr. Nash is turning 65 in June 2024 and is enrolled in an Affordable Care Act (ACA) plan with offered by GoodCare. GoodCare identifies in its records that Mr. Nash's Medicare Part A and B ICEP begins March 2024. Based on its data from Mr. Nash's ACA plan, GoodCare knows that Mr. Nash lives within the service area of several of its MA plans. A representative of GoodCare calls Mr. Nash in May 2024. She informs Mr. Nash that because he'll be eligible for Medicare soon, he can enroll in a plan that GoodCare offers just for people with Medicare. She provides information on GoodCare MA plans available in Mr. Smith's area and asks if he is interested in enrolling in one of these or learning more. Mr. Nash expresses his interest in enrolling in GoodCare's MA plan with prescription drugs. GoodCare already has Mr. Nash's personal information via its internal systems and, while on the call, the representative obtains what is needed for the MA enrollment that GoodCare doesn't already have. The representative uses this information to complete the telephonic enrollment request. GoodCare confirms the MA plan Mr. Nash wants to enroll in and asks for his Medicare number. GoodCare explains the legal requirements for enrollment, release of information, and confirms Mr. Nash's understanding and acknowledgement/approval to process the request.

37. Who May Complete the Enrollment?

- A Medicare beneficiary is generally the only individual who may execute a valid request for enrollment in or disenrollment from an MA plan. However, state law may allow another individual to execute an enrollment or disenrollment request on behalf of the beneficiary.
- CMS will allow a legal representative or another individual to execute an enrollment or disenrollment request on behalf of a beneficiary if authorized under state law.
    - Depending on state law, this may include court-appointed legal guardians, individuals with a durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws if they have the authority to act in this manner.
- If there is uncertainty regarding whether another person may sign for a beneficiary, Agents should check with the Plan Sponsor.

38. Title Page-Beneficiary Information, Acknowledgements, and Enrollee Discrimination Prohibitions

39. Beneficiary Pre-enrollment Information

Plan Sponsors must ensure that, before enrollment, CMS' required questions and topics regarding beneficiary needs related to their health plan choice are fully discussed by agents with the beneficiary or their authorized representatives. The agent must ask:

- The kind of health plan in which the beneficiary wishes to enroll (such as low premium and higher copay (or vice versa)).
- Does the beneficiary require hearing, dental, and/or vision coverage?
- Does the beneficiary have any other health care needs, such as needing durable medical equipment or physical therapy?
- Does the beneficiary have any other specific health care needs?

40. Beneficiary Pre-enrollment Information – Network Providers and Out of Network Coverage

Prior to enrollment the agent must also:

- check to see if the beneficiary's PCP and Specialists are in network. If not, the agent must explain that the beneficiary will need to choose new ones or pay out of pocket.
- check to see if the beneficiary's preferred hospital is in-network. If not, the agent must explain that the beneficiary will need to choose a new one.
- check to see if there are other facilities the beneficiary prefers that need to be in the plan's network.
- review coverage for out-of-network providers and services (e.g., except in emergency or urgent situations, the plan does not cover services by out-of-network providers (i.e., doctors who are not listed in the provider directory)).
- review PPO or PFFS out-of-network coverage

41. Beneficiary Pre-enrollment Information –Drugs

The agent must discuss prescription drug coverage and costs with the beneficiary prior to enrollment if the beneficiary wishes to obtain Part D coverage. Specifically, the agent must:

- check to see if the beneficiary's prescriptions are on the formulary. If not, the agent must explain that the beneficiary may have to pay the full price of the prescription.
- check to see if the beneficiary's pharmacy is in network. If not, the agent must explain that the beneficiary will need to choose a new pharmacy.

42. Beneficiary Pre-enrollment Information –Other Benefit Information

The agent must discuss a variety of other information about plan benefits with the enrollee prior to enrollment. The agent must:

- review coverage for services furnished by providers outside of the United States.

- explain the potential effect that enrolling in the plan will have on other, current coverage, which may in some cases mean that the beneficiary is disenrolled from their current health coverage (for example, another MA plan, Medigap).
- explain that the plan is not a hearing/dental/vision "rider" but a full health plan covering all Medicare benefits.
- explain that plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
- explain that Evidence of Coverage provides all of the costs, benefits, and rules for the plan.

43. Beneficiary Pre-enrollment Information –Cost

Agents must also discuss costs with beneficiaries or their authorized representatives prior to enrollment. The agent must:

- go over plan premiums (if the plan has one) and the Part B premium.
- if applicable, review the current plan premium vs. another plan premium.
- go over cost-sharing such as deductibles, copayments, and coinsurances including PCP copay, specialist copay, inpatient hospital copay, and any other copays for services/items beneficiary needs.
- discuss the costs/limitations on dental, vision, and hearing.

44. Beneficiary Pre-enrollment Information – Complaints, Cancellation, and Items Applicable to Only Certain Types of Plans

- Prior to enrollment agents must review with beneficiaries how they can file a complaint.
- They must also explain the right to cancel the enrollment and provide the date through which cancellation can occur.
- If a beneficiary is interested in/eligible for enrollment in an MSA, the agent must review with the beneficiary the need to maintain a trust/custodial account to remain enrolled in the MSA.
- If a beneficiary is interested in/eligible for enrollment in a special needs plan, the agent must discuss the following with the beneficiary as applicable:
    - The need to qualify for chronic/disabling condition requirement for C-SNPs
    - The need to have Medicaid to qualify for D-SNP.
    - The need to remain in an institutional skilled nursing facility to qualify for I-SNP.

45. Beneficiary Acknowledgements When Enrolling

Enrollment mechanisms must require the applicant's acknowledgement/consent that they:

- must keep Medicare Part A and Part B if enrolling into an MA plan and must keep Part A or Part B if enrolling into a Part D plan.
- agree to abide by the plan's membership rules as outlined in the enrollee materials.
- consent to the release of information to Medicare and other plans. Information may be used to track enrollment and for other purposes, as allowed under federal law.

- understand that enrollment in another MA plan, PDP, or MA-PD plan automatically disenrolls them from their current plan (the model PFFS and MSA enrollment mechanisms provide modified language as appropriate).
- understand their right to appeal service and payment denials the plan makes.

46. Enrollment Discrimination Prohibitions

- Marketing representatives may NOT:
    - Deny or discourage beneficiary enrollment based on:
        - anticipated need for health care services;
        - race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, or evidence of insurability; or
        - geographic location within the service area.
- Marketing representatives must comply with their obligations under other federal anti-discrimination rules and requirements.
- Marketing representatives may not engage in any discriminatory activity such as attempting to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas, or vice versa.
- Marketing representatives may not ask health screening questions during the completion of the enrollment request, unless it is necessary to determine eligibility to enroll in a SNP.
- MA organizations are only permitted to send health assessment forms after enrollment.

47. Title Page – Post-Enrollment Activities and Rules

48. Post-Enrollment Request: Beneficiary Notifications Prior to Effective Date

After the plan receives the request for enrollment and before the effective date of coverage all plans must provide the enrollee with:

- a notice acknowledging receipt of the complete enrollment request and showing the effective date of coverage (must be provided no later than 10 calendar days after receipt of the completed enrollment request).
- a copy of the completed paper enrollment if the beneficiary requests the form.
- evidence that the enrollment request was received (e.g., a confirmation number), for enrollment requests submitted via the internet or telephone.
- proof of health insurance coverage so that they may begin using plan services as of the effective date (must include the data necessary to access benefits).

49. Post-Enrollment Request: Beneficiary Notifications, Prior to Effective Date

Regardless of how an enrollment request is made, Plan Sponsor must explain:

- the charges for which the prospective member will be liable (premiums, late enrollment penalty, coinsurance, deductible) if this information is available at the time the acknowledgement notice is issued.
- the prospective member's authorization for the disclosure and exchange of necessary information between the MA organization and CMS.
- the lock-in requirement.
- the potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B at the time coverage begins and they have used MA plan services after the effective date.
- the effective date of coverage and how to obtain services before the receipt of an ID card (if the MA organization has not yet provided the ID card).

50. Post-Enrollment Request: Beneficiary Notifications

- In some instances, the Plan Sponsor will be unable to provide the materials and required notifications to new enrollees before the effective date. In these cases, all materials described in the previous slide must be provided no later than 10 calendar days after receipt of the completed enrollment request.
- Once the Plan Sponsor receives a reply from CMS indicating whether the individual's enrollment has been accepted or rejected, the Plan must notify the individual in writing of CMS' acceptance or rejection of the enrollment within ten calendar days. (There are exceptions to this notice requirement for certain types of transaction rejections.)
    - The enrollment confirmation notice must explain the charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees, or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance.

For those eligible for the low-income subsidy, the enrollment confirmation notice must specify the limits applicable to the level of subsidy to which the person is entitled.

51. Post-Enrollment: When does coverage begin?

Election Period	**Enrollment Effective Date**
Initial Coverage Election Period (ICEP) and Initial Enrollment Period for Part D (IEP)	First day of the month of entitlement to Medicare Part A and Part B or the first of the month following the month the enrollment request was made if after entitlement has occurred.
Annual Election Period	January 1 of the following year.
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MA organization receives an enrollment request.
Medicare Advantage Open Enrollment Period (MA OEP)	First day of the month after the month the MA organization receives an enrollment request.
Special Election Period	Generally, the first day of the month after the month the MA organization receives an enrollment request. However, exceptions apply for certain SEPs.

