Compliance Training

Broker Relations / Marketing Dept
Central Health Plan of California
Purpose

- Your interactions in the marketplace with beneficiaries is important to us. The purpose of this module is to make you aware of:
  - Our Marketing Misrepresentation/Complaint Resolution protocol and how it works.
  - The most commonly misunderstood sales practices by agents and how to avoid them.
- It is our goal, as well as yours, to present clear, complete, accurate information, and ensure that potential enrollees have the opportunity to make a well informed enrollment decision.
- This training is required as part of your annual certification and you will be required to retake this training (and/or possibly review other related modules) should we receive a complaint on your behalf depending on the nature of the complaint.
In the event a notification is received by Central Health Plan of California (Plan) of a beneficiary/member complaint or marketing misrepresentation, the Marketing Misrepresentation/Complaint Resolution Protocol is put into action.

- The purpose of the protocol is for all associated Plan departments and contracted agents to collaborate and:
  - Ensure that the rights of beneficiaries are protected and that they have a positive enrollment experience.
  - Thoroughly investigate claims of possible marketing misrepresentation and work towards a resolution.
  - Reinforce proper marketing behavior and adherence to CMS Medicare Marketing Guidelines by agents of the Plan.
  - Document all investigations involving agents of the Plan for record retention.
Who can submit a complaint or allegation to the Plan?

- Anyone! A trigger for an investigation can originate from any individual, department, or watch group who suspects wrongful activity by an agent and/or the Plan including:
  - Beneficiaries, Plan members, their relatives/friends
  - Other agents / general agencies / FMOs
  - Plan departments including (but not limited to):
    - Enrollment/Disenrollment or Member Services
    - Broker Relations/Sales Department
    - Compliance Department
  - Other health plans in marketplace
  - CMS/DOI/DMHC
  - Other related entities/agencies
How are allegations reported?

1. Complaint Based
   - Complaints or instances of marketing misrepresentation or misconduct involving existing members or potential beneficiaries are received from various sources:
     - Complaint Tracking Module (CTM) from 1-800-Medicare
     - Outbound Enrollment Verification (OEV) Calls
     - Anonymous submissions

2. Non-Complaint Based
   - Reported broker errors or noncompliance with Medicare Marketing Guidelines and/or Plan rules are detected through:
     - Enrollment Application Submission Errors
     - CMS or Plan Surveillance Activities, Secret Shoppers
     - DMHC Monitoring
     - Routine Audits
     - Anonymous submissions
Marketing Misrepresentation: Classification

Marketing Misrepresentation

Complaint Based:
Complaints or instances of marketing misrepresentation or misconduct involving existing members or potential beneficiaries.

Examples can include:
- Insufficient or erroneous explanations
- Marketing misconduct

Non-Complaint Based:
Reported broker errors or noncompliance with Medicare Marketing Guidelines or Plan rules.

Examples can include:
- Untimely application submission
- Violating 48-hour scope of appointment waiting period
Marketing Misrepresentation/Complaint Resolution Protocol: Investigation

Plan department receiving the allegation forwards it to Compliance for research, determination, and response.

Compliance requests pertinent information and documentation from relevant departments to provide research support and evidence including a response from the complainant, the enrolling agent, and/or other relevant parties including witnesses, translators, providers, and so forth.

Once Compliance has reached a determination regarding the case, they communicate the outcome to the relevant departments. If a Corrective Action Plan (CAP) is requested for the enrolling agent, this is communicated to the Broker Relations Department.
Marketing Misrepresentation/Complaint Resolution Protocol: Resolution

The Broker Relations Department notifies the agent of the outcome of the Compliance case review and if there has been any Corrective Action issued involving re-training or disciplinary action.

Agent completes and returns attestation of CAP and completes any required retraining or disciplinary action as required by the CAP. Broker Relations will monitor agent activity (if required by CAP).

Once CAP attestation is received, Compliance will confirm case closure and the complaint is considered resolved. The complainant is notified of the case outcome.
What can trigger a complaint based investigation?

