Cornerstone
Senior Marketing

AN INTEGRITY COMPANY

AGENT COMPLIANCE GUIDE

BEST PRACTICES IN MEDICARE COMPLIANCE

2020

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SECTION 1:

LEAD GENERATION

Before the sale, before actual contact with the consumer is even made, you need to make sure your Lead Generation practices are compliant. In this section, we'll cover the rules and regulations that govern this process including Permissible Contact rules, BRC guidelines and Compliant use of Generic Marketing Materials (which includes your Website and Social Media).

LEAD GENERATION

MARKETING THROUGH UNSOLICITED CONTACT IS PROHIBITED

Examples of Unsolicited Contact:

- Door-to-Door Solicitation (Door Knocking)
- Leaving Flyers, Leaflets, etc. at residences or on cars
- Approaching potential enrollees in common areas such as parking lots, lobbies, sidewalks, retail stores, etc.
- Telephonic or electronic (cold-calling, texting, etc.)
- Calling attendees of a Sales Event (unless express permission is given for a follow-up call)
- Calling a "referral" from a current client

What you CAN do:

- Call individuals when valid "permission to call/contact" is given
- Give your contact info to current clients who want to refer a friend/relative (the referred individual needs to contact you directly)
- Call your current MA enrollees to promote other Medicare plan types or to discuss plan benefits (ex. contact your PDP enrollees to promote MA-PD products)
- Call current enrollees to discuss/inform them about general plan information, such as: Annual Enrollment Period (AEP) dates, plan changes, educational events, etc.
- Return phone calls/messages or leave information at a residence if your prescheduled appointment becomes a No-Show
- Email potential enrollees, provided all emails contain an opt-out function and follow other generic marketing material guidelines.

LEAD GENERATION

Other Important Information

- Permission to Call/Contact is event-specific and not open-ended permission for future contact
- Bait-and-Switch strategies are also prohibited (ex. making unsolicited contact about other business as a means of generating leads for Medicare plans)
- Remember, referrals from current clients do not give you "permission to contact"

BRC GUIDELINES:

A BRC (Business Reply Card) is designed and intended to be used as a direct marketing material for the purpose of gathering permission to call a potential lead. They **Do Not** have to be mailed; however, they can be displayed/distributed at sales and educational events or be located on a Webite or Social Media (electronic BRC).

Things to Remember:

- **MAY** provide BRC's at Educational and Sales Events
- BRC's must include a statement informing the consumer that an agent may call them as a result of returning the BRC
- **MAY NOT** ask for a consumer's Date of Birth
- **MAY** ask for Age or Date of Medicare Eligibility
- **MUST** be retained and available upon request for the remainder of the selling year plus 10 additional years

LEAD GENERATION

GENERIC MARKETING MATERIALS:

We understand that marketing materials play a critical role in your daily business activities, but it is vital that you ensure your generic marketing materials are compliant with CMS guidelines. Follow the guidance below when creating your own marketing materials. Also, keep in mind **Lead Vendors' materials aren't always compliant** so it's a good idea to review those, as well, to ensure they are complaint. We've also included a "Generic Marketing Material Checklist" that should help you remain compliant.

General Guidance:

- To be considered "Generic," materials can't include Company Names or Logos, Plan Specific Names, Product Specific Names, Specific Benefit Info, STAR Ratings, etc.
- All text on materials, including footnotes and disclaimers, must be printed with a font size equivalent to or larger than **Times New Roman 12pt font.**
- **DO NOT** use the word "Entitled" when referring to Medicare Benefits. Use "Eligible" instead.
    - Can only use "Entitled" in relation to Part A for Federal Medicare Products.
- Use caution when using the word "Senior".
    - Can't limit your audience to those over 65, some Medicare beneficiaries are under 65.
- **DO NOT** use absolute superlatives like "the best," or "highly rated," or "the most doctors," unless it can be substantiated.
- Agency / Broker name and address must appear on the mailing envelope or postcard—must identify who the sender is.
- **DO NOT** use the word "free" in relation to a Benefit.
- Websites and Social Media are governed by the same regulations as normal printed material.

LEAD GENERATION

GENERIC MARKETING MATERIALS:

Personal Business Cards:

- **MAY NOT** be attached to marketing pieces, but can be included with them.
- **DO NOT** use the word "Medicare" in your title (ex. Medicare Specialist).
- **DO NOT** list Benefits on business cards.
- Use caution using images of Flags or the colors Red, White & Blue that could be misinterpreted as being affiliated with a state or United States government agency.

General Guidance:

- Agency / Broker name and address must appear on the mailing envelope or postcard—must identify who the sender is.
- Any time you mention a Medicare PDP, you must first use the phrase "Part D Prescription Drug Plan."
- **DO NOT** claim that you are endorsed by or affiliated with Medicare or CMS.
- **DO NOT** use the word "Entitled," use Eligible or some other word instead.
- **Any advertisement or invitation to a sales / marketing event inviting beneficiaries to a group session to possibly enroll must include the following disclaimer:**
  A sales person will be present with information and applications. For accommodations of persons with special needs at sales meetings, call <toll-free number> (TTY 711), <days and hours of operation>.

LEAD GENERATION
CHECKLIST

GENERIC MARKETING MATERIALS:

Regulations	
Material(s) cannot market for the upcoming plan year prior to October 1.	
In order for material to be considered *generic*, they must not contain:	
• Carrier Logos or Brands • Plan Specific Names (Example: Plan A) • Product Specific Names (Example: Medicare Complete) • Benefit Information	
Star Ratings	
Does the material refer to a plan(s) 'Star Ratings'? If yes, the material is not generic as Star Ratings are specific to plans, benefits and service.	
Lead Cards / Business Reply Cards (BRC)	
The marketing piece cannot "require" the consumer(s) to provide contact information.	
The marketing piece cannot ask for the consumer's "date of birth." May request date of Medicare eligibility and/or age.	
Content / Style	
The marketing piece must clearly identify the sender.	
The content of the marketing piece when printed, must have text with a font size equivalent to or larger than Times New Roman twelve (12)-point, including headers, footnote and/or disclaimers.	
The content cannot be inaccurate, misleading or otherwise make misrepresentations (e.g., incorrect enrollment period title).	
The content cannot include the use of absolute superlatives (e.g., the best, the biggest, the "highest ranked").	
The content cannot include the terms Medicare, CMS or the Department of Health & Human Services (DHHS). It is forbidden for any person to use words or symbols, including "Medicare," "Centers for Medicare & Medicaid Services," "Department of Health and Human Services" or "Health & Human Services" in a manner that would convey the false impression that the business or product mentioned is approved, endorsed or authorized by Medicare or any other government agency.	
If the intent is to include benefits in a general fashion, it is recommended that the benefits are cited individually, bulleted out with no branding, logos and/or titles included. Recommended example below. Some Medicare Advantage/Part C plans may offer benefits like: • Preventive Care • Optical • Fitness Membership	

Checklist continued on next page...