52. Post-Enrollment: When does coverage begin?

- If a Plan Sponsor receives an enrollment request and determines the applicant is eligible for more than one election period, it must allow the individual to choose the enrollment effective date.
    - To determine the beneficiary's choice of election period and effective date, the MA organization must attempt to contact the beneficiary and must document its attempts.
    - If the MA organization is unable to obtain the beneficiary's desired enrollment effective date, the MA organization must assign an election period using the ranking of election periods set forth in the regulations.

- Individuals eligible for the employer group health plan (EGHP) SEP and one or more other election periods who make an election via the employer or union election process will be assigned an effective date according to the EGHP SEP unless the individual requests a different, allowable, effective date.
- If one of the election periods for which the individual is eligible is the ICEP, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and Part B.

53. Title Page – Disenrollment

54. Disenrollment from MA, Part D, or Cost Plans

There are two types of disenrollment:

- Voluntary disenrollment:
    - An enrollee chooses to disenroll from a plan because they no longer want to be enrolled.
- Involuntary disenrollment:
    - In certain situations, the plan may be required or may have the option to end an enrollee's membership. The disenrollment is not the enrollee's choice.

- Plans or their marketing representatives may **not** either orally or in writing or by any action or inaction request or encourage any enrollee to disenroll from the plan except in specific situations authorized by CMS.
- Plans may contact enrollees to determine the reason for a voluntary disenrollment but must not discourage an enrollee from disenrolling after they indicate a desire to do so and may not market to the disenrolled individual during the call.

55. Voluntary Disenrollment from MA or Part D Plans

During a valid election period, an enrollee may request disenrollment from an MA or prescription drug plan by:

- enrolling in another plan.
- sending or faxing a signed written notice to the plan sponsor (or employer/union group, if applicable).
- submitting a request via the Internet to the plan sponsor (if the plan offers this option).

- calling 1-800-MEDICARE or for TTY users call 1-877-486-2048.

Enrollees making verbal requests must be instructed to request one of the above methods.

Exceptions:

- Employer or union sponsored plans may have other disenrollment mechanisms.
- To disenroll from an MSA plan enrollees must write to the plan. The enrollee cannot disenroll via 1-800-MEDICARE.
- To ensure disenrollment from a PDP, enrollees should submit a written request or call Medicare in the following situations:
    - Joining an MA PFFS plan without drug coverage
    - Joining an MSA plan
    - When NOT joining any other health or prescription drug plan

56. Voluntary Disenrollment from Cost Plans

- Medicare Cost plan enrollees may end their membership at any time during the year and enroll in Original Medicare.
    - The enrollee must submit a written request and cannot disenroll by calling Medicare.
- A beneficiary who disenrolls from a Cost plan may join a MA plan or a PDP during the Annual Election Period or other MA or Part D election period.

57. Required Involuntary Disenrollment from MA or Part D Plans

Plan sponsors must disenroll an enrollee from the plan in the following situations:

- A permanent change in residence (including incarceration) makes the enrollee ineligible to remain enrolled in the plan.
- The enrollee does not stay enrolled in Part A and Part B for MA and MA/PD plans or does not stay enrolled in Part A or Part B for PDP plans.
- A SNP enrollee loses special needs status (e.g., an enrollee of a dual eligible SNP loses Medicaid eligibility):
    - SNPs can choose to continue enrollment for an individual that no longer meets the special needs status if the individual can reasonably be expected to meet the criteria again within six months.
- An MSA enrollee no longer meets the criteria to enroll in an MSA.

58. Required Involuntary Disenrollment from MA or Part D Plans

Plan sponsors must disenroll an enrollee from the plan in the following situations:

- The enrollee dies.
- The plan sponsor's contract is terminated, withdrawn, or the service area is reduced and excludes the enrollee.
- The member fails to pay their Part D-IRMAA to the government and CMS notifies the plan to effectuate the disenrollment.

- Note that CMS has established a 3-month initial grace period before individuals in an MA-PD or PDP will be disenrolled for failure to pay their Part D IRMAA.
- The member is not lawfully present in the United States.
- A PDP must also involuntarily disenroll an individual who materially misrepresents information to the PDP sponsor regarding reimbursement for third-party coverage.

59. Involuntary Disenrollment When an Enrollee Moves from the Service Area

- MA Organizations:
  - must disenroll enrollees who are not in these (V/T) programs who have been out of the area for more than 6 months (PFFS plans can allow continued enrollment for up to 12 months).
  - may offer an extended visitor/traveler (V/T) benefit of up to 12 months. Under this benefit, enrollees may remain temporarily out of the service area for up to 12 months without being disenrolled.

- Part D Plan Sponsors:
  - must disenroll an enrollee 12 months after identifying that the individual has moved outside of the service area if the plan has been unable to confirm the move with the enrollee.
  - exceptions may apply to enrollees who have a low-income subsidy.

60. Required Involuntary Disenrollment from Cost and MSA Plans

- MSA Plans must additionally disenroll an enrollee who no longer meets MSA eligibility requirements except the MSA Plan may not disenroll beneficiaries who elect the Medicare hospice benefit while enrolled in the MSA Plan.
- Medicare cost plans must disenroll an enrollee:
  - who does not stay continuously enrolled in Part B.
  - who has a permanent change in residence (including incarceration) out of the plan's geographic service area.
  - who has a temporary absence from the service area for more than 90 consecutive days (up to 12 months for plans with an extended absence option).
  - who is deceased.
  - when the cost contract is terminated or non-renewed.
  - when the member is not lawfully present in the United States.
- Cost plans that offer an optional supplemental Part D benefit must disenroll individuals who fail to pay their Part D IRMAA from that optional benefit only (the three-month initial grace period applies).

61. Optional Involuntary Disenrollment from MA, Part D or Cost Plans

- Plan sponsors may involuntarily disenroll an enrollee from the plan (but are not required to do so) if the enrollee:
  - does not pay premiums on a timely basis.

- engages in disruptive behavior (CMS must approve the disenrollment after reviewing the evidence presented by the plan).
- provides fraudulent information on an enrollment request.
- allows another individual to use his or her enrollment card.

- Plan sponsors must take action consistently among all enrollees of each plan.

62. Optional Involuntary Disenrollment from MA, Part D or Cost Plans – Failure to Pay Premium

- If a member fails to pay the plan premium, a Plan Sponsor may choose to:
  - do nothing.
  - disenroll the member after a grace period and notice.
- Plans sponsors must apply the policy they choose uniformly for all plan members. However:
  - MA-PD plans have the option to retain dually eligible members and individuals who qualify for the low-income subsidy (LIS) who fail to pay premiums even if the MA organization has the policy to disenroll members for non-payment of premiums.
  - MA-only plans may retain individuals who are dually eligible for both Medicare and Medicaid (i.e., individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program.
  - PDPs have the option to retain individuals who qualify for the low-income subsidy who fail to pay premiums.

63. Optional Involuntary Disenrollment from MA, Part D or Cost Plans – Failure to Pay Premium, Enrollee Rights

Enrollee's Rights:

- For failure to pay plan premiums the plan sponsor must:
  - notify the enrollee in writing.
  - provide enrollees with a grace period of not less than 2 months.
- Under certain circumstances, individuals may be reinstated for good cause if the beneficiary pays the overdue premiums within 3 calendar months of disenrollment and other criteria are met.
- Enrollees have the right to make a complaint if the plan ends their membership.

64. Additional information

- Guidance for Eligibility, Enrollment, and Disenrollment procedures for Medicare Advantage (MA) plans, including MA-PD plans, and for Cost plans is provided in Chapter 2 of the Medicare Managed Care Manual.
  https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/

- CMS provides instructions for enrolling Medicare beneficiaries in Medicare Prescription Drug Plans (PDPs) in the Agency's PDP Guidance for Eligibility, Enrollment and Disenrollment. https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/index.html
- Guidance for Eligibility, Enrollment and Disenrollment procedures for Medicare cost plans is provided in Chapter 17, Subchapter D of the Medicare Managed Care Manual. https://www.cms.gov/files/document/cy2021-cost-plan-enrollment-and-disenrollment-guidance.pdf-0

Section 1557 Nondiscrimination Training

Slide 1 – Title: Nondiscrimination Training Section 1557 of the Affordable Care Act

Slide 2 – Navigation Instructions

Slide 3 – Terms and Conditions

Slide 4 – Learning Objectives

Following the successful completion of this module, students will be able to:

- Identify the entities that must comply with the nondiscrimination protections of Section 1557 of the Affordable Care Act.
- Name the forms of discrimination prohibited by Section 1557.
- Summarize the steps that must be taken under the 1557 Final Rule of 2024 to serve limited English proficient individuals.
- Summarize the steps that must be taken to serve persons with disabilities.
- Understand the 2020 Rule changes made to the scope of earlier 1557 requirements and how the 2024 Final Rule reverses these changes regarding the definition of sex and adds additional protections for those covered by Section 1557.

Slide 5-Preface

Preface
On July 25, 2022, the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) issued a Proposed Rule revising an earlier rule issued by the Trump Administration in 2020. The Proposed Rule was finalized and published in the Federal Register on May 6, 2024. While some of the Final Rule's provisions become effective 60 days after publication in the Federal Register others do not. For example, the provisions that apply to insurers and plans go into effect in the next plan or policy year in 2025. This module summarizes key points of the Final Rule throughout as deemed appropriate for those participating in this training program.

Slide 6 - Goals of Proposed Rule

Goals enunciated by the Biden Administration in the 2022 Proposed Rule have largely been reflected in the 2024 Final Rule. These include:

- Clarification of the application of Section 1557 nondiscrimination requirements to health insurance issuers that receive federal financial assistance.
- Alignment of regulatory requirements with Federal court opinions to prohibit discrimination on the basis of sex including sexual orientation and gender identity.
- Ensure requirements to prevent and combat discrimination are operationalized by entities receiving federal funding by requiring civil rights policies and procedures.