- Insufficient explanations
  - Only explaining parts of the Plan
  - Omitting required information (i.e. skipping around)
  - Making exaggerated claims or statements
  - Not going over a Plan’s advantages or limitations
  - Not explaining the HMO process and how they work
  - Not telling the beneficiary how enrollment will impact any existing coverage

- Erroneous explanations
  - Misquoting Plan benefits that actually belong to another Plan or drug coverage
  - Misstating providers as being in the Plan’s network
  - Accepting an enrollment outside of a qualifying enrollment period or for a beneficiary who is not eligible.
A Closer Look: Marketing Misrepresentation

- Let’s take a closer look at the kinds of marketing misrepresentation that can happen in the marketplace and why...
Warning Signs: Flags for Marketing Misrepresentation Detection

- There are many ways a beneficiary can alert us of marketing misrepresentation during an OEV call that can trigger a possible investigation for marketing misrepresentation by the Plan. Complaints or statements like (but not limited to):
  - “I don’t remember signing up for this plan.”
  - “I didn’t know I was enrolling in an HMO.”
  - “My agent told me everything was free with no copays.”
  - “Someone just showed up at my door without advance permission.”
  - “I was told I could continue seeing my doctor. Why is he/she not in-network?”
  - “No one told me I needed to change doctors.”
  - “My doctor told me sign the enrollment application in order to continue seeing him/her.”
Insufficient or Erroneous Explanations

- Misquoting Benefits
  - Deductible, coinsurance, and copay amounts
- Misstating services as being covered under preventive care
- Misstating services as covered benefits when they are not
- Using inaccurate or misleading statements
- Using absolute superlatives, (e.g., “the best,” “highest ranked,” “rated number 1”) unless they are substantiated with supporting data.
  - You MAY use qualified superlatives, (e.g., “one of the best,” “among the highest ranked”)
- Comparing different health plans without written agreement from the health plans being compared.
- The Benefit Matrix is also available for BROKER USE ONLY to help compare benefits of our plans. It is NOT approved for use with beneficiaries.
- The materials in an enrollment kit are your tools for compliant selling!
Provider Network Explanations

- Beneficiaries want to be reassured that they can see the doctors they trust under their selected plan option.
- Make sure their specialists are also in the same network as their Primary Care Physician (PCP). **This means the PCP and the specialist must be in the same IPA/medical group.** An authorization is usually necessary from PCP to see specialist.
- Staff you call at a provider’s office cannot be held responsible for knowing the status of a provider’s contract or in-network status.
- You **MUST** tell your beneficiary that they will have to pay more when they obtain eligible services out-of-network. Failing to explain the level of coverage for out-of-network services is considered misrepresentation.
- It is better to tell your prospective beneficiary that you will check online for network providers.
  - Respond to them at a later time if you do not have internet access during the appointment.
Provider Network Explanations (continued)

- Be sure to let your beneficiary know that providers may enter or leave the network at any time.
- Providers may be in-network for some IPAs/Medical Groups, but not for others.
- A provider who is not in the Plan’s network may refuse to treat a patient, except in emergency situations.
- **Always check with the Plan to verify a provider’s in-network status.**
  - Provider Directory is available at [www.centralhealthplan.com](http://www.centralhealthplan.com)
  - Contact Broker Relations for most updated list
  - Paper copies of the Provider Directory are available, however providers may enter or leave the network after the directory is printed. It is always best to confirm online or call the Plan directly.
Example of PCP/IPA Relationship

- Beneficiary currently visits PCP Smith and cardiology specialist Anderson. In Plan’s network, PCP Smith belongs to Feeling Well IPA. Specialist Anderson is under Doing Great IPA.
- Broker is informed by agent that both providers are in Plan’s network.
- Beneficiary enrolls in Plan and wants to visit PCP Smith and specialist Anderson. Feeling Well IPA denies visit to specialist Anderson because the specialist is in a different IPA (Doing Great IPA).
- In order for beneficiary to visit specialist Anderson, beneficiary needs to change IPA from Feeling Well to Doing Great. This change can happen once a month. However, after the IPA change, beneficiary can no longer see PCP Smith.
- Always make sure the providers being seen by beneficiary are in the same IPA. Checking whether providers are in the Plan’s network is not sufficient.
- After enrollment beneficiary can call Member Services to request a PCP/IPA change on a monthly basis.
In-Network vs. Out-of-Network Coverage