LEAD GENERATION
CHECKLIST CONTINUED

Events	
Is the material an invitation for an event?	
If yes: Sales Marketing Events	
The invitation must include these two disclaimers verbatim: • "A sales person will be present with information and applications." • "For accommodation of persons with special needs at sales meetings call <insert phone and TTY number>."	
If yes: Educational Events	
The invitation must explicitly advertise the event as "educational"	
Is a drawing or prize advertised with the event?	
If yes: The invitation must include one of the following disclaimers.	
• "Eligible for a free drawing and prizes with no obligation" or • "Free drawing without obligation." (note – the retail nominal gift amounts may not exceed $15.00)	
This section is *based on* feedback from CMS	
Is there an agent title on the document?	
If yes: Agent titles must reflect the intent of the contact with the consumer. The term 'sales' and 'agent' is recommended to be included in the title. Titles that include the term 'Medicare' or mislead the consumer on the agent's intent are prohibited. Examples of titles required to be corrected: • Medicare Sales Agent • Senior Advisor • Medicare Specialist	
Prohibited Terms	
'Free' Is the term 'free' used in relation to a benefit? (example: Free Exam; Free Gym Membership)	
'**Senior'** Is the term 'senior' used in reference to your audience in a way that may imply plans, or an agents Medicare related services are only available to "seniors"? (example: Sales Meeting for Seniors)	
'**Entitled'** Is the term 'entitled' used? CMS reserves this term to be used only in relation to Part A for Federal Medicare products. **You may use 'eligible'.**	
Product Names	
Required -Does the material use full product names when first disclosed? CMS has requested use of full product specific titles when referring to Medicare Advantage Plans and/Part D Prescription Drug Plans. Simply using "Medicare plans" is only appropriate when speaking to multiple product types (MA/PDP).	
Required -Does the material initially use full product names when first disclosed? Citing the 2014 Medicare and You guide, CMS has requested that when referring to a Medigap policy, you identify it as "Medicare Supplement Insurance" plans first. Medigap may be used thereafter.	

LEAD GENERATION
WEBSITE CHECKLIST

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Detail	Yes	No	N/A	Comments
Registration Information				
• Is your URL Registered (if necessary)?				For certain Carriers, wesbsites of contracted agents/agencies must be registered. Regardless if it carries logos, branding, materials, or is meant for agents or consumers.
• Does the URL Open/work?				
Logo Usage				
• Appropriate Logo usage? Approved by Appropriate Carrier?				
Agent Title				
• Appropriate use of Agent Title?				Cannot mislead consumers into thinking an agent is affiliated with Medicare in any way. Prohibited Titles: Medicare Sales Agent or Senior Advisor. Approved Titles: Sales Agent, Sales Representative, Licensed Sales Agent, Independent Sales Agent, etc.
Contact Page - BRC				
• Appropriate Scope of Product included?				You may post a generic electronic Business Reply Card (eBRC) on your website; however, the following disclaimer must appear, "A sales agent may mail, call, or e-mail as a result of completing the information to discuss Medicare Advantage, Prescription Drug Plans, or Medicare Supplement Insurance". The same content regulations apply to an electronic BRC as to a paper BRC.
• Appropriate Method of Contact included?				
• Free from REQUIRING Prohibited Consumer Contact information: I.E. phone/email?				
• Free from Date of Birth? (Cannot ask for D.O.B - age or date of Medicare eligiblitly is ok)				
• Free from Medical or RX History?				
Disclaimers				
• Are appropriate Event Disclaimers in place (when applicable)?				If advertising a marketing/sales event where there's a possibility of enrolling members include the following disclaimers on all marketing materials: "A sales person will be present with information and applications." and "For accommodation of persons with special needs at sales meetings call <insert phone and TTY number>."
• Are appropriate Nominal Gift Disclaimers in place?				When promoting drawings, prizes, or promise of free gifts include a Nominal Gift disclaimer on all marketing materials stating there's no obligation. For example: "Eligible for a free drawing and prizes with no obligation" or "Free drawing without obligation".
Content				
• Appropriate use of "Free" ?				May not refer to any benefit, item or service as "free", as the costs are built into the plan. May not use the term "free" unless something truly is free, meaning there is no cost to the plan, Medicare/CMS, or the beneficiary in any way. ACTION: Use "at no additional cost" instead.
• Appropriate use of "Senior"?				CMS considers the term "senior" (when used to describe enrollment eligibility) to be discriminatory toward those beneficiaries eligible for Medicare based on disability. ACTION: Revise "senior" to "Medicare beneficiaries" or "seniors and other Medicare beneficiaries"
• Appropriate use of "Entitled"?				Beneficiaries are not entitled to any Medicare benefits, except Part A (if certain requirements are meant) therefore using the term entitled implies that the beneficiary is not receiving something they should be. This is a misleading/inaccurate statement. ACTION: Change to "eligible"
• Appropriate and complete product Terms - Medicare Advantage not MA.				Full titles should be used when first introduced. i.e. Medicare Advantage; Prescription Drug Plan; Medicare Supplement Insurance Plans.
• Free from Benefit/Premiums/Copays info?				Agent web pages may not contain material, including product descriptions and benefits, unless express permission is given by the appropriate Carrier.
• Free from inappropriate use of CMS/ DHHS/Medicare Symbols or name in URL?				Cannot use names, domain names, logos, symbols, colors, etc. that would mislead a consumer into thinking you are affiliated in any way with Medicare or the government in any way.
• Free from inappropriate Private/ Proprietary Materials embedded?				Disclosing Proprietary Information, Media Requests, and Public Relations Materials is not to be disclosed to anyone outside of the company, including the media, under any circumstances without prior approval from the appriate Carrier's Compliance/Legal department.
• Free from Inaccurate/Misleading/ Misrepresentation?				Website content must not: • Speak disparagingly of Medicare, CMS, or a Carrier. • Include contracts or appointment forms. • Include plan materials, enrollment kits, or benefit guides.
• Free from inappropriate posting of events for next AEP Prior to October 1?				Marketing for an upcoming plan year may not occur prior to October 1. Plans/Part D Sponsors must cease current year marketing activities once they begin marketing benefits for the new contract year.