- Require entities to give staff training on the provision of language assistance services for limited English proficient (LEP) individuals effective communication, and reasonable modification to policies and procedures for people with disabilities.
- Require covered entities to provide a notice of discrimination along with a notice of the availability of language assistance services and auxiliary aids and services.
- Prohibit discrimination in the use of patient care decision support tools in covered health programs and activities.
- Clarify that nondiscrimination requirements applicable to health programs and activities include those services offered via telehealth, which must be accessible to LEP individuals and individuals with disabilities.
- Interpreting Medicare Part B as federal financial assistance.
- Refine and strengthen the process for raising conscience and religious freedom objectives.

Slide 7 - Training Roadmap

- What Section 1557 Does
- Race, Color, and National Origin
- Sex Discrimination
- Age and Disability
- Telehealth
- Other provisions (patient care decision support tools, conscience and religious freedom objectives, staff training)
- Exception(s) and Enforcement

Slide 8 – Title Slide: What Section 1557 Does

Slide 9 – ACA Section 1557

Section 1557 is part of the Affordable Care Act (ACA). Section 1557 of the Affordable Care Act (ACA), the Final Rule (2016) originally implementing it, and the Biden Administration's Final Rule (2024) provide nondiscrimination protections for individuals seeking health care and health insurance coverage.

Slide 10 – Building on Earlier Legislation

Section 1557 incorporates earlier civil rights protections regarding race, color, national origin, disability, age, and sex.

More specifically, Section 1557 incorporates existing federal civil rights laws and applies them to federally funded health programs. The prohibited grounds for discrimination are specified in the following laws:

- Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.
- Title IX of the Education Amendments Act of 1972 prohibits discrimination on the basis of sex.
- Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability.
- Age Discrimination Act of 1975 prohibits discrimination on the basis of age.

Slide 11 – Changing Regulatory Approaches to Section 1557

Different Administrations have taken different approaches to implement this section of the law. The Obama Administration's Section 1557 regulations, finalized in 2016, created broad requirements for health insurance issuers, third-party administrators (TPAs), and providers. The Trump Administration took a far narrower approach in its 2020 Final Rule. It reduced the scope of entities subject to 1557 and loosened some nondiscrimination requirements. The regulations issued by both the Obama and Trump Administrations were both subject to challenges.

The Final Rule set forth by the Biden Administration in 2024 harks back to the Obama Administration's more expansive interpretation of Section 1557.

Slide 12 – Related State and Federal Requirements

- In some states, additional requirements protecting people from discrimination may apply. These requirements are ***in addition to*** federal Section 1557 requirements. The federal requirements do not supersede applicable state requirements.
- State requirements address categories including but not limited to race, color, national origin, sex, gender identity, sexual orientation, age, or disability.
- There are also separate federal Medicare program requirements for providing information in another language to people with limited English proficiency.

Slide 13 – Who Must Comply?

Who must comply with Section 1557 and its regulations?

All health programs and activities that are administered by the federal Department of Health and Human Services (HHS) or receive **federal financial assistance (FFA)** from HHS. This includes any entity that operates a health program or activity, any part of which receives FFA. These are referred to as "covered entities."

Federal financial assistance (for purposes of Section 1557) includes grants; property; Medicaid; Medicare Parts A, C, and D payments. Under the 2024 Final Rule, federal financial assistance now also includes Medicare Part B payments. FFA also includes tax credits and cost-sharing subsidies under Title I of the ACA.

Slide 14 – Covered Entities

Section 1557 covered entities include:

- An entity that offers a Medicare Advantage Plan or a Medicaid Managed Care Plan.
- An entity that offers a qualified health plan sold on an Exchange (Marketplace).
- A physician who accepts Medicaid payment of the Medicare cost-sharing for dual eligible individuals.
- A hospital or nursing home that accepts Medicare or Medicaid payment
- A provider who accepts Medicare Part B could now also be considered a covered entity under the Final Rule.

Under Medicare Advantage, those engaged in the marketing and sales of MA products are subject to Section 1557. Because the ACA Marketplaces operate under Title I of the ACA, Section 1557 protections extend to individuals who enroll in coverage through these Marketplaces.

Slide 15 – The Scope of Operations Subject to Section 1557

The Trump Administration in its 2020 Final Rule (2020) took a narrow approach to the entities covered by ACA 1557. It held:

- Entities principally engaged in health care had to comply with Section 1557 for all programs they offered.
- Health insurers, however, were not considered to be principally engaged in delivering health care, and because of that, only programs that received federal funding or are administered under Title I of the ACA, including health plans sold on the ACA Marketplaces, had to comply with Section 1557, but other products sold by those same companies did not.

Example of 2020 Final Rule: An organization offers Medicare Advantage plans – the type of plans that receive federal funding. The organization is also engaged in the sale of other products, such as disability income, that do not receive federal funding. Only the Medicare Advantage plans would fall under the scope of the 2020 rule.

Background

Under the 2016 Obama Administration Final Rule, if a health insurer received federal funding, *ALL of the company's operations were subject to the scope of Section 1557.* The 2020 Final Rule cut back the scope of the 2016 Final Rule in this regard. The Biden Administration's Final Rule of 2024 now returns to a broadened scope of operations covered by Section 1557.

Example of 2024 Final Rule:

An organization offers Medicare Advantage plans – the type of plans that receive federal funding. The organization is also engaged in the sale of other products, such as disability income, that do not receive federal funding. Both the Medicare Advantage plans and the disability income operations would now be covered by Section 1557.

Slide 16 Medicare Supplement (Medigap)

For agents and brokers working in the senior marketplace, it is important to note that the Biden Administration's Final Rule, extends to organizations that offer both Medicare Advantage plans and Medicare Supplement plans. Furthermore, the nondiscrimination rules extend to the sale of Medigap plans offered by insurers that also offer Medicare Advantage plans.

Slide 17 – Forms of Discrimination

As a general rule, covered entities may not discriminate in providing or administering health-related insurance or other health-related coverage based on these characteristics:

- race
- color
- national origin
- sex
- age
- disability

Slide 18 – Prohibited Actions

Covered entities may not discriminate based on the characteristics discussed previously, in these areas:

- Denying, canceling, limiting, or refusing to issue or renew a health insurance plan or other health coverage.
- Denying or limiting coverage of a claim or imposing additional cost-sharing or other limitations or restrictions on coverage.

Example: Blackheart Agency determines it will require all female members to pay an additional $20 copay for any wellness visit.

Result: Prohibited.

Slide 19 - Title Slide: Race, Color, and National Origin

Slide 20 – Discrimination Based on Race, Color, or National Origin

Section 1557 prohibits covered entities from segregating, delaying, or denying services or benefits based on an individual's race, color, or **national origin**.

Examples:
Agent John Smith refuses to accept an application from an individual of a different race.
Result: Prohibited.

Broker Mary Jones has recruited a diverse workforce. Broker Jones encourages agents to prospect through community-based marketing and within their community of influence.
Result: Permissible.

Broker Charles Lee has also recruited a diverse workforce. However, Broker Lee requires agents to work only in areas populated by those of their ethnic backgrounds.
Result: Prohibited.

Mandy Blake is an administrative assistant at the ABC Agency. Her duties include handling walk-in clients. John Washington, an African American male, arrives at ABC's offices seeking assistance with a Medicare Advantage application; he asks to speak to Agent Oliver Howard. Thirty minutes later, Leslie King, a Caucasian female, arrives without an appointment and also asks to speak to Agent Howard. She is admitted to Agent Howard's office while Mr. Washington is asked to continue to wait.
Result: Prohibited.

Slide 21–Individuals with Limited English Proficiency (LEP)

For programs subject to Section 1557, a health plan must take reasonable steps to provide meaningful access to everyone with **limited English proficiency (LEP)** eligible to be served by or likely to be encountered in its health programs and activities.

Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translations.

Such services must be provided free of charge and be accurate and timely. Such services must also protect the privacy of the individual with limited English proficiency (LEP).

Slide 22 – The Meaning of LEP

The 2016 Final Rule (Obama Administration) provided a list of definitions. These definitions were either eliminated or incorporated elsewhere in the 2020 Final Rule. The recently reinterpreted Final Rule (2024) contains a list of definitions.

An individual with **limited English proficiency (LEP)** means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

The definition goes on to say that an individual with limited English proficiency may be competent in English for certain types of communication (*e.g.* speaking or understanding), but still be limited English proficient for other purposes (*e.g.* reading or writing).

Slide 23 - When Are LEP Services Appropriate?

The 2024 Final Rule (Biden Administration) specifies that the OCR will use a two-part test to evaluate when LEP services are appropriate and whether a covered entity has met its obligation:

1. OCR will evaluate and give substantial weight to, the nature and importance of the health program or activity and the particular communication at issue, to the LEP individual.
2. OCR will consider other relative factors including the effectiveness of the entity's written language access procedures.

This evaluation is done on a case-by-case basis.

Slide 24 -The Quality of Language Services

A covered program must adhere to certain quality standards in delivering language assistance services. For instance, health plans subject to Section 1557 may NOT:

- require an individual to provide their own interpreter.
- rely on a minor child to interpret, except in a life-threatening emergency where there is no qualified interpreter immediately available.
- rely on staff other than qualified bilingual or multilingual staff.

