Unit 2 Medicare Marketing Guidelines

Section 1: Marketing Requirements and Other Regulations

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HIPAA Privacy

- HIPAA stands for Health Insurance Portability and Accountability Act.
- Agents have responsibilities for ensuring the privacy of clients' Protected Health Information (PHI) including, but not limited to:
  - Health Information
  - Claims Information
  - Social Security Numbers
  - Banking Information
- This information can only be used for the purpose for which it is collected.

Marketing Requirements and Other Regulations

- Health and Human Services (as well as other government entities) along with plan sponsors are allowed to modify existing and establish new guidelines for how agents must handle PHI and can audit agents and agencies.
- As technology evolves the policies put into place are becoming more and more complex such as a new technology law passed in New York.
- Here are some guidelines for HIPAA compliance and protecting client information.

The NYDFS Cybersecurity Regulation (23 NYCRR 500) is a new set of regulations from the NY Department of Financial Services (NYDFS) that places cybersecurity requirements on all covered financial institutions. The rules were released on February 16th, 2017 after two rounds of feedback from the industry and the public and includes 23 sections outlining the requirements for developing and implementing an effective cybersecurity program, requiring covered institutions to assess their cybersecurity risks and develop plans to proactively address those risks. The NYDFS Cybersecurity Regulation included a phased implementation process, with four distinct phases allowing organizations time to implement more robust policies and controls.

WHO IS COVERED UNDER THE NYDFS CYBERSECURITY REGULATION?

The NYDFS Cybersecurity Regulation applies to all entities operating under or required to operate under DFS licensure, registration, or charter, or which are otherwise DFS-regulated, as well as, by extension, unregulated third-party service providers to regulated entities. Examples of covered entities include:

- State-chartered banks
- Licensed lenders
- Private bankers
- Foreign banks licensed to operate in New York
- Mortgage companies
- Insurance companies
- Service providers

There are limited exemptions to the NYDFS Cybersecurity Regulation. Organizations that employ less than 10 people, produced less than $5 million in gross annual revenue from New York operations in each of the past three years, or hold less than $10 million in year-end total assets are exempt from certain requirements of the Regulation.

Source: Retrieved from https://www.dfs.ny.gov/industry_guidance/cybersecurity

Covered Entity

- A covered entity is a health care provider, a health plan or a health care clearing house which, in its normal activities, creates, maintains or transmits Protected Health Information (PHI) with some exceptions. Most health care providers employed by a hospital are not covered entities. The hospital is the covered entity and responsible for implementing and enforcing HIPAA compliant policies.
- Employers – despite maintaining health care information about their employees – are not generally considered covered entities unless they provide self-insured health coverage or benefits such as an Employee Assistance Program (EAP). In these cases they are considered to be “hybrid entities” and any unauthorized disclosure of PHI may still be considered a breach of HIPAA.

Business Associate

- A business associate is a person or business that provides a service to – or performs a certain function or activity for – a covered entity when that service, function or activity involves the business associate having access to PHI maintained by the covered entity. Examples of Business Associates include insurance professionals, lawyers, accountants, IT contractors, billing companies, cloud storage services, email encryption services, etc.
- Before having access to PHI, the Business Associate must sign a Business Associate Agreement with the Covered Entity stating what PHI they can access, how it is to be used, and that it will be returned or destroyed once the task it is needed for is completed. While the PHI is in the Business Associate’s possession, the Business Associate has the same HIPAA compliance obligations as a Covered Entity.

HIPAA Requirements

- Despite the intentionally vague HIPAA requirements, every Covered Entity and Business Associate that has access to PHI must ensure the ***technical***, ***physical*** *and* ***administrative*** safeguards are in place and adhered to, that they comply with the HIPAA Privacy Rule in order to protect the integrity of PHI, and that – should a breach of PHI occur – they follow the procedure in the HIPAA Breach Notification Rule.
- All risk assessments, HIPAA-related policies and reasons why addressable safeguards have not been implemented must be chronicled in case a breach of PHI occurs and an investigation takes place to establish how the breach happened. Each of the HIPAA requirements is explained in further detail below. Businesses that are unsure of their obligation to comply with the HIPAA requirements should seek professional advice.