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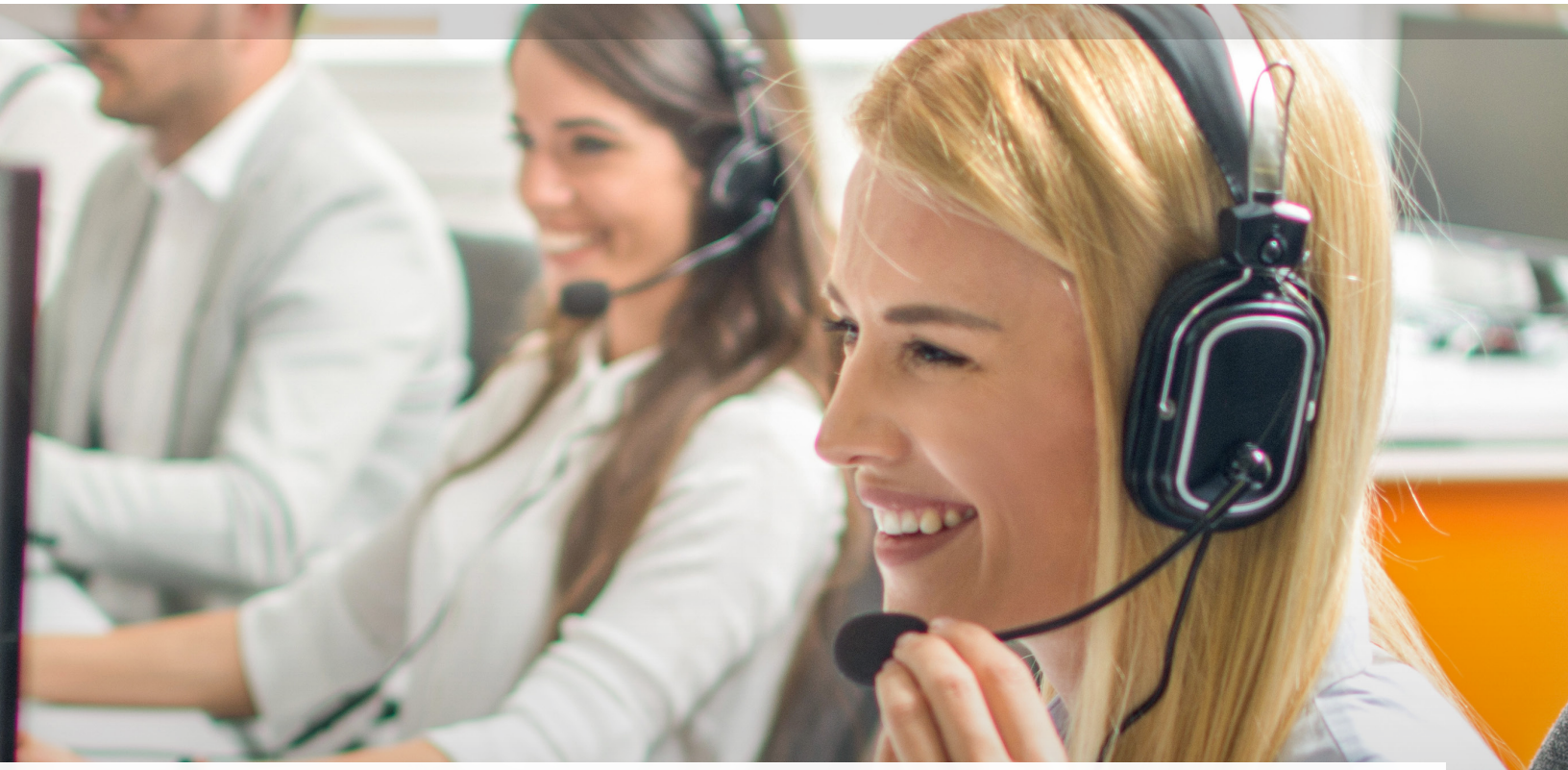

SECTION 2:

GETTING "READY TO SELL"

Before you actually sell an MA/MAPD/PDP product you must first become "Ready to Sell." What does that mean? This section will help explain what it takes to be "Ready to Sell" and offer some helpful tips to help you along the way.

READY TO SELL

READY TO SELL = LICENSED + APPOINTED + CERTIFIED

Licensed

"Licensed" means you have an active Insurance License in each state where you market MA/PDP products (licensed in the state where the client resides).

Appointed

"Appointed" means being contracted with the applicable Carrier and appointed to sell each applicable product in each applicable state.

Certified

"Certified" means you have completed each of the required Carrier specific prerequisite modules (or AHIP equivalents) and the individual product modules for each product you market/sell.

Example: Agent John Smith resides in Nebraska and has clients both there and in Iowa. He wants to present MAPD products from Company XYZ to clients in both states. In order for him to be "Ready to Sell", he would need to:

1. Be actively licensed with the State DOI's of both NE (resident) and IA (non-resident).
2. Be contracted with Company XYZ and appointed to sell that particular MAPD in both NE and IA (have a NE and IA appointment with Company XYZ for the product being presented).
3. Complete the annual AHIP Certification or the Carrier specific pre-requisite modules, the product specific module for the product in question, as well as any other required trainings a Carrier may have.

READY TO SELL
CHECKLIST

TIPS:

- [ ] **Confirm your State Licenses are Up-to-Date**
- [ ] **Verify you are Appointed in each State with each Carrier**
  - ❑ **Make sure your state appointments are complete and accurate for each Carrier**
- [ ] **Verify your Product Certifications before Sales Appointments**
- [ ] **Full Portfolio Certification**
  - ❑ **Certify for all products not just the ones you "plan" on selling, especially PDP's**
- [ ] **Do NOT give out Applications to downline agents who aren't "Ready to Sell"**

CALL US or the Carrier if you are unsure about any of your appointments, certifications, or licenses.