Provider

- If a beneficiary sees a provider who is in the Plan’s network, the beneficiary is responsible for the Plan defined cost-sharing
- If a beneficiary sees a provider out-of-network, the beneficiary is responsible for the entire cost of the service except in urgent and emergent cases

Pharmacy

- If a beneficiary fills a prescription at a pharmacy in the Plan’s network, the beneficiary is responsible for the Plan defined cost-sharing
- If a beneficiary fills a prescription out-of-network, the beneficiary is responsible for the entire cost of the prescription except in emergent cases
Prescription Drug Coverage Explanations

- **Drug Coverage**
  - It is important to verify your beneficiary’s current drug prescriptions.
  - *Always check the Comprehensive Formulary provided by the Plan to confirm your beneficiary’s drugs costs, formulary tier, and drug coverage under their Plan selection.*
    - Online Formulary Search Tool is available here: [http://www.centralhealthplan.com/Benefits/Formulary.aspx](http://www.centralhealthplan.com/Benefits/Formulary.aspx)
    - Or contact Broker Relations
  - Confirm the drug’s status during the “donut hole”
  - Formularies change, and a drug covered last year may not be covered the next year, or may not be covered at the same formulary tier.
  - Ensure that you clearly discuss with your beneficiary the following:
    - They may be responsible for the full costs of the prescriptions drugs once they hit the coverage gap.
    - The importance of the prescription drug discount program
    - How drug coverage works with the Special Needs Plan
Medication Therapy Management Program

- Comprehensive Medication Review
  - Central Health Plan’s Pharmacy Benefits Manager will assess every member enrolled in the Medication Therapy Management (MTM) Program for medication use to identify any medication-related problems.

- On an annual basis, each member enrolled in the MTM Program will complete a real-time, interactive, person-to-person consultation.
  - The purpose of the consultation is to assess medication history, medication use, health status, clinical information, adverse events, and other issues that may affect medication use or outcomes.
  - The findings from the consultation will include a reconciled medication list, an action plan, and recommendations.
  - The findings will be summarized in written form and provided to the member.
Election Periods Explanations

- Election Periods and Eligibility
  - Know the Medicare Election Periods! Know when their beginning and end times are and if there are any eligibility requirements, exceptions, or conditions that need to apply.

1. Part C and D Enrollment Periods
   - Medicare Advantage (MA)
   - Medicare Advantage Prescription Drug Plans (MA-PDs)
   - Prescription Drug Plans (PDPs)

2. Medicare Cost Plans Enrollment Periods
   - Section 1876 of Social Security Act
Election Periods Explanations (continued)

- MA, MA-PD, PDP Election Periods and Eligibility
  - MA Initial Coverage Election Period (ICEP) and Part D Initial Enrollment Period (IEP)
    - The ICEP and IEP occur together as one period when enrolled in Part A & B at first eligibility.
    - It is a 7-month period – starts 3 months before entitlement to both Medicare Part A and Part B (usually their 65th birthday or 25th month of disability) and ends on whichever day is later:
      - The last day of the month preceding entitlement to both Part A and Part B
      - **OR**
      - The last day of the third month after the month in which an individual meets the eligibility requirements for Part B.
  - Beneficiary has one ICEP/IEP election. Once effective in an MA-PD, the ICEP and IEP is used.
Examples of ICEP & IEP

- **Example 1** – Beneficiary enrolls upon initial entitlement to Part A and Part B
  - Mrs. Donovan’s 65th birthday is June 20, 2012. She is eligible for Medicare Part A and Part B beginning June 1, 2012 and has decided to enroll in Part B beginning on June 1. Her ICEP is a seven month window that begins on March 1, 2012 and ends on September 30, 2012.

- **Example 2** – Beneficiary bypasses initial enrollment in Part B due to employer insurance
  - Mrs. Smith’s 65th birthday is April 20, 2010. She is eligible for Medicare Part A and Part B beginning April 1, 2010. Because she is still working and has health insurance through her employer, she has decided not to enroll in Part B during her initial enrollment period for Part B. Upon retiring, she will have the opportunity to enroll in Part B (through a Part B special election period). She has enrolled in Part B effective May 1, 2012. Her ICEP would be February 1 through April 30, 2012.
  - In the second example, the ICEP is only a three month window that ends on the last day of the month preceding Mrs. Smith’s entitlement to Part A and Part B. Because the initial enrollment period for Part B expired in 2010, Mrs. Smith only has until the day before her entitlement to both Part A and Part B to use her ICEP to enroll in a MA plan.
Election Periods Explanations (continued)

