Medicare Parts C & D: 2019 Changes & Updates For SMP Partners

Presented by:
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Technical & Training Consultant
Our Focus

California Health Advocates provides quality Medicare and related healthcare coverage information, education and policy advocacy.

www.cahealthadvocates.org

- **Policy** – Conduct public policy research to support recommendations for improving rights and protections for Medicare beneficiaries and their families

- **Training** – Provide timely and high-quality information on Medicare through our website, fact sheets, policy briefs and educational workshops

- **Advocacy** – Bring the experiences of Medicare beneficiaries to the public, and especially legislators and their staff at federal and state levels, through media and educational campaigns
Senior Medicare Patrol (SMP)

- SMP is a federally funded project
- Established in 1997
- SMPs empower and assist Medicare beneficiaries, their families and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling and education
- 54 SMPs across the country
SMP Message:

- **Protect** Medical Identity by guarding the Medicare card
- **Detect** Fraudulent Billing by reviewing Medicare Summary Notices and Explanation of Benefits
- **Report** Medicare Fraud by calling SMP at 1-855-613-7080
Current trends this month:

1. Durable Medical Equipment (DME)/Back Brace Phone Scams

2. New Medicare card related phone scams

3. Questionable Hospice Enrollment

4. Questionable Claims Detected on MSNs
Beware of DME/Back Brace Scams

- Unsolicited phone calls offering a brace.
- TV commercials and newspaper ads offering “free” Medicare approved braces to alleviate pain.
- Urgently marked postcards notifying beneficiaries of pending eligibility for free Medicare-covered back and/or knee braces.
- DME billed to Medicare that was not provided.
Beware of New Medicare Cards Scams

- Unsolicited calls
  - Offering to send the new Medicare card if person has yet to receive it.
  - Offering to activate the new Medicare card by asking person to verify old Medicare #, which is a Social Security #.
  - Offering to send the new Medicare card along with a complimentary brace Medicare is giving away to alleviate pain.
PROTECT - Guard Your Card

Treat your Medicare card like a credit card number.

- Don’t carry your Medicare card unless you need it.
- Only take it to doctor’s appointments, visits to your hospital or clinic, or trips to the pharmacy.
- Never give your Medicare number to a stranger.

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As you can see from the attached photos, the SHIP logo and California HICAP 800# is on one side and the SMP logo and 855# is on the other side.

The card holder fits the new Medicare card at 4.25" by 2.75" - and is translucent plastic.

Please send your order to Jasmine at jsuo@cahealthadvocates.org - limit 200 at this time.
Beware of Hospice Enrollment Scams

- Medicare beneficiaries who are not terminal, are being tricked into signing up for hospice. They agree to free services while unknowingly being placed into hospice.

- Presentations at low-income senior housing facilities where beneficiaries are offered assistance with cooking and cleaning while unknowingly placed into hospice.

- Unsolicited calls and home visits offering additional benefits for low-income Medicare beneficiaries.
SMP Fraud Alerts are available in different languages including:

You may access these fraud alerts by visiting our California Health Advocates website at:
https://cahealthadvocates.org/fraud-abuse/medicare-fraud-alerts/
**DETECT-Review MSNs & EOBs**

- **Keep track of medical appointments**
  - Use journal or calendar

- **Look for three things on your statements:**
  - Charges for something you didn’t get
  - Billing for the same services or supplies twice
  - Services that weren’t ordered by your doctor

- **Medicare Summary Notice (MSN)**
  - Statement that shows what providers and suppliers billed Medicare in a 3-month period
  - Accessible 24/7 via mymedicare.gov

- **Explanation of Benefits (EOB)**
If you have a Medicare beneficiary who needs assistance, SMP will need:

- Beneficiary’s name, address, date of birth, Medicare number and a good contact number
- Copy of Medicare Summary Notices- VERY IMPORTANT
Placemats Available!

SMP placemats available in English and Spanish.