In addition, a covered program may not rely on an adult accompanying an individual with limited English proficiency, except where such individual specifically requests that the accompanying adult interpret or facilitate communication and such accompanying adult agrees to provide such assistance.

Slide 25 – Communicating with LEP Individuals: Some Examples

Here are some examples of how the antidiscrimination rules for LEP individuals might apply to agents and brokers.

Example A: Agent Esther Milbank, whose primary language is English, is working in an area that is home to many individuals whose primary language is Mandarin Chinese. Esther is asked by these individuals for information on the plans she represents. Esther works with her plan to obtain language assistance services.

Result: The required steps have been taken.

Example B: Agent David Winters is working with a LEP (limited English proficiency) prospect. Rather than seeking out the language assistance services offered by the health plan he represents, David asks the prospect's 10-year-old grandson to help answer the application questions.

Result: Prohibited. The use of a minor is permitted only in a life-threatening emergency when a qualified interpreter is not available.

Slide 26 - Title Page-Sex Discrimination

Slide 27 – Sex Discrimination

Covered entities (such as health plans) must provide equal access to health care, health insurance coverage, and other health programs without discrimination based on sex.

The Meaning of Sex

The 2020 Final Rule, issued by the Trump Administration, defined sex as biologic sex only, meaning whether a person was determined to be male or female at birth. In a May 2021 notice, the Department of Health and Human Services (HHS) said it would now more broadly define sex and interpret and enforce Section 1557 and Title IX's prohibitions on discrimination based on sex to include:

1. discrimination on the basis of sexual orientation; and
2. discrimination on the basis of gender identity.

HHS's Office of Civil Rights (OCR) indicated it would use this interpretation as a guide when processing complaints and conducting investigations.

Slide 28 – Background – May 2021 OCR Decision Regarding Section 1557

According to HHS's May 2021 notice, its reasoning behind including sexual orientation and gender identity within the meaning of sex for Section 1557 interpretation and enforcement purposes is to be consistent with the Supreme Court's decision in *Bostock v. Clayton County*.

Bostock Decision – On June 15, 2020, the Supreme Court held that Title VII of the Civil Rights Act of 1964's prohibition on employment discrimination based on sex encompasses discrimination based on sexual orientation and gender.

The case plaintiff, Gerald Bostock, was fired after he expressed interest in a gay softball league at work. Mr. Bostock was an employee of Clayton County, within the Atlanta metropolitan area, as an official for its juvenile court system. He had been employed since 2003, with good performance records through the years until his firing in 2013.

The majority in a 6-3 decision, concluded that the plain language and meaning "because of sex" in Title VII necessarily included discrimination based on sexual orientation and gender identity. Since Bostock, two federal circuits have concluded that the plain language of Title IX's Education Amendments of 1972 prohibition on sex discrimination must be read similarly. In addition, on March 26, 2021, the Civil Rights Division of the US Department of Justice issued a memorandum to Federal Agency Civil Rights Directors and General Counsel concluding that the Supreme Court's reasoning in *Bostock* applies to Title IX of the Education Amendments of 1972.

As made clear by the Affordable Care Act, Section 1557 prohibits discrimination "on the grounds prohibited under Title IX."

Slide 29 – Meaning of Sex: 2024 Final Rule

The Final Rule, issued by the Biden Administration in 2024, continues this broader interpretation of the meaning of sex stating:

Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of:

- sex characteristics, including intersex traits
- pregnancy or related conditions
- gender identity
- sex stereotypes

Slide 30 - Marital Status

The Final Rule includes a new provision that prohibits entities covered under Section 1557 from discriminating on the basis of sex regarding an individual's marital, parental, or family status. The Final Rule also prohibits discrimination on the basis of association or relationship. For example, a medical practice could not refuse to see a female patient because she has a same-sex spouse or partner.

Slide 31 – Examples of Sex Discrimination

Example 1: Agent Leslie Chen places a substantial amount of business with Health Plan A. She directs her male clients to Health Plan A. This plan offers generous benefits. At the same time, Agent Chen believes that women often have higher health care costs, so she directs her female clients to Health Plan B, which offers less generous benefits, rather than risk her relationship with Health Plan A.

Result: Prohibited action (sex discrimination)

Example 2: Agent Wendell Morris is referred to a man who is considering enrolling in a MA-PD plan. On meeting with the prospect, Wendell suspects that he is gay, based on his attire. Wendell feels uncomfortable dealing with the prospect, so he suggests that participating in Original Medicare would be more appropriate for him and that enrollment is best handled online.

Result: Prohibited action (discrimination based on sexual orientation).

Example 3: Agent Louis Sanchez is a successful agent who has helped many clients secure health insurance both on and off the Affordable Care Marketplace(s). Evan, who was born male and currently self-identifies as female, visits Agent Sanchez's office seeking health insurance. Agent Sanchez makes disparaging comments about Evan's attire and demeanor. He refuses to assist and tells Evan to seek advice about health insurance elsewhere.

Result: Prohibited action (discrimination based on gender identity)

Slide 32 – Discrimination Based on Sex

Sex-specific programs are allowed only if a covered entity can show an exceedingly persuasive justification for the program. This means that the sex-specific nature of the program must be substantially related to an important health-related or scientific objective.

Example: A breast cancer program cannot refuse to treat men with breast cancer solely because its female patients would feel uncomfortable.

Slide 33 – Title Page: Age and Disability

Slide 34 – Age Discrimination

As a general rule, Section 1557 prohibits a covered entity (such as a health plan) from excluding, denying, or limiting benefits and services based on an individual's age.

Example: Agent Vanessa Martinez consistently steers younger retirees to a Medicare Advantage plan she represents, even when a Medicare Supplement policy might better suit their needs because they are healthier and will cost the plan less money. Agent Martinez also consistently steers older retirees to Medicare Supplement policies, even when a Medicare Advantage plan might better suit their needs.

Result: Prohibited discrimination based on age.

Slide 35 – Permissible Age Distinctions

A covered entity (such as a health plan) may take actions based on age when it is a factor necessary to the normal operation of a program or to the achievement of a statutory objective of a program.

Therefore, the general rule does NOT apply to any age distinction authorized under federal, state, or local law. For instance, the Affordable Care Act permits health plans to consider age in setting premiums (within permissible ratios), and this does not violate Section 1557.

Example: Agent Marissa Matthews refuses to sell a Medicare Advantage-Prescription Drug (MA-PD) plan to Solomon, age 55, who does not have ESRD or another disability qualifying him for Medicare.

Result: Permissible. This is not discriminatory since Solomon is not Medicare eligible.

Example: Well-You Health Plan charges Kevin a premium for an ACA regulated plan that is twice that of a younger applicant, Josh.

Result: Permissible. The ACA permits regulated health plans to charge up to three times more based on age, and this does not violate Section 1557.

Different treatment options may be based on age when such variances are justified by scientific or medical evidence or based on a specialty.

For example, pediatricians are not required to treat adults, and gerontologists are not required to treat children.

Slide 36 – Disability

Under Section 1557, an individual may not be excluded or denied benefits or services because of a **disability**. The 2024 Final Rule provides a definition of disability:

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment or being regarded as having such an impairment.

Slide 37 – Reasonable Accommodations for Disabled Persons

Under Section 1557, covered entities ***must*** take the following steps, unless doing so would result in an undue financial burden or would fundamentally alter the program:

- Make reasonable changes in policies, procedures, and practices where necessary to provide equal access to individuals with disabilities.
- Make all programs and activities provided electronically accessible to individuals with disabilities.
- Ensure newly constructed and altered facilities are physically accessible to individuals with disabilities.
- Provide effective communication with individuals with disabilities, including patients and their companions.

The Final Rule substantially carries forth these requirements. Commentators on the Final Rule have also pointed out that entities must in general implement benefit designs in the most integrated setting appropriate to the needs of individuals with disabilities. For example, an insurer could not cover durable medical equipment in an institutional setting but not for individuals living in their own homes.

Slide 38 – Disability: Permissible and Impermissible Actions

Here are some examples of actions to be taken when dealing with individuals with disabilities to comply with Section 1557.

Example A: Equal Access – ABC Brokerage has a no pets policy. This policy must be modified to allow a prospect with impaired vision to be accompanied by their service (“seeing eye”) dog.

Example B: Visual Impairment – Agent Jones is reviewing plan information with Lena, a client. Lena is visually impaired, and the standard materials are in a font size too small for her to read. Agent Jones should contact the plan to obtain large print materials for Lena.

Example C: Physical Accessibility – Agent Menendez is scheduling a sales seminar to present plan benefits for the upcoming year. Agent Menendez must ensure that the location of the seminar is accessible to individuals with disabilities. For example, he must review prospective locations to see that they have ramps in place of or in addition to stairs in entryways.

Example D: Effective Communication – Agent De Rosa was referred to Wilbur, a deaf prospect. Agent De Rosa learns that Wilbur can speak American Sign Language (ASL) and arranges with her manager to have an ASL interpreter available during the appointment.

Slide 39 – Auxiliary Aids and Services

Auxiliary aids and services must be provided to individuals with disabilities, such as those suffering from vision or hearing impairments, free of charge and in a timely manner.

Auxiliary aids and services include, but are not limited to:

- Qualified sign language interpreters
- Large print materials
- Text telephones (TTYs)
- Telephone handset amplifiers
- Captioning
- Braille materials and displays
- Large print materials
- Screen reader software
- Video text display

Slide 40 – Title Page – Telehealth

Slide 41 - Telehealth Services

HHS finalizes that covered entities must not, in their delivery of health programs and activities through telehealth services, discriminate on the basis of race, color, national origin, sex, age, or disability.