2023 https://www.hipaajournal.com/hipaa-compliance-checklist/

Communications and Marketing Definitions

Communications	Marketing
means activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. All activities and materials aimed at prospective and current enrollees, including their caregivers, are “communications” within the scope of the regulations at 42 CFR Parts 417, 422, and 423. **Note:** Where the term enrollee is used, whether a current or prospective enrollee, the term encompasses representatives of the enrollee who are authorized to act on the enrollee’s behalf.	is a subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as other information communicated by the activity or material. The organization's stated intent will be reviewed but not solely relied upon.

Source: Communications and Marketing (42 CFR §§ 422.2260, 423.2260)

Factors for Activity and Material Determination

- Communication activities and materials are distinguished from marketing activities and materials based on both intent and content.

Intent	Content
Material or activities that CMS determines, as described above, are intended to: • Draw a beneficiary's attention to a plan or plans, • Influence a beneficiary's decision-making process when making a plan selection, or • Influence a beneficiary's decision to stay enrolled in a plan (retention-based marketing).	Materials or activities that include or address content regarding: • The plan's benefits, benefits structure, premiums, or cost sharing, • Measuring or ranking standards (for example, Star Ratings or plan comparisons), or • Rewards and incentives as defined under 42 CFR § 422.134(a) (for MA and section 1876 cost plans only).

- To identify marketing activities and materials, CMS will evaluate both the intent and content of the activities and materials to determine if the definition of marketing is met.

Source: https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf

Unit 2 Medicare Marketing Guidelines

Section 2: Sales Events & Permission to Contract

Definition of Marketing/Sales Events

Marketing/sales events are events designed to steer, or attempt to steer, enrollees or potential enrollees toward a plan or a limited set of plans.

Sales Events

Anytime an agent conducts sales or marketing meetings with prospects or clients regarding Medicare Advantage or Part D it is considered a Sales Event. There are two types:

- Marketing/Sales Events
- Educational Events

Marketing/Sales Events

Marketing/Sales Events are designed to steer or attempt to steer potential enrollees, or the retention of current enrollees, toward a Plan or limited set of Plans. The following requirements apply to all marketing/sales events:

- Plans/Part D sponsors must submit talking points, if applicable, and presentations to CMS prior to use, including those to be used by agents/brokers.
- Sign in sheets must clearly be labeled as optional.
- Health screenings or other activities that may be perceived as, or used for, “cherry picking” is prohibited.
- Plans/Part D Sponsors may not require attendees to provide contact information as a prerequisite for attending an event.
- Plans/Part D Sponsors may not use information collected for raffles or drawings for any purpose other than raffles or drawings.

Educational Events

Educational events are designed to inform beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs.

- Must be advertised as educational
- Hosted in a public venue by the Plan/Part D sponsor or an outside entity
- May include communication activities and distribution of communication materials
- May answer beneficiary-initiated questions
- May set up a marketing appointment and distribute business cards and contact information for beneficiaries to initiate contact
- Part D sponsors holding or participating in educational events may not conduct sales or marketing presentations or distribute or accept plan applications.
- Part D sponsors may schedule appointments with residents of long-term care facilities upon a resident's request. If a resident did not request an appointment, any visit by an agent or broker is prohibited as unsolicited door-to-door marketing.

Sales Events (Cont'd)

If a marketing event directly follows an education event, the beneficiary must be made aware of the change and given the opportunity to leave prior to the marketing event beginning.

- Marketing events are prohibited from taking place within 12 hours of an educational event, in the same location. The same location is defined as the entire building or adjacent buildings.
- Make available and receive beneficiary contact information, including Business Reply Cards, but not including Scope of Appointment forms
- May not market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary and documented by the plan in a Scope of Appointment, business reply card, or request to receive additional information, which is valid for 12 months following the date of beneficiary's signature date or the date of the beneficiary's initial request for information.

Marketing or sales events are group events that fall within the definition of market at §423.2260.