To place an order, contact Jasmine at jsuo@cahealthadvocates.org

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California Health Advocates Projects

- **Senior Medicare Patrol** 1-855-613-7080
  - *Empowering Seniors to Prevent Fraud*

- **Counseling Tools**
  - *Fact Sheets and Comparison Charts* (updated with 2019 info coming soon)

- **Medicare Education for Professionals, including Tribal Organizations**
  - Customized training modules
Objectives

1. Learn about 2019 Medicare Premiums & Deductibles
2. Identify Medicare Enrollment Periods
3. List options available to beneficiaries in non-renewing plans
4. Learn basic information about 2019 plan landscape
5. Identify situations that allow a SEP and/or guaranteed issue period
6. Highlight changes and limitations for Duals/LIS program
7. Review more fraud prevention tools
8. List Resources for more information
Objective 1

LEARN ABOUT MEDICARE’S 2019 PREMIUMS & DEDUCTIBLES
2019 MEDICARE PREMIUMS & DEDUCTIBLES

PART A –
- Premium Free for most
- Premiums for people with less than 40 qtrs:
  - 30-39 Qtrs: $240
  - Less than 30 Qtrs: $437
- Deductible: $1364 per 3-day in-patient stay
- Co-pays:
  - Day 61-90: $341/day
  - Day 90-150: $682/per lifetime reserve day
  - Skilled nursing facility: day 21-100: $170.50/day

PART B –
- Premium $135.50/month for most
- Maybe less for some under the “hold harmless” provision
- Incomes above $85K (single) and $170K (couple) will pay more – ranging from $189.60 to $460.50
- Deductible: $185/year

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Objective 2

IDENTIFY MEDICARE OPEN ENROLLMENT PERIODS
Technical term “Annual Coordinated Election Period,” commonly called “Open Enrollment”

- Medicare Advantage (MA or Part C) and Part D plans only
- Period: **Oct 15 – Dec 7 – Enrollment effective January 1**
- Must have Part A **or** B to enroll in Part D
- Must have Parts A **and** B to enroll in Part C (MA)
- For more enrollment date information see
  - CHA Fact Sheet A-008
MA enrollee can exercise a one-time-change from January 1 to March 31

- Change will usually be effective the month following

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
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<tbody>
<tr>
<td>MA-PD</td>
<td>MA-PD, MA Only, Original Medicare w/wo PDP</td>
</tr>
<tr>
<td>MA Only</td>
<td>MA Only, MA-PD*, or Original Medicare w/wo PDP*</td>
</tr>
<tr>
<td></td>
<td>*Late Enrollment Penalty (LEP) may apply</td>
</tr>
</tbody>
</table>
Other “Open Enrollments”

- Marketplace plans – aka Qualified Health Plans (QHP) - Covered California
  - October 15, 2018 to January 15, 2019

- Medigap (Medicare Supplemental Plans)
  - 6 months starting with effective date of Part B
  - “Birthday Rule” – 30 days following birthday

- One year extension of Equitable Relief approved by CMS (to September 30, 2019)
Objective 3

LIST OPTIONS AVAILABLE TO BENEFICIARIES IN NON-RENEWING PLANS
Non-Renewing Plans

- Notice to members about non-renewal – plan must send by Oct 2
- Beneficiaries can make change during AEP, SEP
  - AEP dates: Oct 15 – Dec 7
    - Change made during AEP will be effective Jan 1
  - SEP dates: Dec 8 – last day of February
    - Change made during SEP effective 1st day of following month
Medicare Cost Plans

- Medicare Cost plans are NOT Medicare Advantage plans
- Effective January 1, 2019, Cost plans will not renew in areas where two or more Medicare Advantage plans are available.
- Notices have been mailed to those impacted beneficiaries
- Enrollees who do not make a coverage decision by December 31, will go back to Original Medicare
- Guarantee Issue rights apply for most.
  - See CHA Fact sheet B-005
  - Certain conditions apply – contact local HICAP for more information
Consolidated Plans – Basic Rules

- CMS allows plans to move enrollees from a discontinued plan to another within same company – “cross-walked”
  - HICAPs have analyzed their 2019 MA plan availability based contract number.
  - Changes to Part D plans discussed in another slide
- Non-renewal letter by Oct 2 not necessary
  - Special notice with ANoC
- No SEP to change plans - Use AEP
- Can use new MA OEP to select new MA plan
- No guaranteed issue right to buy Medigap
Objective 4

BASIC INFORMATION ABOUT 2019 PLAN LANDSCAPE
Medicare Advantage (MA) Plans

Key changes & enhancements:

- PFFS (Private-fee-for-service) plans discontinued in California
- Supplemental benefits in 2019 are “primarily health-related” under a broader definition of the term, e.g. adult day care, home-based palliative care, in-home supportive services, caregiver support. Meals not included.
  - Must be recommended by a licensed professional as part of a care plan
  - Explanation of Coverage (EOC) must describe details
Medicare Advantage (MA) Plans - Contd.