It provides a definition of telehealth to mean the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. These technologies include videoconferencing, the Internet, streaming media, and wireless communications.

The Final Rule includes additional accessibility requirements for the provision of telehealth services. HHS notes that it will consider complaints raising the issues of whether inadequate reimbursement of telehealth or disparate medical management requirements limiting access to telehealth is discriminatory under Section 1557 on a case-by-case basis.

Slide 42 - Title Page – Other Provisions (Patient Decision Support Tools, Conscience and Religious Exemptions Training)

Slide 43 – Patient Decision Support Tools

The Final Rule applies Section 1557 nondiscrimination requirements to patient decision support tools. A patient care decision support tool means any automated or non-automated tool, mechanism, technology, or combination thereof used to support clinical decision-making in health programs or activities.

Clinical decision support tools aim to provide timely information to clinicians, patients, and others to inform decisions about health care. Examples of these tools include artificial intelligence (AI), algorithms, databases that can provide information relevant to particular patients, reminders for preventive care, and alerts about potentially dangerous situations. These tools are increasingly used in the determination of medical treatments and thus the issue of non-discrimination in their design and use is becoming increasingly important.

Covered entities are charged with an ongoing duty to make reasonable efforts to identify uses of patient decision support tools in their health programs or activities that employ input variables or factors that measure race, color, national origin, sex, age, or disability. For each of these tools employed, reasonable efforts must be made to mitigate the risk of discrimination resulting from the tool's use in health programs or activities.

Slide 44 – Conscience and Religious Freedom Exemptions

In the Final Rule, HHS indicates that it is fully committed to respecting Federal conscience and religious freedom laws. Once notified of a recipient's view that it is exempt from certain provisions, OCR indicates it will promptly consider those views. The Final Rule adds an administrative appeal process for those who receive an adverse determination for their exemption request.

Slide 45- Training: 1557 Coordinator

The Final Rule calls for entities with 15 or more persons to designate at least one employee to coordinate the entity's compliance efforts. The Final Rule refers to this person as a Section 1557 Coordinator.

Slide 46 - Coordinator Responsibilities and Staff Training

Responsibilities of the Section 1557 coordinator include investigation of any grievance in regard to Section 1557 matters. These responsibilities also include coordinating:

- Section 1557 recordkeeping
- implementation of the entity's language access procedures
- implementation of the entity's reasonable modification procedures

In addition, the Section 1557 coordinator would be responsible for coordinating the training of relevant employees on the civil rights policies and procedures related to Section 1557 nondiscrimination matters. Relevant staff would be those involved in direct interactions with patients, clients, or the public and would be limited to the entity's Section 1557 policies and procedures. Initial training would need to take place within one year of the final rule's effective date.

Slide 47 - Title Page - Exception(s) and Enforcement

Slide 48 – Exception(S)

Medical Necessity Standard

The antidiscrimination provisions of Section 1557 do not prohibit covered entities from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

Slide 49 – Enforcement

The Final Rule incorporates the existing enforcement tools and mechanisms that are currently in place. As we have previously seen, those who believe that parts of the Section 1557 rule would violate Federal conscience or religious freedom laws as applied to them could notify HHS of their concerns and those concerns would then be considered.

The Office for Civil Rights (OCR) of HHS enforces Section 1557 for programs that receive funding from or are administered by HHS.

OCR is a fact-finding agency that receives, investigates, and resolves thousands of complaints from the public alleging discrimination in health services and health coverage.

Slide 50 – Consequence of Violations

OCR actions and investigations should not be taken lightly, and violations of Section 1557 are serious. They can result in:

- A health plan's decision to terminate an agent's or broker's appointment with the health plan.
- termination of a health plan's ability to conduct federally funded lines of business (such as those related to Medicare).

- the payment of compensatory damages.

Slide 51 – OCR Actions

When OCR finds violations, it requires the covered entity to take **corrective actions.** This may include revising policies and procedures and/or implementing training and monitoring programs.

If a covered entity refuses to take corrective actions, OCR may undertake proceedings to suspend or terminate federal financial assistance from HHS.

OCR may also refer the matter to the U.S. Department of Justice for possible enforcement proceedings. The Department of Justice has a variety of tools at its disposal to redress violations of Section 1557 under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments Act of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Further information about OCR, its work, and how to contact its offices can be found at www.hhs.gov/ocr

Corrective action – sometimes also called corrective and preventive action are improvements to an organization's processes taken to identify and eliminate causes on non-conformities or other undesirable situations.

Slide 52 – Summary

Section 1557 of the Affordable Care Act includes nondiscrimination protections for individuals seeking health care and health insurance coverage.

It applies to all entities that operate a health program or activity, which receives federal financial assistance and programs created under Title I of the ACA. Federal financial assistance includes amounts paid by Medicaid and Medicare Parts A, C, and D, and under the Final Rule (2024) Medicare Part B. ACA Health Insurance Marketplaces are included because they were created under Title I of the ACA.

Programs subject to Section 1557 may not discriminate based on race, color, national origin, sex, age, or disability. They must take certain steps to meet the needs of persons with limited English proficiency or disabilities.

1. Medicare Parts C and D General Compliance Training

2. Navigation Instructions

3. Terms and Conditions

4. Introduction

The Medicare Parts C and D General Compliance Training course is based on training previously provided by the Medicare Learning Network®, a registered trademark of the U.S. Department of Health & Human Services (HHS).

5. Introduction

This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual general compliance training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422#se42.3.422_1503)
- 42 CFR Section 423.504(b)(4)(vi)(C) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423)
- Section 50.3.2 of the Compliance Program Guidelines (Chapter 9 of the Medicare Prescription Drug Benefit Manual (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf) and (Chapter 21 of the Medicare

Managed Care Manual) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf)

- The "Downloads" section of the CMS Compliance Program Policy and Guidance webpage (https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/CompliancePolicyandGuidance).

Completing this training in and of itself does not ensure a Sponsor has an "effective Compliance Program." Sponsors and their FDRs are responsible for establishing and executing an effective compliance program according to the CMS regulations and program guidelines.

6. Why do I need training

Every year **billions** of dollars are improperly spent because of FWA. It affects everyone-**including you**. This training will help you detect, correct, and prevent FWA. You are part of the solution.

Compliance is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

7. Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training about compliance with CMS program rules.

Learn more about Medicare Part C

Medicare Part C, or Medicare Advantage (MA), is a health insurance option available to Medicare beneficiaries. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to the beneficiaries who enroll in an MA plan.

MA plans must cover all services Medicare covers with the exception of hospice care. They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Learn more about Medicare Part D

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to Medicare beneficiaries enrolled in Part A and/or Part B who enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Medicare- approved insurance and other companies provide prescription drug coverage to individuals living in a plan's service area.

8. Navigating and Completing This Course

This WBT course consists of general compliance program training and a post-assessment.

Anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. You must use this WBT course to satisfy general compliance training requirements.

You do not have to complete the course in one session. It should take approximately 20 minutes to complete this course.

Successfully completing the course requires completing the entire lesson and scoring 70 percent or higher on the Post-Assessment. If you do not successfully complete the course, you will be given the opportunity to review the course material and retake the Post-Assessment.

9. Course Objectives

After completing this course, you should correctly:

- recognize how a compliance program operates
- recognize how compliance program violations should be reported

10. Compliance Program Requirement

The Centers for Medicare & Medicaid Services (CMS) requires Sponsors to implement and maintain an effective compliance program for its Medicare Parts C and D plans. An effective compliance program must:

- articulate and demonstrate an organization's commitment to legal and ethical conduct.
- provide guidance on how to handle compliance questions and concerns.
- provide guidance on how to identify and report compliance violations.

11. What Is an Effective Compliance Program?

An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

- prevents, detects, and corrects non-compliance.
- is fully implemented and is tailored to an organization's unique operations and circumstances.
- has adequate resources.
- promotes the organization's Standards of Conduct.
- establishes clear lines of communication for reporting non-compliance.

An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste, and abuse (FWA). It must, at a minimum, include the seven core compliance program requirements.

12. Seven Core Compliance Program Requirements

CMS requires an effective compliance program to include seven core requirements:

1. Written Policies, Procedures, and Standards of Conduct

These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.

2. Compliance Officer, Compliance Committee, and High-Level Oversight

The Sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

3. Effective Training and Education

This covers the elements of the compliance plan as well as preventing, detecting, and reporting FWA. Tailor this training and education to the different employees and their responsibilities and job functions.

13. Seven Core Compliance Program Requirements

CMS requires an effective compliance program to include seven core requirements:

4. Effective Lines of Communication

Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good faith compliance issues reporting at Sponsor and first-tier, downstream, or related entity (FDR) levels.

5. Well-Publicized Disciplinary Standards

Sponsors must enforce standards through well-publicized disciplinary guidelines.

6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks

Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

NOTE: Sponsors must ensure FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

7. Procedures and System for Prompt Response to Compliance Issues

The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action

14. Compliance Training: Sponsors and Their FDRs

CMS expects all Sponsors will apply their training requirements and "effective lines of communication" to their (First-Tier Downstream, or related entity (FDRs). Having "effective lines of communication" means employees of the Sponsor and the Sponsor's FDRs have several avenues to report compliance concerns.

15. Ethics: Do the Right Thing!

As part of the Medicare Program, you must conduct yourself in an ethical and legal manner. It's about doing the right thing!

- Act fairly and honestly
- Adhere to high ethical standards in all you do
- Comply with all applicable laws, regulations, and CMS requirements
- Report suspected violations

16. How Do You Know What Is Expected of You?

Now that you've read the general ethical guidelines on the previous slides, how do you know what is expected of you in a specific situation?