Sales Events (Cont’d)

Whether on the phone or in person, there are many rules that must be followed.

Guidance Comparison Between Marketing/Sales and Educational Events

The purpose of this document is to provide a reference summary of key event guidelines, highlighting the difference between Education and Marketing/Sales Events. Use it to ensure you are scheduling and conducting the appropriate event type. The list of guidelines is not exhaustive and additional information about the parameters of what is required and allowed for each activity can be found in the most current agent guides or compliance guidelines. Guidance is subject to change. Effective June 2023

Guidance	Marketing/Sales	Educational Event
Report and/or cancel event according to carrier policy	Required	Required
Host the event at a public venue	Required	Required
Advertise as an Educational Event	Not Allowed	Required
Display disclaimer: *For accommodations of persons with special needs at meetings call [insert consumer contact phone number] TTY: 711* on all Event advertising.	Required	Required
Expect secret shoppers	Allowed	Allowed
Invite a provider to speak on general health topics	Allowed	Allowed
Conduct health screening or genetic testing	Not Allowed	Not Allowed
Provide meals (Maximum $15 combined nominal retail value)	Not Allowed	Allowed
Serve light snacks/refreshment within combined $15 nominal value.	Allowed	Allowed
Provide gift cards, gift certificates, or cash giveaways.	Not Allowed	Not Allowed
Provide giveaways with agent contact information	Allowed	Allowed
Provide plan giveaways containing logo, toll-free number and/or carrier website	Allowed	Allowed
Conduct lead generating activities; request members to schedule a future meeting.	Allowed	Not Allowed
Request or accept a referral	Not Allowed	Not Allowed
Post an approved carrier sign-in sheet, labeled "Optional"	Allowed	Allowed
Collect or accept lead cards/business reply cards	Allowed	Allowed
Attach a business card to materials with a single staple or a piece of tape. * Note: at Educational Events, only educational materials may be distributed.	Allowed	Allowed *
Provide a business card if consumer requests one	Allowed	Allowed
Provide a business card to attendees, regardless if asked	Allowed	Allowed
Discuss specific carrier plans/products/benefits	Allowed	Not Allowed
Respond beyond a specific question a consumer asks	Allowed	Not Allowed
Provide educational materials on health care topics	Allowed	Allowed
Distribute plan materials	Allowed	Not Allowed
Distribute or collect enrollment Applications	Allowed	Not Allowed
Schedule a follow-up in-home or one-on-one appointment with a consumer.	Allowed	Not Allowed
Obtain compliant Permission to Contact that is not open-ended and is event-specific. BRCs allowed in common areas.	Allowed	Allowed
Collect a Scope of Appointment form for a future appointment	Allowed	Not Allowed

Product Endorsements/Testimonials

Product endorsements and testimonials must adhere to the following requirements:

- The speaker must identify the Plan's/Part D sponsor's product or company by name;
- Medicare beneficiaries endorsing or promoting a Plan/Part D sponsor must be enrolled in the Plan/Part D sponsor at the time the endorsement or testimonial was created;
- If an individual is paid or has been paid to endorse or promote the plan or product, the advertisement must clearly state this (e.g., "paid endorsement");
- If an individual, such as an actor, is paid to portray a real or fictitious situation, the advertisement must clearly state it is a "Paid Actor Portrayal", and,
- The Plan/Part D sponsor must be able to substantiate any claims made in the endorsement/testimonial.

Note: Reuse of individual users' content or comment from social media sites (e.g., Facebook, Twitter) that promotes a Plan's/Part D sponsor's product is considered a product endorsement/testimonial and must adhere to the guidance in this section.

Source: Product Endorsements/Testimonials. 42 CFR §422.2262(b)

Permission to Contact (PTC)

- Another pre-sale activity that often causes confusion for agents is Permission to Contact.
- Permission to contact can be particularly confusing for telesales agents who often confuse it with the Scope of Appointment (SOA), seeing both items as synonymous with one another which is not the case.
- Permission to contact should always be collected and documented prior to obtaining a SOA.
- Even if a client is an unsolicited walk in or call in, the agent should document it to protect himself/herself in case of an audit or complaint.