- Seamless Conversions, Default, & Passive Enrollments further codified
  - For new Medicare beneficiaries in current non-Medicare plans → MA plans
  - For dual-eligible beneficiaries, including those impacted by non-renewing D-SNPs (Dual-Eligible Special Needs Plan)
- Local HICAPs have information about any impacted plans in their service area
39 Counties have at least 1 MA plan

- 646 plans (with or w/o Rx coverage)
  - 374 HMOs
  - 8 Local PPOs
  - 242 SNPs
  - 22 CCI – Cal MediConnect Plans

19 Counties w/o MA plans: Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Modoc, Mono, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolomne
## Part D Plans – 30!

### 2018 Plan Name Change in 2019

<table>
<thead>
<tr>
<th>Plan Name Change</th>
<th>Old Plan Name</th>
<th>New Plan Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Health Part D Value Plus</td>
<td>changed name to</td>
<td>Aetna Medicare Rx Value Plus</td>
</tr>
</tbody>
</table>

### 2018 Plans Renewing in 2019

<table>
<thead>
<tr>
<th>Plan Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
</tr>
</tbody>
</table>

### 2019 New Plans (8)

<table>
<thead>
<tr>
<th>Plan Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Medicare Rx Value Plus</td>
</tr>
<tr>
<td>Cigna-HealthSpring Rx Secure-Essential</td>
</tr>
<tr>
<td>MII Life Insurance Incorporated – Journey Rx Standard &amp; Rx Value</td>
</tr>
<tr>
<td>Mutual of Omaha Rx Plus &amp; Rx Value</td>
</tr>
<tr>
<td>SilverScript Allure</td>
</tr>
<tr>
<td>WellCare Value Script</td>
</tr>
</tbody>
</table>

### 2018 Plans cross-walked to another 2019 Plans

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Old Plan Name</th>
<th>New Plan Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Blue Cross Medicare Rx Gold</td>
<td>to</td>
<td>Anthem Blue Cross Medicare Rx Standard</td>
</tr>
<tr>
<td>UHC Symphonix Value Rx to</td>
<td>AARP Medicare Saver Plus</td>
<td></td>
</tr>
</tbody>
</table>
Part D Benefit Costs Periods

- Premium: Varies by plan
  - Lowest: $12.90
  - Highest: $117.80

- Deductible: Up to $415 – Retail price for most Rx

- Initial Coverage Period: $416-$3,820
  - Plan pays 75% for covered drugs

- Coverage Gap (Donut Hole) value: up to $3,833.75
  - Co-pays equal 25% for Brand and 37% for Generic drugs (in 2020 generic co-pay drop to 25%)
    - Plus pharmacy dispensing fee – approx. $1-$3
Part D Plan Costs – Contd.

- Out-of-Pocket Threshold: $5,100
  - When this is met, Catastrophic coverage begins
- Catastrophic Coverage Begins: $7,653.75
  - Co-insurance 5% or $3.40 (generic) or $8.50 (brand)
  - Beneficiary remains in this level until end of year
- Evidence of Coverage (EOC) may only be available on-line.
  - Must request printed copy
MEDITCARE PART D PRESCRIPTION DRUG BENEFIT IN 2019

Medicare's Basic Benefit: Besides the monthly premium, you pay ...

100% of your annual deductible (max. $4,155)

25% of prescription costs during your Initial Coverage Period ($955 for someone with no deductible; $511.25 for someone in $4,155 deductible plan)

You reach the $3,820 initial coverage limit — you're headed for the donut hole.

Your drug costs have reached $7,653.75 and catastrophic coverage begins. (You pay 5%, or $3.40 for generics and $8.50 for brand-name drugs, whichever is greater.)

DONUT HOLE COVERAGE GAP

= drug costs of $3,820 to $7,653.75

Before the Affordable Care Act: You paid 100% out-of-pocket while in the donut hole.

After the Affordable Care Act: In 2019, you pay 25% for brand-name drugs and 37% for generics while in the donut hole.

Need help paying for drugs?
You may be eligible for Extra Help. Visit BenefitsCheckUp.org or ssa.gov/prescriptionhelp to apply.