Standards of Conduct (or Code of Conduct) state the organization's compliance expectations and their operational principles and values. Organizational Standards of Conduct vary. The organization should tailor the Standards of Conduct content to their individual organization's culture and business operations. Ask management where to locate your organization's Standards of Conduct.

Reporting Standards of Conduct violations and suspected non-compliance is **everyone's** responsibility.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

17. What Is Non-Compliance?

Non-compliance is conduct that does not conform to the law, Federal health care program requirements, or an organization's ethical and business policies. CMS identified the following Medicare Parts C and D high risk areas:

- Agent/broker misrepresentation
- Appeals and grievance review (for example, coverage
- and organization determinations)
- Beneficiary notices

- Conflicts of interest
- Claims processing
- Credentialing and provider networks
- Documentation and Timeliness
- requirements
- Ethics
- FDR oversight and monitoring
- Health Insurance Portability and Accountability Act (HIPAA)
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care

For more information, refer to the Compliance Program Guidelines in the **Medicare Prescription Drug Benefit Manual** (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf) and **Medicare Managed Care Manual** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf) on the CMS website.

Know the Consequences of Non-Compliance

- Failure to follow Medicare Program requirements and CMS guidance can lead to serious consequences, including:
- Contract termination
- Criminal penalties
- Exclusion from participating in all Federal health care programs
- Civil monetary penalties

Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non- compliant behavior may be subject to any of the following:

- Mandatory training or re-training
- Disciplinary action
- Termination

18. Non-Compliance Affects Everybody

Without programs to prevent, detect, and correct non-compliance, we all risk: Harm to beneficiaries, such as:

- Delayed services
- Denial of benefits
- Difficulty in using providers of choice
- Other hurdles to care

Less money for everyone, due to:

- High insurance copayments
- Higher premiums
- Lower benefits for individuals and employers
- Lower Star ratings
- Lower profits

19. How to Report Potential Non-Compliance

Employees of a Sponsor

- Call the Medicare Compliance Officer
- Make a report through your organization's website
- Call the Compliance Hotline

First-Tier, Downstream, or Related Entity (FDR) Employees

- Talk to a Manager or Supervisor
- Call your Ethics/Compliance Help Line
- Report to the Sponsor

Beneficiaries

- Call the Sponsor's Compliance Hotline or Customer Service
- Make a report through the Sponsor's website
- Call 1-800-Medicare (1-800-633-4227)

Don't Hesitate to Report Non-Compliance

When you report suspected non-compliance in good faith, the Sponsor can't retaliate against you. Each Sponsor must offer reporting methods that are:

- Anonymous
- Confidential
- Non-retaliatory

20. What Happens After Non-Compliance Is Detected?

Non-compliance must be investigated immediately and corrected promptly. Internal monitoring should ensure:

- No recurrence of the same non-compliance
- Ongoing CMS requirements compliance
- Efficient and effective internal controls
- Protected enrollees

21. What Are Internal Monitoring and Audits?

Internal monitoring activities include regular reviews confirming ongoing compliance and taking effective corrective actions.

Internal auditing is a formal review of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures.

22. Lesson Summary

Organizations must create and maintain compliance programs that, at a minimum, meet the seven core requirements. An effective compliance program fosters a culture of compliance.

To help ensure compliance, behave ethically and follow your organization's Standards of Conduct. Watch for common instances of non-compliance, and report suspected non-compliance.

Know the consequences of non-compliance, and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.

Compliance Is Everyone's Responsibility!

Prevent: Operate within your organization's ethical expectations to prevent non-compliance!

Detect & Report: Report detected potential non- compliance!

Correct: Correct non-compliance to protect beneficiaries and save money!

23. Appendix A: Resources

Disclaimers

This Web-Based Training (WBT) course was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the course for your reference.

This course was prepared as a service to the public and is not intended to grant rights or impose obligations. This course may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network® (MLN)

Glossary

For glossary terms, visit the **Centers for Medicare & Medicaid Services Glossary** (https://www.cms.gov/glossary).

24. Appendix B: Job Aids

Job Aid A: Seven Core Compliance Program Requirements

The Centers for Medicare & Medicaid Services (CMS) requires that an effective compliance program must include seven core requirements:

1. Written Policies, Procedures, and Standards of Conduct

These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.

2. Compliance Officer, Compliance Committee, and High-Level Oversight

The Sponsor must designate a compliance officer and a compliance committee to be accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.

3. Effective Training and Education

This covers the elements of the compliance plan as well as the prevention, detection, and reporting of fraud, waste, and abuse (FWA). This training and education should be tailored to the different responsibilities and job functions of employees.

4. Effective Lines of Communication

Effective lines of communication must be accessible to all, ensure confidentiality, and provide methods for anonymous and good- faith reporting of compliance issues at Sponsor and first-tier, downstream, or related entity (FDR) levels.

5. Well-Publicized Disciplinary Standards

Sponsors must enforce standards through well-publicized disciplinary guidelines.

6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks

Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

NOTE: Sponsors must ensure FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

7. Procedures and System for Prompt Response to Compliance Issues

The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.

1. Combating Medicare Parts C and D Fraud, Waste and Abuse

2. Navigation Instructions

3. Terms and Conditions

4. Introduction

The Medicare Learning Network® (MLN) offers free educational materials for health care professionals on the Centers for Medicare & Medicaid Services (CMS) programs, policies, and initiatives. Get quick access to the information you need.

Publications & Multimedia
(https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/mln-publications)

Events & Training
(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Events-and-Training)

Newsletters & Social Media
(https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive)

5. Introduction

This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual general compliance training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503 (b)(4)(vi)(C) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422#se42.3.422_1503)
- 42 CFR Section 423.504 (b)(4)(vi)(C) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423#se42.3.423_1504)
- Medicare Program and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf)
- Section 50.3.2 of the Compliance Program Guidelines (Medicare Prescription Drug Benefit Manual, Chapter 9 [https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf] and Medicare Managed Care Manual, Chapter 21, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c21.pdf

Sponsors and their FDRs (First-tier, Downstream, and Related Entities) are responsible for providing additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

6. Why do I need training

Every year **billions** of dollars are improperly spent because of FWA. It affects everyone-**including you**. This training will help you detect, correct, and prevent FWA. You are part of the solution.

Combating FWA is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

7. Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training for preventing, detecting, and correcting FWA.

FWA training must occur within 90 days of initial hire and at least annually thereafter.

Learn more about Medicare Part C

Medicare Part C, or Medicare Advantage (MA), is a health insurance option available to Medicare beneficiaries. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to the beneficiaries who enroll in an MA plan.

MA plans must cover all services Medicare covers with the exception of hospice care. They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Learn more about Medicare Part D

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to Medicare beneficiaries enrolled in Part A and/or Part B who enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Medicare-approved insurance and other companies provide prescription drug coverage to individuals living in a plan's service area.

8. Course Objectives

After completing this course, you should be able to:

- Recognize FWA in the Medicare Program
- Identify major FWA laws and regulations
- Recognize potential consequences and violation penalties
- Identify methods to prevent FWA
- Identify how to report FWA
- Recognize how to correct FWA

9. Introduction and Learning Objectives

This lesson describes fraud, waste, and abuse (FWA) and the laws that prohibit it. It should take about 10 minutes to complete.

After completing the lesson, you should be able to correctly:

- Recognize FWA in the Medicare Program
- Identify the major FWA laws and regulations
- Recognize potential consequences and penalties associated with violations

10. Fraud

Fraud is knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to get a federal health care payment when no entitlement would otherwise exist. Knowingly soliciting, getting, offering, or paying remuneration (for example, kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by federal health care programs. Making prohibited referrals for certain designated health services is another example. Fraud requires intent to get payment and knowledge the actions are wrong.

The Criminal Health Care Fraud Statute (18 United States Code (USC) 1347) makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years. It is also subject to criminal fines up to $250,000. The statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie connected to delivering or paying for health care benefits, items, or services to either:

- Defraud any health care benefit program
- Get (by means of false or fraudulent pretenses, representations, or promises) money or property owned by, or controlled by, any health care benefit program.

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare program by submitting medically unnecessary power wheelchair claims.

Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

11. Waste and Abuse

Waste describes practices that, directly or indirectly, result in unnecessary Medicare Program costs, like overusing services. Waste is generally not considered to be criminally negligent but rather the misuse of resources.

Abuse describes practices that, directly or indirectly, result in unnecessary Medicare Program costs. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards of care.

For the definitions of fraud, waste, and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf) and Chapter 9 of the Prescription Drug Benefit Manual on the Centers for Medicare & Medicaid Services (CMS) (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf) website.

12. Examples of FWA

Examples of actions that may constitute Medicare **fraud** include:

- Knowingly billing for services of higher complexity than services actually provided or documented in patient medical records.
- Knowingly billing for services or supplies not provided, including falsifying records to show item delivery
- Knowingly ordering medically unnecessary patient items or services
- Paying for federal health care program patient referrals
- Billing Medicare for appointments patients don't keep

Examples of actions that may constitute Medicare **waste** include:

- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition
- Ordering excessive lab tests

Examples of actions that may constitute Medicare **abuse** include:

- Billing for unnecessary medical services (unknowingly)
- Charging excessively for services or supplies
- Misusing codes on a claim, like upcoding (assigning an inaccurate medical procedure or treatment billing code to increase payment) or unbundling codes

13. Differences Among Fraud, Waste, and Abuse

There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating unnecessary Medicare Program costs but do not require the same intent and knowledge.