Permission to Contact (PTC)

Agents aren't allowed to call prospective clients about MA-PD or Part D unless the client specifically asks to be called. Agents can only call a potential client when the client has given express written permission to contact them. PTC can be obtained by a prospect returning a business reply card in a 6-to-12-month time frame and that discloses who will contact, what products will be discussed and by what specific method the consumer can expect contact. The following is the recommended disclaimer "*By submitting this form, I understand a licensed agent may contact me by telephone or email to discuss Medicare Advantage and Part D Prescription Drug Plans."* Adding this to the bottom of the business reply card (postal or electronic) will allow agents to obtain valid permission to contact the prospect that submits the form about Medicare Advantage or Part D Prescription Drug Plans.

Plans/Part D Sponsors may make unsolicited direct contact with potential enrollees using the following methods:

- Conventional mail and other print media (e.g., advertisements, direct mail)
- The MA organization must provide notice to all beneficiaries whom the plan contacts at least once annually, in writing, of the individual's ability to opt out of future calls/contacts regarding plan business.
- Email provided all emails contain an opt-out function

Plans/Part D sponsors ***may not***:

- Use door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence;
- Approach potential enrollees in common areas (e.g., parking lots, hallways, lobbies, sidewalks, etc.); or,
- Use telephonic solicitation, including text messages and leaving electronic voicemail messages.

Note: Agents/brokers who have a pre-scheduled appointment with a potential enrollee who is a "no-show" may leave information at that potential enrollee's residence. If a potential enrollee provides permission to be contacted, the contact must be event-specific, and may not be treated as open-ended permission for future contacts.

Scope of Appointment (SOA)

- One of the most confusing items for many agents is the Scope of Appointment
- The SOA is required at least 48 hours prior to a scheduled appointment, the Part D plan (or agent or broker, as applicable) must agree upon and record the Scope of Appointment with beneficiary, except for:
  A. SOAs that are completed during the last four days prior of a valid election period for the Beneficiary.
  B. Unscheduled in person visits (walk-ins) initiated by the beneficiary.

  In other words, you cannot have a potential enrollee sign the scope and immediately begin their appointment.
- While it is expected that the SOA be taken at some point prior to the sale or meeting, if a client takes it out of the agent's hands by requesting an immediate appointment or information, or simply walks into the agent's office, the SOA can be taken on the spot.

- When should the Scope of Appointment be gathered?
- Requirements for a Valid Scope of Appointment
- Submission
- Record Retention

What is Scope of Appointment? (SOA)

When conducting marketing activities, an agent may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed before the meeting with that individual. Prior to meeting with any Medicare eligible consumer to discuss Medicare Advantage plans, Medicare Advantage-Prescription Drug plans, Prescription Drug Plans or section 1876 Cost Plans, the agent must obtain a Scope of Appointment from the prospect identifying specifically which product lines will be discussed. Agents may discuss only those products that were agreed upon in advance.

This includes:

- Appointments with new members/clients
- In-home sales appointments or personal/individual appointments with an existing member/clients in the office, coffee shop, or similar location

Scope of Appointment is NOT required for:

- Formal/Informal Sales events [these are already reported to CMS]
- Medicare supplement presentations [though a suggested best practice is to secure a SOA prior to a Medicare Supplement appointment, in order to present PDP options in the event a consumer decides to inquire about PDP during the appointment]

When should the Scope of Appointment be gathered?

The prospect should agree to the “Scope of appointment” prior to the appointment, *when practical.*

If the SOA is taken at the time of the appointment, the reason must be documented as specifically as possible on the form. Ex: scope change by customer or agent, walk-in, unexpected guest