- **MA, MAPD, PDP Election Periods and Eligibility (Continued)**
  - **Annual Election Period (AEP) - Yearly:** October 15 – December 7
    - Beneficiary has one AEP election
    - Only period besides IEP to purchase Part D coverage
    - Become effective January 1st of the following year
  - **Medicare Advantage Disenrollment Period**
    - January 1 through February 14
    - Members can disenroll back to Original Medicare + PDP
  - **Special Election Period (SEP)**
    - Qualifies for extra help (Low Income Subsidy)
    - Qualifies for Medicaid
    - Member moves out of the plan’s service area
    - Plan decides to leave the Medicare program or reduce its service area at the end of the year
  - *Medi-Medi beneficiaries are not bound by any time frame restrictions*
Election Periods Explanations (continued)

- MA, MAPD, PDP Election Periods and Eligibility (Continued)
  - Open Enrollment Period of Institutionalized Individuals (OEPI)
    - Continuous for individuals who moves into, resides in, or moves out of an institution
    - Institution includes SNF, LTC, rehab hospital, and psychiatric hospital
    - OEPI ends two months after the month the individual moves out of the institution
  - It is considered a misrepresentation when you tell a beneficiary that their Plan coverage will become effective on a certain date only to find out that they are not eligible to enroll.
Election Periods Explanations (continued)

- Medicare Cost Plans Enrollment Periods and Eligibility
  - Available in certain areas of the country
  - Beneficiaries can join even if they only have Medicare Part B
  - Should an enrollee with Medicare Part A & B see a provider out-of-network, Original Medicare will cover the costs for service.
    - The enrollee would only be responsible for Part A & B coinsurance and deductibles.

- Open Enrollment Period for Section 1876 Cost Plans
  - Eligible to enroll anytime the plan is accepting new members
  - Leave anytime to return to Original Medicare
Enrollment Explanations

- Inform prospects/members how enrollment in the Plan selection will impact any existing coverage!
- Beneficiaries are restricted to enrollment in **ONE** Medicare Advantage Plan at a time.
- Clearly explain that their enrollment in the new plan will automatically end their enrollment in another Medicare Health plan or prescription drug plan.
- You **must** explain the risk of Late Enrollment Penalty (LEP) if they don’t enroll in a creditable Part D plan that is as good as or better than Medicare.
What *else* can trigger a *complaint* based investigation?

**Marketing Misconduct**
- Unsolicited marketing
- Aggressive marketing – applying intimidating, high pressure, or scare tactics to enroll a beneficiary
- Cross-selling of health care and/or non-health care related products
- Violating referral and incentive guidelines
- Marketing or submitting enrollment applications to the Plan *without* confirmation of certification completion
- Questionable, unethical, or unbecoming behavior as outlined in the Code of Conduct
A Closer Look: Marketing Misconduct

Let’s take a closer look at the types of agent behavior that is prohibited in the marketplace...
What is considered to be unsolicited marketing?

- Door-to-door solicitation, including leaving information such as a leaflets or flyers at a residence or car.
- Approaching beneficiaries in common areas (like parking lots, hallways, lobbies, sidewalks, etc.)
- Telephonic or electronic solicitation including leaving voicemails, emails, or text messages, and unsolicited outbound telemarketing (cold calling). Calls can only be made to beneficiaries who initiate the contact.
- Using a beneficiary’s initial permission for contact as an extended right to continue calling the beneficiary going forward. Permission is event-specific, not an open-ended permission for future contact.
- Calling former members who have voluntarily disenrolled or current members in the process of disenrolling to market plans or products.
- Contacting beneficiaries to confirm receipt of mailed information.
- Marketing unrelated health care products (such as annuities or life insurance).
- Mail and other print media such as advertisements and direct mail are **NOT** considered to be unsolicited marketing.
Aggressive marketing

- Inappropriately influencing the beneficiary’s decision to enroll or selection of a plan or provider.
- Examples include:
  - Forcing the member to enroll against their wishes
  - Steering a beneficiary to a specific provider or IPA/Medical Group
  - Enforcing conditions upon enrollment
    - Ex: Telling the member they will receive a gift only if they enroll.
    - Nominal gifts (with a retail cost of $15 or less) can be provided but must be to all potential enrollees regardless of enrollment.
  - Pressuring the member to enroll immediately or else they will miss their enrollment opportunity.
What are the guidelines on referrals and incentives/gifts?