14. Understanding FWA

To detect FWA, you need to know the **law**.

The following pages provide high-level information about the following laws:

- Federal Civil False Claims Act (FCA)
- Federal Criminal Health Care Fraud Statute
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Statute)
- Civil Monetary Penalties Law (CMPL)
- Exclusion Statute
- Health Insurance Portability and Accountability Act (HIPAA)

For details about specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

15. Federal Civil False Claims Act (FCA)

The civil provisions of the FCA (31 USC 3729-3733) make a person liable to pay damages to the Government if they knowingly:

- Conspire to violate the FCA
- Carry out other acts to obtain property from the Government by misrepresentation
- Conceal or improperly avoid or decrease an obligation to pay the Government
- Make or use a false record or statement supporting a false claim
- Present a false claim for payment or approval

Additionally, under the criminal FCA (18 USC 287), individuals or entities may face criminal penalties, including fines, imprisonment, or both for submitting false, fictious, or fraudulent claims.

Examples:

A Medicare Part C plan in Florida:

- hired an outside company to review medical records to find additional diagnosis codes it could submit to increase risk capitation payments from CMS.
- was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported.
- failed to report the unsupported diagnosis codes to Medicare.
- agreed to pay $22.6 million to settle FCA allegations.

The owner-operator of a medical clinic in California:

- used marketers to recruit individuals for medically unnecessary office visits.
- promised free, medically unnecessary equipment or free food to entice individuals.
- charged Medicare more than $1.7 million for the scheme.
- was sentenced to 37 months in prison.

Damages and Penalties

Penalties for violating the civil FCA may include recovery of up to 3 times the amount of the government's damages due to the false claims, plus $11,000 per false claim filed.

16. Federal Civil FCA (continued)

Whistleblowers: A person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

Protected: A person who reports false claims or brings legal actions to recover money paid on false claims is protected from retaliation.

Rewarded: A person who brings a successful whistleblower lawsuit receives at least 15 percent, but not more than 30 percent, of the money collected.

17. Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 USC 1346-1349) states, "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program or obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the custody or control of, any health care benefit program ... shall be fined under this title or imprisoned not more than 10 years, or both."

Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law.

Examples:

A Pennsylvania pharmacist:

- Submitted claims to a Medicare Part D plan for non-existent prescriptions and drugs not dispensed
- Pleaded guilty to health care fraud
- Received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan

The owner of multiple Durable Medical Equipment (DME) companies in New York:

- Falsely represented themselves as one of a nonprofit health maintenance organization's (that administered a Medicare Advantage plan) authorized vendors
- Provided no DME to any beneficiaries as claimed
- Submitted almost $1 million in false claims to the nonprofit; $300,000 was paid
- Pleaded guilty to one count of conspiracy to commit health care fraud

18. Criminal Health Care Fraud Statute, continued

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000
- Imprisonment for up to 20 years

If the violations resulted in death, the individual may be imprisoned for any term of years or for life.

For more information, refer to 18 USC Section 1347 (https://www.govinfo.gov/content/pkg/USCODE-2017-title18/pdf/USCODE-2017-title18-partI-chap63-sec1347.pdf).

19. Anti-Kickback Statute

The Anti-Kickback Statute (AKS) (42 USC 1320a-7b(b)) makes it a crime to knowingly and willfully offer, pay, solicit, or get any remuneration directly or indirectly to induce. Or reward patient referrals or business generation involving any item or service payable by a federal health care program. When a provider offers, pays, solicits, or gets unlawful remuneration, they violate the AKS.

The safe harbor regulations (42 CFR 1001.952) describe various payment and business practices that, although they potentially implicate the AKS, aren't treated as AKS offenses if they meet certain regulatory requirements. Individuals and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their businesses.

Comparison of the Anti-Kickback Statue and Stark Law handout has more information.

Example:

A physician operating a pain management practice in Rhode Island:

- Conspired to solicit and receive kickbacks for prescribing a highly addictive version of the opioid Fentanyl
- Reported patients had breakthrough cancer pain to secure insurance payments
- Received $188,000 in speaker fee kickbacks from the drug manufacturer
- Admitted the kickback scheme cost Medicare and other payers more than $750,000
- The physician must pay more than $750,000 restitution and is awaiting sentencing.

Damages and Penalties

Violations are punishable by:

- A fine up to $25,000
- Imprisonment up to 5 years, or both

For more information, refer to the Social Security Act (the Act), Section 1128B(b) (https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm).

20. Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law (42 USC Section 1395nn), often called the Stark Law, prohibits a physician from referring a patient to get designated health services from a provider with whom a physician or a physician's immediate family member has a financial relationship unless an exception applies.

Designated health services:

- Clinical lab services
- Physical therapy, occupational therapy, and outpatient speech-language pathology services
- Radiology and other imaging services
- Radiation therapy services and supplies
- DME and supplies
- Parental and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Example:

A California hospital was ordered to pay more than $3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician groups outside the fair market value standards or that were improperly documented as exceptions.

Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of approximately **$25,000** can be imposed for each service provided. There may also be around a **$160,000** fine for entering into an unlawful arrangement or scheme.

For more information, visit the Physician Self-Referral webpage and refer to the Act, Section 1877 (https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral).

21. Civil Monetary Penalties (CMP) Law

The Civil Monetary Penalties Law (CMPL) (42 USC 1320a-7a) authorizes The Office of Inspector General (OIG) to seek Civil Monetary Penalties (CMPs) and sometimes exclusions for a variety of health care fraud violations. Violations that may justify CMPs include:

- Arranging for an excluded individual's or entity's services or items
- Failing to grant OIG timely records access
- Filing a claim you know or should know is for an item or service that wasn't provided as claimed or is false or fraudulent
- Filing a claim you know or should know is for an item or service for which we won't make payment
- Violating the AKS
- Violating Medicare assignment provisions
- Violating the Medicare physician agreement
- Providing false or misleading information expected to influence a discharge decision
- Failing to provide an adequate medical screening exam for patients who present to a hospital emergency department with an emergency medical condition or in labor
- Making false statements or misrepresentations on applications or contracts to participate in federal health care programs

Section 1128A(a) of the Social Security Act has more information (https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm).

Example:

A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted unsubstantiated claims to Medicare Part D for brand name prescription drugs the pharmacy could not have dispensed based on inventory records.

Damages and Penalties

Penalties and assessments (https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1003#p-1003.210(a)) vary based on the type of violation. The penalties can be around $10,000 to $50,000 depending on the specific violation. Violators are also subject to three times the amount:

- Claimed for each service or item or
- Of remuneration offered, paid, solicited, or received

22. Exclusion Statute

The Exclusion Statute (42 USC 1320a-7) requires the OIG exclude individuals and entities convicted of these offenses from participating in all federal health care programs:

- Medicare or Medicaid fraud, as well as other offenses related to delivering Medicare or Medicaid items or services
- Patient abuse or neglect
- Felony convictions for other health care-related fraud, theft, or other financial misconduct
- Felony convictions for unlawful manufacture, distribution, prescribing, or dispensing controlled substances

The OIG also maintains the List of Excluded Individuals and Entities (LEIE)(https://exclusions.oig.hhs.gov/).

The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS)(https://sam.gov/content/home and https://sam.gov/content/exclusions), which enables various federal agencies, including the OIG, to take debarment actions.

When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same. For more information, refer to 42 Code of Federal Regulations (CFR) Section 1001.1901 https://www.ecfr.gov/current/title-42/chapter-V/subchapter-B/part-1001#p-1001.1901(a).

Example:

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the U.S. Food and Drug Administration concerning oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. At the time the unconvicted executive was excluded, there was evidence he was involved in misconduct leading to the company's conviction.

23. Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) created greater access to health care insurance, strengthened health care data privacy protection, and promoted standardization and efficiency in the health care industry.

HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.

Example:

A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

Damages and Penalties

Violations may result in Civil Monetary Penalties (CMPs). In some cases, criminal penalties may apply.

24. Lesson 1 Summary

There are differences among fraud, waste, and abuse (FWA). One of the primary differences is **intent and knowledge**.

Fraud is knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to get a federal health care payment for which no entitlement would otherwise exist.

Waste and abuse may involve obtaining an improper payment but not the same intent and knowledge.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

- Civil Monetary Penalties
- Civil prosecution
- Criminal conviction, fines, or both
- Exclusion from all Federal health care program participation
- Imprisonment
- Loss of professional license

Lesson 2

25. Introduction and Learning Objectives

This lesson explains the role you can play in fighting against fraud, waste, and abuse (FWA), including your responsibilities for preventing, reporting, and correcting FWA. It should take about 10 minutes to complete. Upon completing the lesson, you should correctly:

- Identify methods of preventing FWA
- Identify how to report FWA
- Recognize how to correct FWA

26. Where Do I Fit In?

As a person providing health or administrative services to a Medicare Part C or Part D enrollee, you are likely an employee of a:

- Sponsor (Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
- First-tier entity (Examples: Pharmacy Benefit Management [PBM]; hospital or health care facility; provider group; doctor's office; clinical laboratory; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents)
- Downstream entity (Examples: pharmacies, doctor's office, firms providing agent/broker services, marketing firms, and call centers)
- Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®)

27. Where Do I Fit In? (Continued)

The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with first-tier downstream, or related entities (FDRs). This stakeholder relationship flow chart shows examples of functions relating to the Sponsor's Medicare Part C contracts. First-tier and related entities of the Medicare Part C Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