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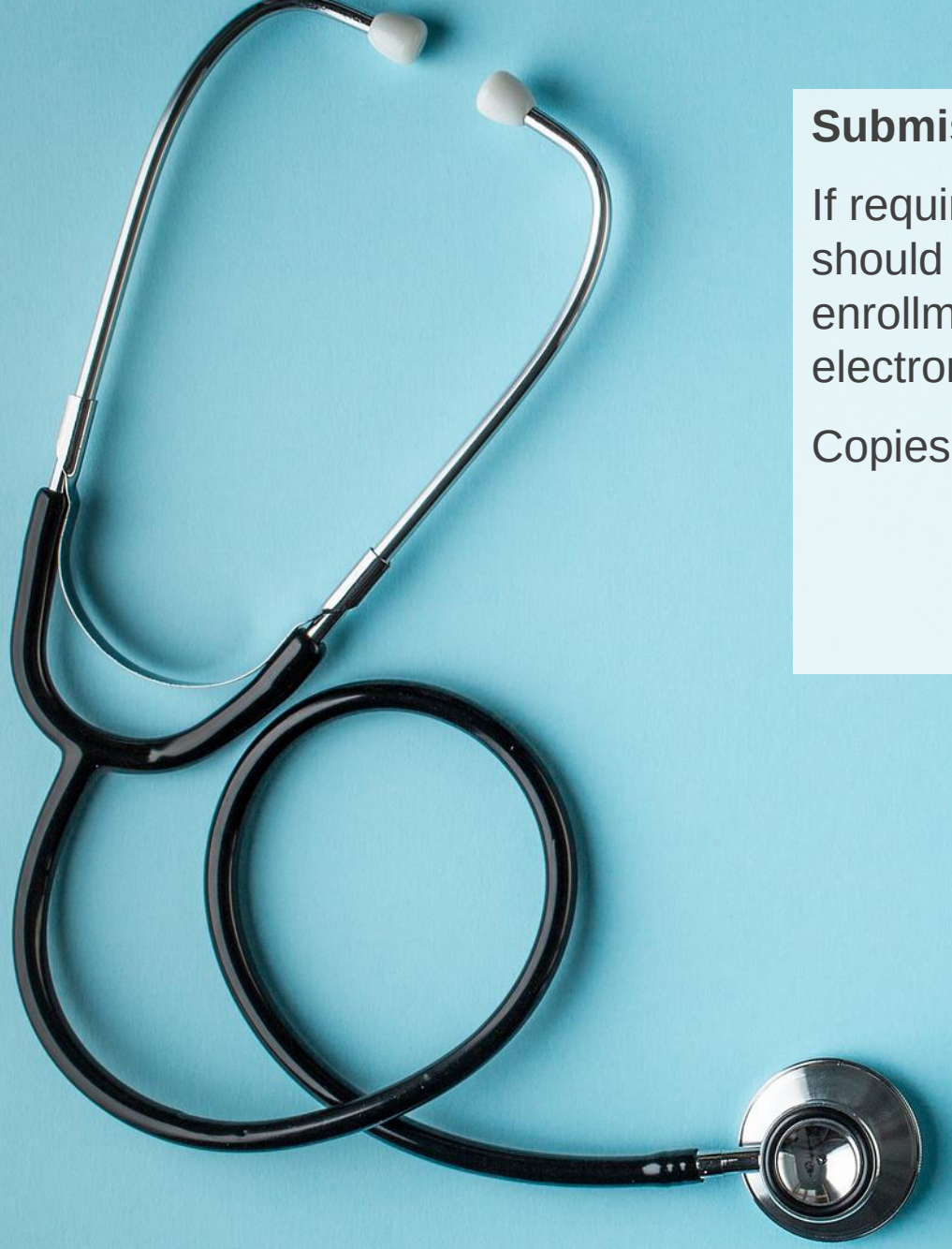
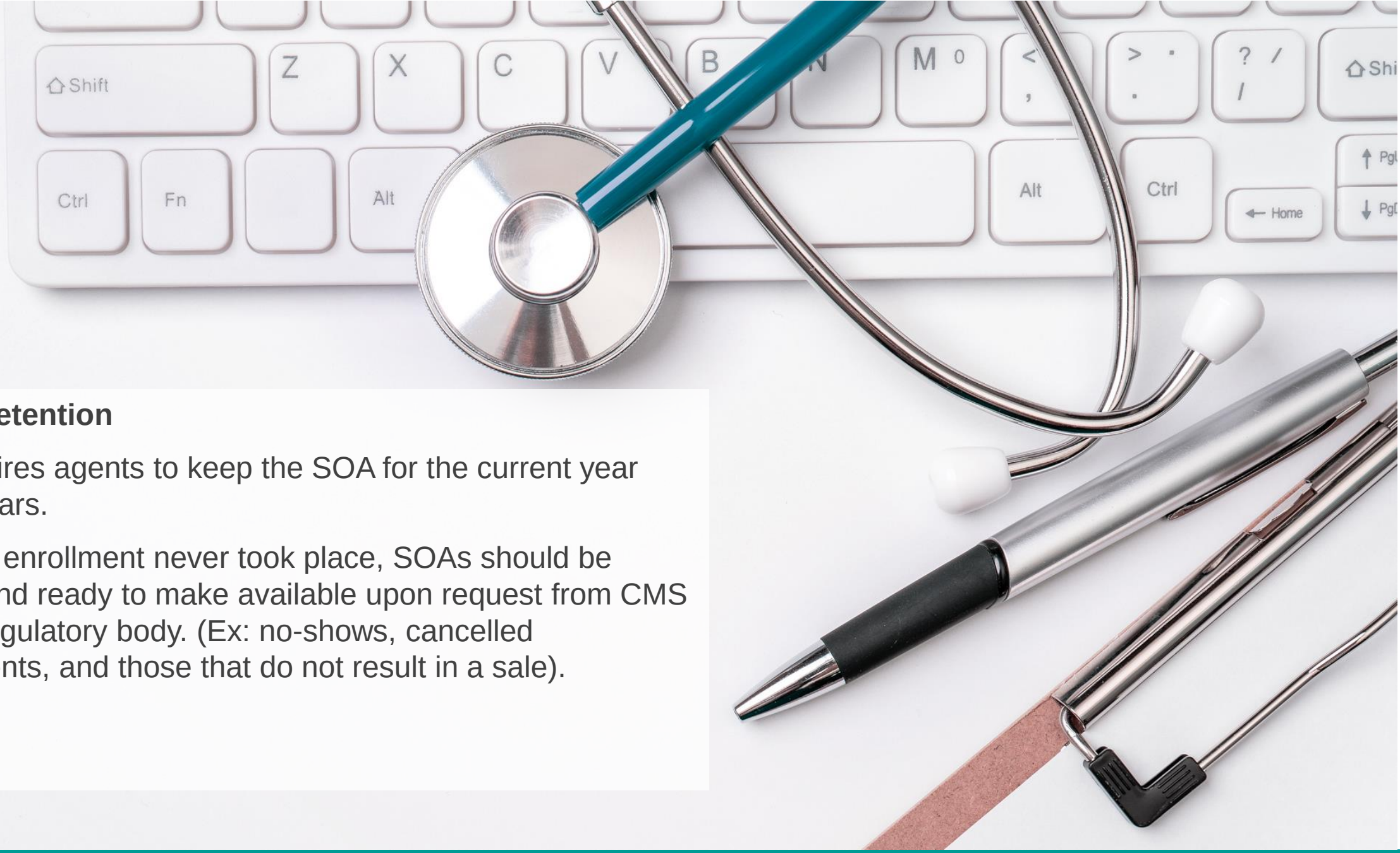