- **Referrals**
  - You **can** ask for referrals from active members (obtain addresses **ONLY**)
  - You **can** offer a thank you gift to members for leads if the retail cost is $15 or less.
  - You **CANNOT** enroll a beneficiary’s friend that they have separately invited to your sales appointment, unannounced.

- **Incentives/Gifts**
  - You **CANNOT**:
    - Offer items that could be reasonably considered a meal and/or offer multiple items bundled and provided as a meal. Items/snacks must be $15 or less per attendee.
    - Offer cash promotions
    - Give gifts as a condition of enrollment
    - Mention gifts for referrals in solicitation letters
Cross-Selling

- Cross-selling of health care and non-health care related products during a sales presentation is prohibited
- Non-health care related products – any insurance product not involving medical and/or health coverage
  - Examples – life insurance, annuities
- Health care related products – any insurance product that involves medical and/or health coverage
  - Examples – dental coverage
# Dos and Don’ts of Cross-Selling

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<thead>
<tr>
<th>Product Type</th>
<th>DOs</th>
<th>DON’Ts</th>
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<tbody>
<tr>
<td>Health Care Related</td>
<td>Dental coverage cross-selling is allowed.</td>
<td>Market any health related product during a marketing appointment beyond the scope agreed upon by the beneficiary, and documented by the plan, prior to the appointment.</td>
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<tr>
<td>Non-Health Care Related</td>
<td>Cross selling on non-health related products is allowed on inbound calls when requested by the beneficiary.</td>
<td>Leave brochures on non-health related products at sales activities.</td>
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Marketing without Certification Confirmation

- Per CMS Medicare Marketing Guidelines §120.3 on Agent/Broker Training and Testing:
  - “Plan sponsors must ensure that all brokers agents are trained and tested annually on Medicare rules and regulations and on details specific to the plan products they sell.”

- As such, all required and requested certification documentation must be received and all required exams must have achieved a passing score in order to complete certification.

- Marketing or submitting enrollment applications to the Plan without receiving prior confirmation of certification completion will lead to an investigation.

- You **MUST** receive confirmation from the Plan of certification completion **prior** to marketing and submitting enrollments on behalf of the Plan.
Questionable, unethical, or unbecoming behavior

- Instances of forgery, cheating, fraudulence, deceit, and/or dishonesty are reported to the Compliance Department for investigation.
- Rude, unprofessional, unethical, or offensive behavior can also lead to an investigation.
- Avoid this by making sure to conduct all marketing activities with integrity and honesty.
- Approach all beneficiaries with professionalism and good manners by practicing proper personal conduct and polite etiquette.
What can trigger a non-complaint based investigation?

- Untimely submission of Enrollment Application
- Use of unapproved or outdated marketing collateral
- Marketing in an areas where patients receive health care services
- Violating Marketing Event guidelines
- Violating the 48-hour Scope of Appointment Waiting Period
- Enrolling a member in a plan that does not cover their service area.
- Marketing for next year prior to the Annual Election Period
- Common enrollment application submission mistakes
- Protected Health Information (PHI) violation
A Closer Look: Non-complaints

Let’s take a closer look at the common allegations an agent or health plan can receive to trigger a non-complaint based investigation and why...
Untimely submission of Enrollment Application

- Enrollment forms must be submitted by the Plan to CMS within 7 days of completion (beginning with the Application Receive Date on Page 4).
- Plan requires enrollment forms to be submitted by the agent or General Agency via Enrollment Fax Number: (626) 388-2371 within **24 hours of application receive date regardless of any upcoming holidays or weekends.**
- Always make sure to carefully review the enrollment form disclaimer with the beneficiary and be sure that there are no enrollment conflicts with their plan coverage selection.
Use of unapproved or outdated marketing collateral