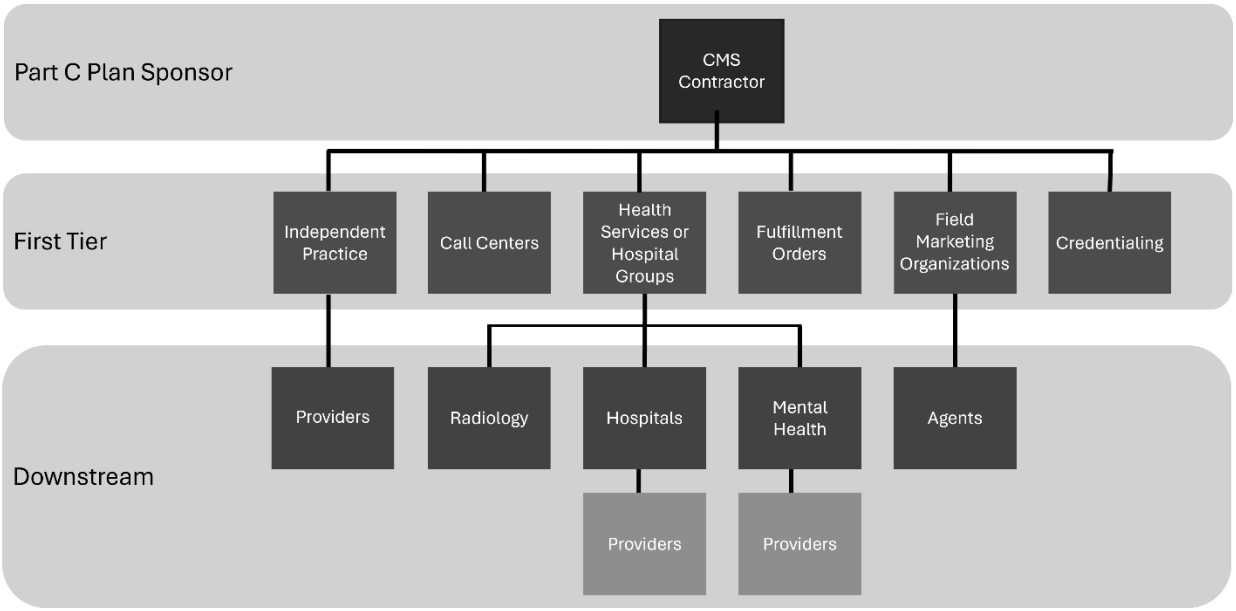
Examples of first-tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first-tier entity is an independent practice, then a provider could be a downstream entity. If the first-tier entity is a health service/hospital group, then radiology, hospital, or mental health facilities may be the downstream entity. If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.

A Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions that relate to the Sponsor's

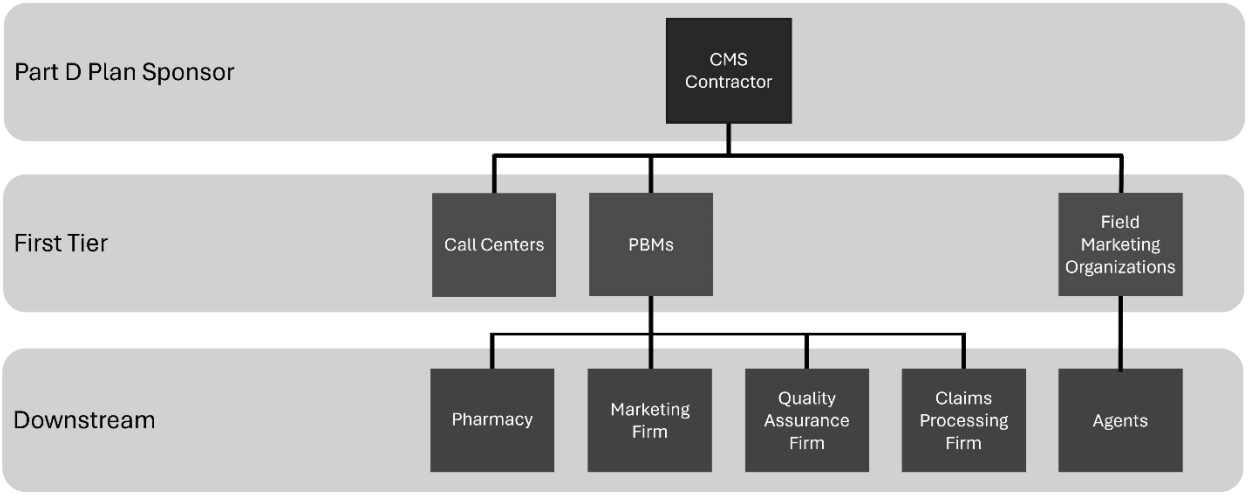
Medicare Part D contracts. Medicare Part D Sponsor first-tier and related entities may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Examples of first-tier entities include call centers, pharmacy benefit managers (PBMs), and field marketing organizations (FMO). If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a FMO, then agents could be a downstream entity.

I'm an employee of a Part C Plan Sponsor or their first-tier or downstream entity



I'm an employee of a Part D Plan Sponsor or their first-tier or downstream entity



28. What Are Your Responsibilities?

You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare noncompliance.

- **FIRST,** you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
- **SECOND,** you have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations of which you may be aware.
- **THIRD,** you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

29. How Do You Prevent FWA?

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS guidance
- Verify all received information

30. Stay Informed About Policies and Procedures

Know your entity's policies and procedures.

Every Sponsor and First-Tier, Downstream, and Related Entity (FDR) must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.

Standards of Conduct should describe the Sponsor's expectations that:

- All employees conduct themselves in an ethical manner
- Appropriate mechanisms are in place for anyone to report noncompliance and potential FWA
- Reported issues will be addressed and corrected

Standards of Conduct communicate to employees and FDRs compliance is everyone's responsibility, from the top of the organization to the bottom.

31. Report FWA

Everyone must report suspected instances of FWA. Your Sponsor's Code of Conduct should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.

Report any potential FWA concerns you have to your compliance department or your Sponsor's compliance department. Your Sponsor's compliance department will investigate and make the proper determination. Often, Sponsors have a Special Investigations Unit (SIU) dedicated to investigating FWA. They may also maintain an FWA Hotline.

Every Sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting. Review your organization's materials for the ways to report FWA.

When in doubt, call your Compliance Department or FWA Hotline.

32. Reporting FWA Outside Your Organization

If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), or CMS.

Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation.

Details to Include When Reporting FWA

When reporting suspected FWA, include:

- Contact information for the information source, suspects, and witnesses
- Alleged FWA details
- Alleged Medicare rules violated
- Suspect's history of compliance, education, training, and communication with your organization or other entities

Where to Report FWA

Medicare Providers:

HHS Office of Inspector General:

- Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
- Fax: 1-800-223-8164
- Online: (https://oig.hhs.gov/fraud/report-fraud/)
- Mail: U.S. Department of Health & Human Services Office of Inspector General
  ATT: OIG Hotline Operations
  PO Box 23489
  Washington, DC 20026

For Medicare Parts C and D:

Investigations Medicare Drug Integrity Contractor (I MEDIC) at 1-877-7SafeRx (1-877-772-3379)

For all other Federal health care programs:

CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

Medicare Patients:

Online: Help Fight Medicare Fraud

33. Corrective Action

Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with CMS requirements.

Develop a plan to correct the issue. Ask your organization's compliance officer about the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future noncompliance.
- Tailor the corrective action to address the particular FWA problem or deficiency identified. Include timeframes for specific actions.
- Document corrective actions addressing noncompliance or FWA committed by a Sponsor's employee or FDR's employee, and include consequences for failure to satisfactorily complete the corrective action.
- Monitor corrective actions continuously to ensure effectiveness.

Corrective Actions

Corrective actions may include:

- Adopting new prepayment edits or document review requirements
- Conducting mandated training
- Providing educational materials
- Revising policies or procedures
- Sending warning letters
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment
- Terminating an employee or provider

34. Indicators of Potential FWA

Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.

The following pages present potential FWA issues. Each page provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy, or other entity involved in delivering Medicare Parts C and D benefits to enrollees.

35. Key Indicators: Potential Beneficiary Issues

- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the medical service the beneficiary (identity theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

36. Key Indicators: Potential Providers Issues

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Does the provider bill the Sponsor for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary patient services?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Does the provider's prescription have their active and valid National Provider Identifier (NPI) on it?
- Is the provider's diagnosis for the member supported in the medical record?

37. Key Indicators: Potential Pharmacy Issues

- Are drugs being diverted (drugs meant for nursing homes, hospices, and other entities being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires dispensing brand drugs?
- Are PBMs billed for unfilled or never picked up prescriptions?
- Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispensed As Written)?
- Are Eligibility facilitation services (E1s) and the information they provide being used for purposes other than for determining patient eligibility?

38. Key Indicators: Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics, marking up the prices, and sending to other smaller wholesalers or pharmacies?

39. Key Indicators: Potential Manufacturers Issues

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer knowingly provide samples to entities that bill Federal health care programs for them?

40. Key Indicators: Potential Sponsor Issues

- Does the Sponsor encourage or support inappropriate risk adjustment submissions?
- Does the Sponsor lead the beneficiary to believe the cost of benefits is one price when the actual cost is higher?
- Does the Sponsor offer beneficiaries cash inducements to join the plan?
- Does the Sponsor use unlicensed agents?

41. Lesson 2 Summary

- As a person providing health or administrative services to a Medicare Part C or D enrollee, you play a vital role in preventing fraud, waste, and abuse (FWA). Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.
- Report potential FWA. Every Sponsor must have a mechanism for reporting potential FWA. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.
- Promptly correct identified FWA with an effective corrective action plan.