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SECTION 3:

STAYING COMPLIANT BEFORE, DURING AND AFTER THE SALE

There are so many things to remember in terms of compliance before, during, and even after the sale, we thought we'd highlight some of the things you need to be aware of when marketing MA products.

SCOPE OF APPOINTMENT (SOA):

When conducting marketing activities, in-person or telephonically, a Plan/Part D Sponsor may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed upon before the meeting with that individual.

Things to Remember

- SOA's are required for **ALL** Sales Appointments or Personal/Individual Appointments with existing or new/potential members
- May only discuss products at an appointment that were agreed upon and documented in the SOA form
- Must be completed prior to the meeting/appointment
- Accepted forms of SOA Documentation
    - CMS-Approved SOA form (either CMS model or a CMS approved Carrier version)
    - CMS-Approved oral recording of Sales Appointment Confirmation
    - CMS-Approved BRC
- Attach a copy of the signed SOA form to all applications before you submit them (Carrier specific, know SOA guidelines for each of your Carriers)
- Make sure the client INITIALS are beside the products they wish to discuss
- Keep SOA's for at least 10 years and have them available upon request (even if you submit with the application)

SCOPE OF APPOINTMENT (SOA):

FAQ's

1. **If a beneficiary requests to discuss another health related product during an appointment, what do I need to do?**
   A new SOA form is required if the beneficiary has requested to discuss another product type during the appointment. However, a new appointment is not required. The additional product can be discussed after a new SOA is filled out.

2. **Is an SOA required for a Sales Event?**
   No. Beneficiaries are not required to complete and sign the Scope of Appointment form prior to participating at a sales event because they are not personal/individual appointments.

3. **Can an SOA be collected at a Sales and/or Educational Event for a future appointment?**
   Yes. Beneficiaries may sign a Scope of Appointment form at a sales presentation to a group of beneficiaries for a follow-up appointment. And the follow-up appointment may be held at the venue immediately following the sales presentation, if the beneficiary so chooses.

4. **If I'm selling for more than one Plan, can I use CMS's Model SOA form for all Carriers?**
   Yes.

5. **Can I market non-health care related products (such as Annuities or Life Ins) at an appointment?**
   No. You'd need to schedule a new appointment (at least 48 hrs later if possible).

6. **What should I do if my client brings an unexpected guest with them to a sales meeting?**
   You'll need to obtain a new SOA for the guest and provide an explanation in the appropriate field.

STAYING COMPLIANT
BEFORE THE SALE

MAKING A COMPLIANT MA/PDP PRESENTATION:

Prior to the Appointment

Complete a compliant Scope of Appointment form for ALL in attendance

- ❑ Only discuss products agreed upon in the Scope of Appointment
- ❑ Make sure the beneficiary initials the boxes next to products they want to discuss

Call Your Prospect to Ask These Questions

- ❑ **Does someone have a Power Of Attorney for making your financial decisions?** If they will be signing your enrollment form, have them bring a copy of the POA document.
- ❑ **Would you like to invite any friends, relatives, or other Medicare eligible individuals to hear the presentation?**
- ❑ **Is there any additional information that you think I should know?**
- ❑ Tell them to bring a list of key service providers and any current prescriptions they would like to verify.

Make sure you are "Ready to Sell" all products you could conceivably discuss

- ❑ Licensed, Appointed & Certified
- ❑ Unqualified Sales result in Loss of Compensation and possible termination

MAKING A COMPLIANT MA/PDP PRESENTATION:

During the Presentation

- ❑ **Show up on time and clearly introduce yourself**
- ❑ **Stress that you do not work for Medicare**
- ❑ **Disclose you may be compensated for this sale**
- ❑ **Only discuss products agreed upon in the SOA**
    - ❑ **If the beneficiary requests to discuss other products not agreed upon in the original SOA, complete another SOA and then the appointment may continue**
- ❑ **Eligibility (Medicare A & B, must live in service area, no ESRD)**
- ❑ **Lock-in / Disenrollment / Enrollment Periods**
- ❑ **Value-Added Services**
- ❑ **Thoroughly Review the Provider Network and Drug Formulary**
- ❑ **Healthcare Delivery Models (IPA, IPOD's – if applicable)**
- ❑ **Confirm Provider Network and Provider Access**
- ❑ **Role of PCP / Specialist Referrals (if applicable)**
- ❑ **Carefully Review Plan Benefits & Premiums**
- ❑ **Dental/Vision Benefits (if applicable)**
- ❑ **Part B Premium Requirement (must continue to pay)**
- ❑ **Out-of-Pocket Costs (Office Visits/Urgent Care/Hospital/ER/Ambulance)**
- ❑ **Thoroughly Review Copays and Coinsurance**

Checklist continued on next page...

STAYING COMPLIANT
BEFORE THE SALE

- ❑ **Prescription Drug Tiers, Copays**
- ❑ **Special Needs (DME, etc.)**
- ❑ **Explain what their new card will be used for**
- ❑ **Use flipbook, agent guide, etc.**
- ❑ **Review Statements of Understanding**
- ❑ **Effective Date of Coverage**
- ❑ **Customer Service Telephone Numbers**
- ❑ **Give them your Contact Info**
- ❑ **Make sure the application is filled out fully and accurately**
- ❑ **Submit the applications the same day you receive them**
- ❑ **NEVER help a consumer enroll via a Consumer Website if you are physically present (you can assist them over the phone)**
    - ❑ **Only enroll clients online using an agent enrollment tool such as MedicareCenter.com, LEAN, Connecture, mProducer, Ascend, etc.**
- ❑ **Ask Yourself: Is this the best plan for my Client?**
- ❑ **Urge the client to call you or the Plan with questions/issues – NOT Medicare**

MAKING A COMPLIANT MA/PDP PRESENTATION:

After the Appointment

- [ ] **Call the beneficiary to Follow-Up**
  - ❑ See if they have any questions about the plan they enrolled in
  - ❑ Make sure they fully understand the plan they chose
    **Especially the Benefits/Coverages, Copays/Coinsurance, & Provider Network*
  - ❑ Make sure your client has your contact info so they can contact **YOU** for any further questions or information they may need.