For more information, visit ncoa.org

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# Benchmark Plans

<table>
<thead>
<tr>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Medicare Rx Saver</td>
<td>Aetna Medicare Rx Saver</td>
</tr>
<tr>
<td>Humana Preferred Rx Plan</td>
<td>Envision Rx Plus</td>
</tr>
<tr>
<td>SilverScript Choice</td>
<td>Humana Preferred Rx Plan</td>
</tr>
<tr>
<td>Symphonix Value Rx (United Healthcare – UHC)</td>
<td>Journey Rx Standard (MII Life Insurance Inc.)</td>
</tr>
<tr>
<td>WellCare Classic</td>
<td>SilverScript Choice</td>
</tr>
<tr>
<td></td>
<td>AARP Medicare Rx Saver Plus (UHC)</td>
</tr>
<tr>
<td></td>
<td>WellCare Classic</td>
</tr>
</tbody>
</table>

* Zero Premium & Deductible for people below 135% FPL - e.g. full dual-eligibles, Medicare Savings Program (QMB/SLMB/QI), or LIS
Part D and IRMAA (Income Related Medicare Adjustment Amount)

- 2019 Base Beneficiary Premium to calculate IRMAA is $31.90
- Incomes above $85,000 (single) and $170,000 (couple)
  - Range from $12.40 to $77.40
  - Based on 2017 Income Tax returns
Part D Late Enrollment Penalty (LEP)

- Applicable if has Part A or B and was eligible to enroll
  - At age 65
  - If receiving SSDI
  - And didn’t have creditable Rx coverage, e.g. employer, retiree plan, American Indian Health, or getting Rx through the VA

- 1% per month of 2019 national base premium of $33.19 per month that delayed enrollment
Part D Late Enrollment Penalty (LEP) Example

- Mike got Medicare Parts A and B August 2006. Didn’t enroll in Part D and had no creditable coverage.
  - Was healthy and travelled a lot!
- In 2018 had a heart attack and needed prescription coverage.
- Will be subject to LEP from August 2006 to December 2018 – $49.45 on top of Part D premium for 2019
Opioid Prescription Limitations
- Including Benzodiazepines

- Opioid prescription fills for treatment of acute pain
  - No more than 7 day’s supply
- Plan sponsors must implement a flag on 90 Morphine Milligram Equivalent (MME)
  - When enrollee’s cumulative MME per day across their opioid prescriptions >= 90 MME
  - Pharmacist must consult with prescriber, document discussion, and if OK, use an override code that consultation occurred.
For those considered “at risk” for Rx abuse

- “At risk” beneficiaries identified based on specific dosage of opioids and/or obtain them from multiple prescribers and pharmacies.
  - Existing appeals process applicable
- Plan must establish a drug management program
- Plan can “lock in” to selected prescribers and/or pharmacies.
Opioid Prescription Limitations - Contd.

- Plan can also limit SEPs for Dual/LIS eligible beneficiaries identified “at risk” for abuse
- Beneficiaries exemptions:
  - Treated for active cancer-related pain
  - Receiving palliative or end-of-life care
  - In Hospice
  - In long term care
- All plans must adhere to new rules
- Plan’s Evidence of Coverage (EOC) has more information
More Part D Changes

- Lengthening Adjudication Timeframes for Redeterminations and IRE Reconsideration
  - From 7 to 14 days in each stage
- 30-day Transition supply (aka Approved Month’s Supply) in LTC settings from 90 days
- Plans given more flexibility in substituting generics for brand drugs without prior notice
- MA plans must disclose the Part B drugs that are subject to step therapy in their ANOC and EOC. Enrollees may be rewarded for participation
Objective 5

IDENTIFY SITUATIONS THAT ALLOW A SEP AND/OR GUARANTEED ISSUE PERIOD (TO ENROLL IN A MEDIGAP)
### Situations

<table>
<thead>
<tr>
<th>Situation</th>
<th>SEP?</th>
<th>Guaranteed issue?*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium increase</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Cost-sharing increase</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Benefits reduced</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>MA plan terminates provider contract</td>
<td>Maybe</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Review Your Rights to Purchase a Medigap Policy, CHA fact sheet B-005, event 3 on p.4*
MA-Provider Contract Termination

- If MA plan terminates contract with provider, does enrollee get SEP?
  - Yes if CMS determines
  - No if
    - Changes to network are effective Jan 1
    - Enrollees notified prior to start of AEP
“Significant” network change