- Agents are only allowed to use marketing materials that have been created, approved, and filed with CMS by the Plan.
- To check if your marketing material has been approved for use, look for the material ID code found on the bottom of the first page.
  - Example of a material ID taken from the Comprehensive Formulary: H5649_090712_1088_CF CMS Approved
- Agents are not allowed to create their own marketing materials for any type of communication without prior approval.
- Agents **cannot** change or make alterations to any materials that have been filed.
- Marketing materials must be used as intended
  - Example: an *enrollment application with a business card stapled to the front cannot be mailed to beneficiaries.*
- Materials that include an agent/broker’s phone number must ALSO include:
  - The statement “Calling agent/broker number will direct an individual to a licensed agent/broker.”
  - The Plan sponsor’s customer service phone number and TTY number.
- Enrollment Kits must be presented as a whole, and not distributed in parts or separate from the other included and required marketing pieces.
- Always verify that you are using the correct materials for the plans being discussed and that the materials are current for the Plan year in which the beneficiary will enroll.
Marketing in a healthcare setting

Per Chapter 3 of the CMS Medicare Marketing Guidelines §70.12, marketing activities are **prohibited** from being conducted in healthcare settings in the following locations:

- Areas where patients primarily intend to receive healthcare services or are waiting to receive health care services.
  - This generally includes waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas, pharmacy counter areas
  - This also extends to marketing activities planned in health care settings outside of normal business hours.
- Only upon request from the beneficiary may appointments be scheduled in long-term care facilities that the beneficiary resides in (like nursing homes, assisted living facilities, board and care homes).
- Common areas where marketing is allowed include hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.
Marketing Event Guidelines

- All group marketing events must be reported to the Plan sponsor for upload to CMS via the Event Submission Form that can be obtained from the Broker Relations Department.
- Plan requires events to be submitted by the 15th of the month for events taking place the following month.
- If the event cannot take place as scheduled, Plan must be notified of the cancellation. CMS must be notified of any cancellations that occur less than 48-hours before the originally scheduled start time.
- A plan representative must be present as required by CMS to inform attendees of the cancellation and distribute information about the plan sponsor for at least 15 minutes after the start of the event except in the case of inclement weather.
- Event sign-in sheets must include a disclaimer to notify beneficiaries that providing contact information is optional.
- An allegation can result should an event be unreported or not take place as scheduled.
Marketing Event Guidelines (continued)

Educational Events
- Designed to inform beneficiaries about Medicare
- Must be advertised as “educational” and held in public venues
- May **NOT** include sales activities, including:
  - Discussing or distributing plan-specific information such as
    - Premiums, benefits, materials, including
      - Summary of Benefits, Provider Directory, Pharmacy Directory
  - Displaying or distributing business reply cards, scope of appointment forms, enrollment forms, sign-in sheets
- May **NOT** set up sales appointments or get consent for an outbound call
Referrals

- Plan representatives may request referrals only from current members and not during individual marketing appointments
  - Requests for names and address is permitted
  - Requests for phone numbers and emails is **NOT** permitted
- An offer for a gift in exchange for a lead is **NOT** permitted
- Cash promotions for referrals is **NOT** permitted
- Thank you gifts with maximum value of $15 and maximum of $50 annually is permitted (cannot be cash or easily converted to cash)
- Thank you gifts must be available to all members that provide a referral and not conditioned on actual enrollment
Scope of Appointment (SOA)

- Agents **must** obtain a Scope of Appointment *at least 48 hours* prior to the appointment that needs to be submitted *with* the enrollment application.
- The purpose of the Scope of Appointment and the 48 hour waiting period is to:
  - Allow a 2-day ‘pause’ or ‘cool-down’ period between discussions of Plan products to circumvent beneficiary confusion while allowing them to make confident choices between Plans.
  - Help the broker document the beneficiary’s:
    - Permission or request for solicitation
    - Understanding and agreement of what will be discussed
Scope of Appointment (Continued)

- Types of Scopes of Appointments:
  - Paper copy with signature
  - Phoned in oral recording *by the Plan sponsor ONLY*

You are bound to only discuss during that appointment products agreed upon by the beneficiary for that appointment. If other products need to be discussed, a second SOA must be completed for the new product before the appointment can continue (within the guidelines of the 48 hour rule).