STAYING COMPLIANT
THINGS TO KNOW

DO'S AND DON'TS:

DO	DON'T
Clearly Identify the Products to be discussed, and ONLY discuss those agreed upon in the Scope of Appointment (SOA)	Discriminate in any way including discouraging enrollment for disabled
Announce you don't work for Medicare and you could be compensated for this sale	Attempt to enroll someone with a diminished capacity to understand
Quote Accurate Rates	Say that you or the plan is CMS-endorsed or recommended by the Federal Government
Ask the prospect if they have ESRD, but no other health questions	Use misleading, conflicting, or confusing statements
Hold meetings in handicapped-accessible facilities	Engage in high-pressure sales or scare tactics
Communicate to non-English speakers in a way they will understand	Collect financial info during pre-enrollment activities
Advise the client how to use the Formulary	Imply Medicare is only available to Seniors
Use only Materials that meet CMS requirements	Ask to see a prospect's RX's unless they ask for help
Complete enrollment forms ONLY for those who are unable to do so them-selves	Offer Monetary or Promotional gifts to induce enrollment or to compensate based on use of services

COMPLIANCE METRICS:

Below are some of the common metrics companies use to measure your overall compliance as it relates to the sales process.

- **Cancelled Applications**
- **Rapid Disenrollments**
- **Late Applications**
- **Member Complaints**
- **PCP Auto-Assignments**

CANCELED APPLICATIONS:

A Cancelled App is defined as a submitted application that is cancelled by the consumer before the applications effective date.

Top Reasons for Cancelled Apps:

- Inaccurate Provider Network Information
- Inaccurate Drug Formulary Information
- Inaccurate Cost or Benefit Information
- Unsuitable Plan Enrollment
- Client Confusion with the Plan

Tips for Reducing Cancelled Apps:

- Verify the Provider Network and double-check to ensure the client's provider is still participating in the plan.
- Make sure all medications the client has are covered by the plan.
- Explain all costs associated with the plan accurately and thoroughly to make sure the client fully understands all costs involved.
- Discuss all benefits and make sure the client understands what benefits are covered and what is not covered. Ex. Dental, Vision, Gym Memberships, etc.
- Make sure the plan you are marketing/selling is the best option for the client. If it is, they should have no reason to cancel/switch plans.
- Over 1/2 of all Cancelled apps come from Dual SNP products. (Not surprising since they can switch plans any time). Take extra time with these clients to make sure they fully understand the plan and that the plan is the best fit for their needs.

RAPID DISENROLLMENTS:

A Rapid Disenrollment is the voluntary disenrollment of a member from an MA/PDP plan within the first 3 calendar months after their initial enrollment effective date.

Top Reasons for Rapid Disenrollments:

- Inaccurate Provider Network Information
- Inaccurate Benefit/Coverage Info (Ex. Copay/Coinsurance, Dental/Vision, etc.)
- Incorrect Drug Formulary Information
- Unsuitable Plan Enrollment
- Inaccurate Plan Description

Tips for Reducing Rapid Disenrollments:

- **Confirm** enrollee's providers are participating.
- **Provide and explain thouroughly** (and multiple times, if needed) the plan's benefits and coverages (especially Dental/Vision benefits), its limitations and rules, including: copays, coinsurance, provider network, Coverage Gap, and Part D Penalty.
- **Verify** enrollee's medication coverage. Can use online search tools available to you or reference www.medicare.gov.
- **Ensure** that the chosen plan is the best option for your client and the correct plan is chosen on the enrollment form.
- **Pay particular attention** to your Dual SNP clients; over 60% of all Rapid Disenrollments come from this market segment.
- **Explain** enrollee is **not** joining a supplement plan.
- **Review Next Steps** at the time of enrollment.
- **Urge** them to attend Member Events in their area.
- **Send** the member a Thank You Card.

LATE APPLICATIONS:

CMS requires enrollment forms to be submitted to them within seven (7) calendar days from the date the agent "receives" the application. Therefore, Carriers have their own timeliness requirements in order to give them ample time to get the enrollment form submitted to CMS within the 7 day timeframe. **Most Carriers require that the Completed Enrollment Form be submitted to them within 48 hours of the date the agent receives the application.**

TIPS for Reducing Late Apps:

- Submit Apps the SAME DAY you receive them
- Submit the whole, completed app—no missing pages or information
- Use an Online Enrollment method if available for agents — **NOT** via a consumer enrollment portal (agents cannot be present when consumers enroll through a consumer facing online portal)
- **Write Legibly in Black Ink** (preferably) so processing isn't delayed
- Use the correct application (ex. 2020 application for 2020 product)
- Use Your FMO's Agent Portal to Upload your enrollment forms (you should get a confirmation of receipt immediately so you know the enrollments have been submitted and received) - **Most Secure Method!**
- You may also be able to Email or Fax your applications to your FMO, contact them for preferred processes.
- If submitting apps directly to a Carrier, verify correct Fax #'s or Email addresses by calling your marketing team (if they aren't listed on the application itself)

MEMBER COMPLAINTS:

A member complaint happens when a beneficiary files a formal complaint against an agent. There are two types of complaints: **Complaints to Medicare (CTM)** or a **Complaint to a Carrier**. While it's important to avoid all complaints, it's more important to avoid a CTM. A complaint to a Carrier is better and less painful than one directly to CMS. Contact us for further guidance, we have job aids specific to the causes listed below.

Top Causes for Member Complaints:

- Inaccurate Benefit/Coverage Information
- Inaccurate Copay/Coinsurance Information
- Inaccurate Provider Network
- Inaccurate Plan Description
- Unsuitable Plan Enrollment

TIPS for Avoiding Complaints:

- **Confirm** the enrollee's providers are participating in the plan.
- **Thoroughly explain** (multiple times, if needed) plan's benefits, coverages, limitations, and rules including copays, coinsurance, provider network, Coverage Gap, and Part D Penalty.
- **Verify** enrollee's medication coverage. Can use online search tools available to you or reference www.medicare.gov. Provide tier level and any restrictions (i.e., prior authorization, quantity limit, step therapy). Also, explain preferred vs. non-preferred pharmacy, if applicable.
- If you quote a COST (copay, deductible, premium, etc.) make sure it's correct.
- **Ensure** that the chosen plan is the best option for your client.
- **Conduct** a final review of the enrollment form and confirm all information is complete.
- **Verify** the enrollee understands all necessary components of the plan.