CMS determines

- If network change is “significant”
  - Substantial or potential effect on enrollees
- Group(s) of beneficiaries eligible for SEP
  - Current or recent use of services from terminated provider
Network changes made by MA plan without cause

- Network adequacy requirements
  - ≥30-day prior notice to affected enrollees
    - Info for other network providers
    - Info to request continuity of care from terminated provider
  - Allow access to care from non-contracted providers at network cost-sharing amounts
SEPs: “Significant” network change

- MA plan notifies enrollees eligible for SEP
  - ≥30-day prior notice
- SEP effective immediately upon notification
  - Continues for two additional months
- Change effective 1st day of following month
- Can go back to Original Medicare or another MA plan
Guaranteed issue right to buy Medigap?

- Yes b/c the MA plan terminated contract with medical provider who is treating you. *(Your Rights to Purchase a Medigap Policy, CHA fact sheet B-005, p.4, Event 3 (A))*

- If SEP granted, enrollee may disenroll from MA plan

- One option: return to Original Medicare and buy guaranteed issued Medigap.
Those who stay in plan

- Find new network provider – get plan’s help
- Request continuity of care
- Right to appeal
  - New provider not qualified
  - Plan not managing enrollee’s care
5-Star Overall Plan Rating

- 5★ SEP - Dec 8, 2018 to Nov 30, 2019
- Applies only when a plan has 5-star overall rating

<table>
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<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>Original Medicare, Original Medicare + PDP, MA-PD, MA-only</td>
<td>5★ MA-PD, MA-only or PDP*</td>
</tr>
</tbody>
</table>

- Part D coordinating SEP
- 5★ plan to 5★ plan allowed
- Medicare’s Plan Compare reflects Star ratings

*LEP may apply
Low Performing Plans

- CMS has established specific conditions for measuring performance, which contribute to the Star ratings.
- Low performing plans trigger
  - Enrollee notifications
  - SEP rights
- Medicare’s Plan Comparison reflects plans that are below 3 Stars
Objective 6

HIGHLIGHT CHANGES AND LIMITATIONS FOR DUALS/LIS PROGRAM
LIS Beneficiaries in Non-Benchmark Plans

- LIS-eligible beneficiaries may enroll in non-benchmark plans.
- Premium depends on
  - Full or partial LIS
  - Basic vs. Enhanced plan
- Part D subsidy amount is $34.79
- Premium payment = difference between premium for basic coverage and the LIS benchmark amount. CMS uses a formula.
- Medicare Plan Finder calculates this amount for LIS-eligible beneficiaries.
Special Enrollment Period (SEP) for Dual-Eligibles and Other LIS Eligible Beneficiaries

- Changed from monthly to once per quarter (January – September)
  - Extra limitations for beneficiaries identified as potential risk for misuse or abuse of Opioids
  - Once between October & December – Effective January 1

- Separate SEP: **One time** within 3-months of effective date of assignment or notification
  - When LIS or Dual status is gained, lost, or changed
  - When CMS auto-assigns, reassigns, or passively enrolls in a plan
Scenario

- Myra has full LIS in 2019, and she enrolls in Humana Walmart Rx Plan with a premium of $29.90. She receives a bill for $5.10 and calls HICAP for help.

- She has to pay $5.10 which is the supplemental premium not covered by the LIS benchmark amount.

- This is an Enhanced Plan. Offers low co-pays during deductible. Base premium is $24.80 and value of enhancement is $5.10
Objective 7

REVIEW MORE FRAUD PREVENTION TOOLS
BETTY IS BACK!
“Betty and the Medicare Health Plan – Making the Right Choice” is now available in electronic format in English/Spanish (one side is in English/one side is in Spanish).
Changes to 2019 Medicare Communications and Marketing Guidelines

- Name change
  - The Medicare Marketing Guidelines, CMS’ regulations are now named the Medicare Communications and Marketing Guidelines

- One of the biggest changes in the new guidelines is how marketing materials are categorized.
  - Materials will now be classified into two sections: Communications and Marketing.
    - Communications are “activities and use of materials to provide information to current and prospective enrollees,” making it the more general of the two. Materials that fall under this category are not subject to review by CMS.
    - Marketing materials are often more specific and provide detailed information. The purpose of these materials is to draw a beneficiary’s attention to a certain plan and influence their decision. These could potentially include information on the plan’s benefit structure, cost sharing, and measuring or ranking standards. Marketing materials are subject to CMS review.