- You may **NOT:**
  - Rewrite or use your own SOA form.
  - Substitute dates or make changes to the SOA after the appointment.
Scope of Appointment 48-hour Waiting Period Exceptions

- There are a few exceptions to the 48 hour waiting period:
  - “Walk-ins” or beneficiary initiated face-to-face sales events
    - In instances where a beneficiary visits a Plan or Agent/Broker office of his/her own accord, a SOA must be documented prior to discussing MA, PDP, or cost plans.
  - Enrollments that occur from a formal or informal marketing/sales event
  - Same day appointments can be made for beneficiaries approaching:
    - The last day of the beneficiary’s ICEP
    - The last day of the AEP (December 7th)
  - Always clearly document the reason for the exception on the 2nd page of the SOA.
Enrollment of members outside the service area

- Explaining benefits of a plan to a beneficiary who does not live in the service area of that plan is misleading.
- The beneficiary will expect to begin receiving the benefits presented on their expected effective date but will find out they are not eligible.
- So make sure that your beneficiary’s permanent address on file with the Medicare and/or Social Security office is within the service area of the plan they intend to enroll in.
- Plan 001 is available in LA, Southwestern SB, and Northern Orange counties.
- Plan 002 is only available in LA County and Southwestern SB County, **NOT** Orange counties.
- Be aware of the service area of each plan offered. If unsure, call or email the Broker Relations Dept. to confirm.
Marketing prior to the Annual Election Period

- Per CMS Medicare Marketing Guidelines §70.10.2:
  - Agents are NOT to:
    - “Solicit or accept enrollment requests for a January 1st effective date prior to the start of the Annual Enrollment Period (AEP) unless the beneficiary is entitled to another enrollment period.”
    - “Market for an upcoming plan year prior to October 1st.”
  - AEP takes place annually between October 15th - December 7th.
Common Enrollment Application Submission Mistakes

- Missing pages
- Missing signatures and/or dates
- Incomplete applications
- Selected PCP/IPA not contracted
- Plan 002 enrollment in Orange County
- Untimely submission (outside 24 hours of receipt)
- Did not indicate Plan selection (001 or 002)
- Did not select IPA
Protected Health Information (PHI) Violations

- Part of your responsibility as an agent is the secure handling of personal information for your beneficiaries.
  - It is mandatory to retain records for at least 10 years.
  - Keep PHI locked in an office, drawer, or car.
  - Keep client files out of plain view.
  - Do not repeat beneficiary information in areas that are indiscreet.
  - Do not reuse old beneficiary documents to print on the backside.
  - Do not email or post beneficiary information online without taking steps to properly secure your communication or posting.
  - Review your Fraud, Waste, and Abuse Training for the 18 PHI identifiers.

- Destruction of PHI
  - PHI (including complete, withdrawn, incomplete, or incorrect applications with complete/partial beneficiary information) must be properly disposed of via shredding and should not be reused or placed in a bin for recycling/trash.
Disciplinary Actions

- There can be multiple violations that result from a single enrollment transaction. Agents with multiple violations within their monitoring period will be reviewed to determine if additional disciplinary action is necessary.

- Compliance will address all elements involved with the enrollment transaction.

- Corrective Action is not always required, depending on the determination from Compliance.

- Multiple violations overall can result in progressive corrective action.

- **Progressive level of Discipline**
  1. Verbal warning
  2. Written Warning
  3. Re-education and/or retraining
  4. Suspension
  5. Termination
  - Any combination of the above depending on the circumstances.
What do you do when you receive an allegation?

- You will first be notified of an allegation by the Broker Relations Department. You will be contacted by phone and email of the allegation and asked to provide your response to several questions regarding the allegation. You will be allowed 48-hours to respond via secure email or fax.
  - This is your opportunity to provide documentation and/or notes to supplement Compliance’s investigation.
  - Your response must include address all questions completely.
- Once submitted, your response will be sent to the Compliance Department for consideration.
- Broker Relations will communicate the outcome of the investigation to you (and your General Agency, if applicable).
- If Corrective Action is necessary, you will have 3 days to complete the attestation and will be subject to a monitoring period (if detailed in your Corrective Action Plan).
- If you disagree with the outcome and wish to appeal, please contact the Broker Relations Department on the appeal process.
What can you do to remain compliant?