- Urge clients to contact YOU or the Plan **(NOT CMS)** with any questions or issues.
- **FOLLOW-UP after the appointment** to be sure they still understand the plan.
- Ensure you are **not present** with a client enrolling on a **consumer facing website/portal.**

AVOIDING MEMBER COMPLAINTS

- ❑ Complete a thorough Needs Assessment with the consumer to understand the consumer's medical, prescription, and financial needs.
- ❑ Recommend the best plan suited for the consumer based on those needs.
- ❑ Explain how the consumer's needs are being met by this plan.
- ❑ Review the Summary of Benefits page by page with the consumer.
  - Place additional emphasis on the copayment and coinsurance topics.
  - Advise the consumer whether or not the particular benefit plan has an annual limit on the maximum out-of-pocket amount of cost sharing for in-network and out-of-network services (if applicable)
  - Inform the consumer that a Medicare Advantage plan may limit the annual out-of-pocket maximum a member pay for cost sharing.
  - Notify the consumer that there are no limits on the out-of-pocket spending for cost sharing in Medicare Part A and Part B.
- ❑ Review all benefits, including customized features, cost sharing (deductibles, copayments, and coinsurance); and all plan terms, conditions, and limitations.
  - Then discuss with the consumer what benefits they are looking for, what benefits are important to them, and clearly inform the consumer whether or not those benefits are covered by the plan.

- ❑ Be sure to inquire about any assistance they may require or receive for paying medical or prescription costs.
  - If a consumer receives Medicaid or Low Income Subsidy (LIS) cost-sharing help, do not guarantee a particular copayment or coinsurance cost to the consumer.
  - Advise them the State will determine the level of cost-sharing help.
- ❑ Explain the service area, prescription drug formulary, coverage gap, catastrophic coverage, and tiers.
- ❑ Identify what services and medications the consumer is currently using and clearly inform the consumer whether or not those services or medications are covered by the plan.
- ❑ Disclose how in-network and out-of-network differ and research whether the consumer's provider(s) would be in-network or out-of-network.
  - Explain that Health Maintenance Organization (HMO), Health Maintenance Organization Point-of-Sale (HMO-POS), and Preferred Provider Organization (PPO) plans have a contracted network of doctors, specialists, hospitals, and pharmacies.
  - Ensure that the consumer is aware whether or not the plan requires a Primary Care Physician (PCP) referral for specialist visits.
  - Utilize the Plan Provider Directory and/or contact the provider directly to verify that they are in- network.
- ❑ Utilize additional probing questions and seek consumer feedback to confirm the consumer understands the plan and agrees the plan is the right fit for them.

PCP AUTO-ASSIGNMENTS:

Some Carriers require a valid Primary Care Physician (PCP) to be listed on the enrollment form. If a valid PCP # and Name are not listed, a PCP will be auto-assigned to the beneficiary. Some carriers monitor this number because they have found through research the auto-generation of a PCP leads to dissatisfaction with the plan in general; which in turn leads to complaints, app cancellations, and rapid disenrollments among other things.

***Remember this is Carrier specific requirement so all Carriers may not monitor this element.**

TIPS to Avoid PCP Auto-Assignments:

- List the PCP Name and Number **EXACTLY** as they are listed in the Provider Directory.
- Use the most accurate, up-to-date provider look-up source (generally an online provider directory).
  - Don't use a physician offices or web searches (not affiliated with the Plan) for a source
- Ensure the Provider or Facility is In-Network for the plan the consumer is enrolling in.
- Always list a PCP when required on the enrollment form—**DO NOT leave blank or put N/A**
- Ask consumers what types of doctors and facilities are important to them, including specialists they only see occasionally.
  - Take the time to look up all physicians (even specialists) and facilities.
- If a consumer doesn't have a PCP, help them find one that's In-Network and list one. They can switch at any time.

STAYING COMPLIANT
PRE-AEP

MARKETING DURING PRE-AEP AND PRIOR TO OCTOBER 1:

There are many interpretations of the marketing regulations during Pre-AEP. Knowing what you can and can't do during this period (Oct. 1 - Oct. 14) can be very confusing. Here are a few tips to help keep you compliant.

During Pre-AEP (Oct 1 - Oct 14) You CAN:

- Educate consumers by providing plan information
- Conduct marketing activities as long as you don't "receive" or "solicit" an application
- Leave an application with the client for them to fill out and submit on/after Oct 15th (don't write your name or agent # on the app)
- Host Marketing/Sales Events

During Pre-AEP (Oct 1 - Oct 14) You CANNOT:

- **Receive/Accept/Solicit enrollment forms prior to Oct 15th**
- Write your name or writing # on an Application (prior to Oct 15th)
  Remember any enrollment form received before Oct 15th with any indication of agent involvement (i.e. Agent name or writing #) will be investigated by the respective Carrier.
- Strongly urge or pressure a client to fill out an application NOW

Prior to Oct. 1, Agents MAY:

- **Contact** existing members to schedule a plan review prior to Oct. 1.
- **Schedule** an appointment for Oct. 1 or later.
- **Hold and promote** member-only educational meetings or sales meetings on current year plan benefits at anytime
- **Promote** member-only educational meetings to discuss changes to plan benefits for the upcoming plan year prior to Oct. 1, for meetings scheduled Oct. 1 and beyond. Invitations to members may be sent via mail, telephone, and email.

STAYING COMPLIANT
PRE-AEP

Prior to Oct. 1, Agents may NOT:

Before October 1st agents may not conduct marketing activities for an upcoming plan year. Agents also may not solicit or accept enrollment applications for a January 1 effective date prior to the start of the Annual Election Period (AEP), unless the client is entitled to another enrollment period (i.e. Special Election Period).

During the Pre-AEP period, from October 1-14, agents can market for the upcoming plan year but cannot solicit or accept enrollment applications until October 15.

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SECTION 4:

SALES EVENT COMPLIANCE

Hosting Sales/Marketing events can be a good way to attract new clients and educate them on Medicare and the choices they have when choosing a Medicare plan. However, there are many compliance risks in hosting events, so we've highlighted some of the most important things you should remember when hosting an event.

EVENT COMPLIANCE

First of all, let's look at the two types of Events: **Educational Events and Sales Events:**

Educational Event:

An **Educational Event** is an event designed to **inform Medicare beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs** and does not include marketing activities (i.e. the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans).

What CAN you do at an Educational Event?