CMS determines the category that the material falls into by reviewing both the content and the intent of the piece.
Contact via Email

30.6 – Electronic Communication Policy 42 CFR §§ 422.2268(b), 423.2268(b) A Plan/Part D sponsor may initiate contact via email to prospective enrollees and to retain enrollment for current enrollees. Plans/Part D sponsors must include an opt-out process on each communication to elect to no longer receive emails.

*Agents still cannot make unsolicited telephone calls to beneficiaries or approach potential enrollees in common areas
How to Avoid Enrollment Fraud

Watch Out for People Who:

- Pressure you with time limits
- Ask for you Medicare number, Social Security number, and bank information
- Threaten you with loss of your Medicare benefits if you do not sign up
- Offer gifts to enroll
- Say they represent Medicare
- Call uninvited

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How to Protect Yourself from Potential Enrollment Fraud

- Protect your Medicare and Social Security Number
- Be wary of any unsolicited calls from anyone asking for personal information
- Rely on government websites and emails for unbiased information
- Request translation services when needed
- Confirm everything that an agent tells you before making a final decision, get it in writing if you can.
- Be aware of your right to choose how you receive Medicare Coverage
- Do your homework before signing up with a plan
  - Review your current plan notice “Annual Notice of Change”
  - Think about what matters most
    - Does it fit your budget
    - Does it cover all of your drugs
  - Ask all your physician, hospitals, DME suppliers if they take the plan
  - Check the plans Star Rating

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Rules for Meeting with an Agent

During the meeting, Medicare plans and people who work with Medicare **can't:**

- Charge you a fee to process your enrollment into a plan.
- Steer you into a particular plan.
- Communicate incorrect information about their plan type or use inappropriate statements like their plan is "the best" or "highest ranked."
- Tell you about other plan options you haven't agreed to discuss, unless you specifically ask about them (to discuss these options, you need to complete a separate appointment form).
- Pressure you to join their plan by saying things like "you have to join this plan or you won't have coverage next year."
- Ask you to give names and phone numbers or addresses so they can sell to your friends or family.
- Ask you to sign the enrollment form before you’re ready to join.
Examples of Enrollment Fraud

- An agent enrolled a beneficiary into a plan without their permission.
- Agent told the beneficiary that their physician takes the plan.
- Agent offers free trips, meals in returning for signing up.
- Agent misrepresents the plans benefits.
- Agent tells beneficiary they have to sign up or they will lose their Medicare.
How to Report Enrollment Fraud

If you feel a plan or agent has violated Medicare’s marketing rules

- Save all documented proof
  - Any signed papers
  - Agents business card
  - Any marketing material
  - Any phone records

Report Enrollment Fraud to SMP

855-613-7080
Resources

- Medicare’s Manuals
  
  
  - CMS Internet Only Manual (IOM) System
  - 24 Internet Only Manuals (IOMs)
  - Incorporates CMS guidance and transmittals

2019 Medicare Communications and Marketing Guidelines

FIGHT FRAUD IN YOUR COMMUNITY

Tips you can share:

- Spread our Protect, Detect and Report Message
- Share and post our CA-SMP fraud alerts
- To order free materials, schedule a presentation at no-charge, or to report a case, call 1-855-613-7080

THANK YOU!

Like and follow our CHA and SMP Facebook pages

Subscribe to our e-newsletter www.cahealthadvocates.org
Objective 8

LIST RESOURCES FOR MORE INFORMATION
2019 Medicare Communications and Marketing Guidelines

Resources

- CMS’s Announcement for 2019 plans, including “landscape resource files”: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html
- Understanding Medicare Part C & D Enrollment Periods (CMS Prod. No. 11219)
- Reassignment CMS fact sheet (CMS Prod. No. 11221-P)
- CHA Fact Sheets B-005, C-003
More Resources – Contd.

- 2018 Choosing a Medigap Policy (CMS Product No. 02110)
- Understanding The Extra Help (SSA Publication No. 05-10508)
- Fact Sheets – by subscription cahealthadvocates.org
- Center for Medicare Advocacy (CMA) report on 2019 and future changes
- For personalized counseling call HICAP at 1-800-434-0222
California Health Advocates

www.cahealthadvocates.org

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