CMS Checklist for Enrollment of Medicare Part C MA Plans and Medicare Part D PDPs

Consistent with 422.2274(c)(12) and 423.2274(c)(12), plans must ensure that all agents and brokers (employed, captive, and independent) discuss the following CMS developed list of items during the marketing and sale of an MA or Part D plan, prior to the beginning of the enrollment process:

- ❑ Review the beneficiary specific information: What kind of health plan does the beneficiary wish to enroll in (such as low premium and higher copay (or vice versa)?
- ❑ Check to see if beneficiary's PCP and Specialists are in network. If not, explain that they will need to choose new ones or pay out of pocket.
- ❑ Check to see if the beneficiary's prescriptions are on the formulary and their pharmacy is in network. If not, explain that they will need to choose a new pharmacy or may have to pay the full price of the prescription.
- ❑ Does beneficiary require hearing, dental, and/or vision coverage?
- ❑ Does the beneficiary have any other health care needs, such as needing durable medical equipment, physical therapy?
- ❑ Check to see if the beneficiary's preferred hospital is in-network. If it is not, explain that they will need to pick a new one.
- ❑ Are there other preferred facilities that need to be in-network?
- ❑ Does the beneficiary have any other specific health care needs?
- ❑ The right to cancel this enrollment as well as the specific date through which cancellation may occur.
- ❑ Go over premiums, including Part B premium, {insert dollar amount} per month/quarter/year. [This one only applies if there is a premium >$0.] If applicable, review current premium vs. another plan premium.
- ❑ Review beneficiary cost-sharing such as deductibles, copays, and coinsurances. Go over deductible cost, 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.
- ❑ Review coverage for out-of-network providers and services (e.g., except in emergency or urgent situations, plan does not cover services by out-of-network providers (i.e., doctors who are not listed in the provider directory)).
- ❑ Review coverage outside the United States.
- ❑ Explain the potential effect that enrolling in this plan will have on other, current coverage, which may in some cases mean that the individual is disenrolled from the beneficiary's current health coverage (e.g., another MA plan, Medigap).
- ❑ Explain that this is not a hearing/dental/vision "rider" but a full plan.
- ❑ 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 the costs, benefits, and rules for the plan.
- ❑ Review how to file a complaint.
- ❑ Items only applicable to certain plan types: Review PPO or PFFS out-of-network coverage.
- ❑ Review need to qualify for chronic/disabling condition requirement for C-SNPs
- ❑ Review need to have Medicaid to qualify for D-SNP.
- ❑ Review need to remain in institutional skilled nursing facility in order to qualify for I-SNP.
- ❑ Review need to maintain trust/custodial account in order to remain enrolled in MSA.