- Educate consumers about Medicare, Medicare Advantage, Prescription Drug, or other Medicare Programs
- Offer Promotional Items as long as they are of nominal value and free of benefit info. These items can display the Plan Name, Logo, Toll-free Number, and/or Website
- Display a banner with the Plan Name and/or Logo (as long as it doesn't include any specific product information)
- Distribute Business Cards and Contact Information for beneficiaries to initiate contact
- Set up a future marketing appointment and collect Scope of Appointment Forms
- Answer questions asked by consumers (provided the response doesn't go beyond the scope of the question asked)
- Provide Meals, Snacks, or Gifts (as long as they meet the Nominal Value requirement)

What CAN'T you do at an Educational Event?

- Distribute plan specific materials
- Distribute plan specific premiums/benefits
- Distribute enrollment forms or mandatory sign-up sheets
- Discuss plans offered
- Collect or Distribute plan applications
- Cannot be held at in-home or one-on-one settings (must be held in a public venue and must be advertised as Educational)
- Conduct a Sales Event immediately following an educational event in same general location

EVENT COMPLIANCE

SALES EVENT:

A **Sales/Marketing Event** is a marketing event where **all allowable types of Marketing Activities can occur,** and is designed to steer, or attempt to steer, potential enrollees toward a plan or a limited set of plans. Agents may educate beneficiaries just like at an educational event, but they can also market specific plans, discuss plan specific benefits and many other compliant marketing activities.

- There are also two different types of Sales Events: **Formal and Informal**
  - **Formal Events** are a more structured event using an audience/presenter type format.
  - **Informal Events** utilize a less structured format; for example, a table, kiosk, etc. that is manned by a sales representative where consumers must initiate the conversations.

Things to Remember

- Sales Events MUST be reported to each applicable Carrier you are representing.
  - Each Carrier has their own process and time-frame requirements - Make sure you know how/when to report your events.
- If an event must be cancelled, know each Carriers process and time-frame requirements.
- If cancelled within the minimum required time-frame, a representative must be present to notify potential attendees of the cancellation (stay at least a half an hour past the scheduled start time).
- Gifts, Snacks, or any promotional items must not exceed the “Nominal Gift” limit of $15.
- Sign-in Sheets must be optional.
- **Cannot require** attendees to provide contact information.
- Marketing in Healthcare settings is permitted in common areas such as hospital or nursing home cafeterias or community, recreational, or conference rooms.
  - In Pharmacies, you must be “outside” of the areas where individuals wait for services from or interact with pharmacy providers and/or obtain medications (typically at least 15ft away from the counter)

EVENT COMPLIANCE

DO'S AND DON'TS:

DO'S AND DON'TS AT AGENT HOSTED EVENTS		
Activity	**Educational Event**	**Formal Sales | Informal Sales**
File With CMS (via the applicable Carrier/s)	No*	Required
Host Event at a Public Venue	Required	Required
Conduct Lead Generating Activities	Yes	Yes
Distribute/Collect Enrollment Applications	No	Yes
Distribute/Collect SOA Forms for a Later Meeting	Yes	Yes
Provide Business Cards	Yes	Yes
Distribute Marketing Materials	No	Yes
Discuss Plans Offered	No	Yes
Distribute Sales/Plan Materials	No	Yes
Provide Giveaways displaying agent Contact Info	No	Yes
Provide Gift Cards/Certs, Cash, etc. as giveaways	No	No
Meals Allowed	Yes	No
Snacks Allowed	Yes	Yes
Nominal Gifts Allowed	Yes	Yes
$15 Retail Value Limit Applies	Yes	Yes
Restrict Event Admission	No	No
Provide educational materials on healthcare topics	Yes	Yes
***Even though not filed with CMS, certain Carriers may require educational events to be filed with them.**		

EVENT COMPLIANCE

HOW TO REPORT A SALES EVENT:

It obviously depends on which carrier you're dealing with, as they each have their own process. For assistance reporting events compliantly, contact your Carrier or FMO. Highlighted below is the process for 4 of our largest MA Carriers.

Aetna/Coventry

1. Fill out the Seminar Reporting Template (contact your local Rep for the Template)
2. Where you send it depends if you are licensed within an Aetna/Coventry local market or not.
   A. **Licensed agents within an Aetna or Coventry** local market submit their seminar events directly to their market representative. The local market then submits the events to Agent Oversight.
   B. **Licensed agents not licensed within an Aetna or Coventry** local market submit the spreadsheet directly to Agent Oversight's MedicareSemi@aetna.com mailbox.

Anthem

1. Log into the Anthem Medicare Certification Training Center https://anthem.cmpsystem.com/
2. Click on "Sales Event Tracker"
3. Click on "Create Event"
4. Fill out the Event, Venue, and Marketing Information boxes
5. Click "Submit Event" to submit it to Anthem or "Save Event" to save it for future submission

EVENT COMPLIANCE

Humana

1. Fill in the needed information on their Excel Spreadsheet (contact us for the Excel Template)
2. Email it to the local MSS (Market Support Staff) in your area
3. The Market Support Staff enters the seminar information into their reporting system and will send back a schedule confirmation (Allow 2 weeks' notice during ROY and 3 weeks during AEP)

UnitedHealthcare

1. Use the Event Request Form (Contact us for the Excel Templates - New Event, Cancel or Change) ** You will need MACROS enabled for this to work.*
2. After opening, if needed, select "Enable Content" and/or "Enable Editing"
3. Select the appropriate tab of the spreadsheet
   A. 3 tabs: Instructions, New Events, Change or Cancel Events (Changes/Cancellations must be done at least 1 business day prior to event)
4. Fill in all fields labeled "Required"
5. Click on "Validate and Submit" to send to UHC (must have MACROS enabled for this to work) **Alternative method is to send to your FMO and they can submit it for you.*
6. Must be submitted at least 7 calendar days prior to the event

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SECTION 5:

PRIVACY/SECURITY

When it comes to privacy and security incidents, it is important to remember that members and consumers can easily be affected. It is your responsibility to keep the sensitive information of your clients secure.
YOU ARE THE FIRST LINE OF DEFENSE!

PRIVACY/SECURITY

All employees, contracted workers, and business associates (including agents) have a responsibility to protect the sensitive information of clients/members. Protecting this sensitive information can reduce the risk of identity theft and the negative impact it will have on your clients.

There are two types of sensitive information you need to be aware of and protect:

- **PHI—Protected Health Information**
- **PII—Personally Identifiable Information**

Both can be classified as any "non-public" personal information that can individually identify someone (i.e. SSN, DOB, medical info, etc.). All consumer and member information, including demographics, should be considered protected and confidential.