- Always be prepared and err on the side of caution
- Take detailed notes or lists during enrollment transactions and keep better documentation where you can reference details about your meeting with each client.
  - Keep details from specific discussions about benefits, drugs/medications, providers that are in or out of the network, questions from the beneficiaries and how you responded, who else attended or was present during the meeting, and the date/time.
  - In an investigation, being able to provide documentation of an enrollment transaction better protects broker in a he-said/she-said situation
- Take the time to clearly explain benefits
  - Clearer communication and listening to your beneficiary is key!
- Stay up-to-date with CMS Medicare Marketing Guidelines available here: http://www.cms.hhs.gov/ManagedCareMarketing/
- Always strive to increase and maintain product knowledge
- Know your marketing materials
- Practice proper personal conduct and good etiquette
What to do when you have questions or concerns

- If you have any questions or concerns, contact the Broker Relations Department via:
  - Email: brokers@centralhealthplan.com
  - Phone: (626) 388-2390 ext. 3895
  - Fax: (626) 388-2379

- Our hours are Monday-Friday 8:30am-12:30pm and 1:30pm-5:30pm, excluding weekends and holidays.
Agent/Broker Compensation

Commission Processing, Payment, and Oversight

- CMS has established limits on agent and broker compensation in order to ensure that compensation does not create incentives for agents and brokers to assist beneficiaries with plan selection using criteria other than the beneficiaries’ health care needs and preferences.

- Designed to eliminate inappropriate moves of beneficiaries from one plan to another.
Medicare marketing regulations: Agent/Broker Compensation

- Compensation is defined as:
  - Pecuniary or non-pecuniary remuneration of any kind related to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and finder’s fees.
- It DOES NOT include:
  - Payment of fees to comply with state appointment laws
  - Training, certification, testing costs
  - Reimbursement for mileage to, and from, appointments with beneficiaries
  - Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.
Medicare marketing regulations: Agent/Broker Compensation

- The monthly MARx agent/broker compensation report that is generated when an enrollment occurs will provide plan sponsors with the information necessary to determine whether they should make an initial or renewal payment.

<table>
<thead>
<tr>
<th>If member's enrollment was effective between...</th>
<th>Then the commission cycle is set at...</th>
<th>Commission payment amounts applied by the Plan is set at...</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2009 through December 31, 2011</td>
<td>6-cycle years (Initial year followed by 5 renewal years)</td>
<td>$500 for initial year (lump sum) $250 for renewal years (per member per month)</td>
</tr>
<tr>
<td>January 1, 2012 through December 31, 2012</td>
<td>10-cycle years (initial year followed by 9 renewal years)</td>
<td>$500 for initial year (lump sum) $250 for renewal years (per member per month)</td>
</tr>
<tr>
<td>January 1, 2013 through December 31, 2013</td>
<td>Lifetime</td>
<td>$517 for initial year (lump sum) $259 for renewal years (per member per month)</td>
</tr>
<tr>
<td>January 1, 2014 through December 31, 2014</td>
<td>Lifetime</td>
<td>$532 for initial year (lump sum) $266 for renewal years (per member per month)</td>
</tr>
</tbody>
</table>
Medicare marketing regulations: Agent/Broker Compensation

- **Central Health** compensates **full cycle year 1 commission** for mid-year enrollments
- Referral fees and bonuses fall within CMS compensation guidelines
- Oct 1, Nov 1, Dec 1 enrollments that disenroll to another plan effective Jan 1 are not considered rapid disenrollments
- Disenrollments within 3 months of effective date due to special circumstances (obtaining LIS and/or Medi-Cal, death, moving out of service area, etc.) are not considered rapid disenrollments; agent/broker will be paid for actual months of enrollment
- Plan sponsors must not pay agents who are:
  - No longer appointed to sell in the State
  - Have not been annually trained and tested per the plan’s policies and procedures with a passing score of at least 85%
  - Have been terminated for cause by the Plan
Medicare marketing regulations: Agent/Broker Compensation

- **Example**
  
  A beneficiary enrolls into Plan A with an effective date of Jan 1. In May, the beneficiary enrolls into Plan B. In Oct, the beneficiary decides to change plans again. This time, the beneficiary enrolls into Plan Z.

- Plan A: recover May – Dec
- Plan B: pay May – Sep; recover Oct – Dec
- Plan Z: pay Oct – Dec only