Things to Know

- All employees, contracted workers, and business associates (including agents) are required to report any potential or actual inappropriate disclosures or uses of consumer/member PHI/PII.
- All privacy breaches (even potential breaches) must be reported to either the:
  - Compliance Department of the affected Carrier/s or
  - Your FMO's Compliance Department:
- You must Encrypt all portable storage devices housing sensitive information, including flash drives, CD's, cell phones, laptops, tablets, etc.

Examples of Inappropriate Disclosure or Privacy Breaches

- Emails or Faxes containing PHI/PII sent to the wrong person/address
- Lost or Stolen unencrypted electronic storage devices housing consumer PHI/PII
  **If fully encrypted this would not be considered a breach of privacy*
- Lost or Stolen hard copies of consumer PHI/PII
- Discussing member/customer information in public settings

PRIVACY/SECURITY

TIPS:

- Use Secure Email and include a Privacy Disclaimer when emailing sensitive info
- Recheck Email Addresses and Fax #'s before sending
- When Faxing use a cover page with the HIPAA disclaimer
    - **Acceptable Disclaimer:** CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting the information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.
- Encrypt all portable storage devices housing sensitive info
  Remember, Password Protecting is NOT the same as Encrypting
- Do not leave laptops, tablets, enrollment forms, etc. (anything housing sensitive client information) unattended in a non-secure place (i.e. your car, sales event kiosk/booth, etc.) where they could be stolen or lost
- Properly dispose of all sensitive information (i.e. shred it)
- Do not discuss sensitive info in public places where others could overhear your conversation
- Don't bring unauthorized guests with you to appointments (ex. spouse, other agent, friend, etc.)
- **Immediately report any suspected breach to the affected Carriers or your FMO!**

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SECTION 6:

FDR REQUIREMENTS

Do you have downline agents and/or employees working for you? *If so, there are certain regulations that you must follow. These regulations deal with the oversight you have over your agents and/or employees, and what you do to keep them and your business operations running compliantly.*

FDR REQUIREMENTS

FDR stands for **First** Tier, **Downstream**, and **Related** Entity. CMS requires all FDR's of MA/PDP Plan Sponsors to have proper oversight over their non-agent employees and downline agents. In order to meet these requirements, CMS expects each FDR to implement and maintain an effective compliance program. **CMS and Plan Sponsors now have the authority to come directly to YOU and conduct Compliance Audits.** Having an effective compliance program in place will help you adhere to the FDR requirements highlighted below and keep your organization/agency compliant.

7 Core Element of an Effective Compliance Program

1. **Written Policies and Procedures**
2. **Compliance Officer & Committee**
3. **Training & Education**
4. **Effective Lines of Communication**
5. **Well-Publicized Disciplinary Standards**
6. **Routine Monitoring and Identification of Risk**
7. **System for Prompt Response to Issues (without Retaliation)**

FDR REQUIREMENTS

WHAT YOU NEED TO DO - GETTING STARTED:

1. **Designate a Compliance Officer**

   - It can be anyone you deem competent enough to oversee all aspects of the program and make sure your organization and all downline agents contracted with you are remaining compliant. They will be responsible for developing, operating, and monitoring the compliance program as a whole. They will need to train and educate employees on compliance as well as monitor and track agent performance in regards to compliance.Furthermore, they will need to independently investigate compliance matters and ensure that any necessary corrective action is taken.

2. **Draft a set of Policies & Procedures**

   - Your P&P's will serve as a framework for all actions and conduct within your organization and serve as a guide for the day-to-day operations of your business. They should cover the rules and regulations that your employees and business partners are to adhere to; as well as lay out the fundamental principles and values expected of your employees and business partners. **WE HAVE A TEMPLATE AVAILABLE!**

3. **Draft of Code of Conduct**

   - A Code of Conduct is designed to promote honest, ethical, and lawful conduct by all employees, officers, and directors within your organization. Remember, the actions of all people affiliated with your organization affect the reputation and integrity of your Company. You can draft your own or use your Carriers' Codes of Conduct. If you're contracted with multiple Carriers you'd need to distribute each Code of Conduct. We've found it easier to draft your own that meets all the requirements. **WE HAVE A TEMPLATE AVAILABLE!**

FDR REQUIREMENTS

FDR REQUIREMENTS YOU NEED TO COMPLETE:

1. **Distribute your Code of Conduct and Policies & Procedures to all Non-Agent Employees and/or Contractors**
   - Complete within 90 days of Hire and Annually thereafter
   - Proof of Completion should be kept for a minimum of 10 years (ex. attestation page employees sign stating they've read and will adhere to the Code of Conduct and P&P's)
2. **Deliver the CMS Medicare Parts C & D Fraud, Waste, & Abuse and General Compliance Training to all Non-Agent Employees and/or Contractors**
   - Complete within 90 days of Hire and Annually thereafter
   - Must be the CMS version—can be found at www.cms.gov and type "Fraud waste and abuse training" in the search box
   - Proof of Completion should be kept for a minimum of 10 years (ex. attestation page, attendance logs, certificates of completion, etc.)
3. **Check each Non-Agent Employee/Contractor against the OIG and GSA excluded parties' lists**
   - Complete PRIOR to Hire and MONTHLY thereafter
   - If any of your employees is on either list, they must be removed from all duties related to Medicare Advantage and/or Part D
   - Proof of Completion should be kept for a minimum of 10 years (ex. screenshots, print outs, saved PDFs for GSA checks, etc. - must include a Date/Time stamp of when search took place)
4. **Maintain Proper Oversight of your Downline Agents**
   - How do you monitor your agents' sales practices, the marketing materials they use, their lead generation practices, etc.?
   - What type of Training/Support do you offer them to ensure they are selling compliantly?
   - What communication methods do you use to keep them abreast of all compliance issues?
   - What types of compliance related information do you communicate to them?

RESOURCES & CONTACTS

CMS updates their Marketing and Communications Guidelines annually but at the time this Guide was produced, the 2020 MCMGs had not been released.

It's a good practice to check the links below and stay familiar with the Medicare Marketing Guidelines and Managed Care Manuals.

If you have questions, reach out to your Compliance team. We're here to help with any questions you may have.

Medicare Marketing Guidelines for MA and Part D

Medicare Managed Care Manual - Chapters 13 and 21

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