Submission

If required by the carrier, a completed Scope of Appointment should be submitted to the carrier with each MAPD or PDP enrollment application. This includes all applications keyed in electronically or submitted through any electronic means.

Copies of SOAs should be kept on file by the agent for 10 years.



Record Retention

CMS requires agents to keep the SOA for the current year plus 10 years.

Even if an enrollment never took place, SOAs should be retained and ready to make available upon request from CMS or other regulatory body. (Ex: no-shows, cancelled appointments, and those that do not result in a sale).

CMS Approved Carrier Presentations

- Each insurance carrier files an approved presentation with CMS for each selling season.
- Agents and brokers can file additional presentations and materials through the carrier.
- For most agents, the carrier materials will be enough and should be followed to the letter. If the agent sticks to this material, he/she should always be compliant with CMS regulations.
- The presentations and their associated materials must be given to the prospective client regardless of the mode of sale.
- Here are some things that are required for a compliant sales presentation.
  - Scope of Appointment (Communications)
  - Star Ratings Document (Marketing)
  - Summary of Benefits (Marketing)
  - Appendix 1

Required materials and content (42 CFR §§ 422.2267, 423.2267)

Unless otherwise noted, the materials below designated as communications materials do not require HPMS submission.

§§ 422.2267(a)(2), 423.2267(a)(2) - For markets with a significant non-English speaking population

- ID cards are exempt from the translation requirements for markets with a significant non-English speaking population described at §§ 422.2267(a)(2) and 423.2267(a)(2).

§§ 422.2267(d)(1), 423.2267(d)(1) - When multiple enrollees are living in the same household

- When mailing materials to more than one individual living in the same household, the materials (e.g., envelope, cover letter) must clearly notate each individual name.
- Members in community residences (e.g., nursing facilities, group homes) must receive their own copy of non-beneficiary-specific materials, regardless of whether they have the same address.

§§ 422.2267(d)(2), 423.2267(d)(2) – When materials are delivered electronically

- Documents delivered electronically will be considered to be received by the enrollee as of the date the plan sends it; not when the enrollee opens/accesses it.

§§ 422.2267(d)(2)(i), 423.2267(d)(2)(i) – When materials are delivered electronically without prior authorization from the enrollee

- It is acceptable to state “currently available” if the documents have been posted prior to the notice.

§§ 422.2267(e), 423.2267(e) - CMS Required Materials and content

Unless otherwise noted, any CMS Required Material not listed below (or required under §§ 422.2267(b)(e) and 423.2267(b)(e)) are considered communications.

Plans may enclose additional benefit/plan operation materials with CMS Required Materials unless prohibited below or in instructions (e.g., ANOC instructions). These materials should be made distinct from the required material(s) and be related to the beneficiary’s plan.

Scope of Appointment (Communications)	
To Whom Required:	Must be documented for all marketing activities, in-person, telephonically, including walk-ins to Plan/Part D sponsor or agent offices.
Timing:	Prior to the appointment.
Method of Delivery:	Beneficiary signed hard copy, telephonic recording, or electronically signed.
HPMS Timing and Submission:	Not applicable.
Format Specification:	No model required, must include required content.
Guidance and Other Needed Information:	x The following requirements must be on the scope of appointment form or on the recorded call: o Product types to be discussed o Date of appointment o Beneficiary and agent contact information o Statement stating, no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur. x A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon.
Translation Required (5% Threshold):	Yes.

Star Ratings Document (Marketing)	
To Whom Required:	Must be provided to all prospective enrollees when an enrollment form is provided. For online enrollment, Star Ratings document and SB must be made available electronically (e.g., via link) prior to the completion and submission of enrollment request.
Timing:	Must be provided prior to enrollment.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 1090. Must be uploaded within 21 calendar days of the release of the updated information.
Format Specification:	Model required. Standardized Star Ratings document is generated from HPMS.
Guidance and Other Needed Information:	x All Plans/Part D sponsors must provide the Star Ratings document. x New Plans/Part D sponsors that have no Star Ratings are not required to provide until the following contract year. x Updated Star Ratings must be used within 21 calendar days of release of updated information on Medicare Plan Finder. x Updated Star Ratings must not be used until CMS releases Star Ratings on Medicare Plan Finder. x Only the Plan logo may be added to the document (no other changes or alterations are permitted).
Translation Required (5% Threshold):	Yes.

Summary of Benefits (Marketing)	
To Whom Required:	Must be provided to all prospective enrollees when an enrollment form is provided.
Timing:	Must be available by October 15 of each year.
Method of Delivery:	Hard Copy or electronic and only if enrollee has opted into receiving electronic version.
HPMS Timing and Submission:	Code 1099 File & Use. Submitted prior to October 15 of each year.
Format Specification:	No model required, must include required content.
Guidance and Other Needed Information:	Appendix 2 of the MCMG.
Translation Required (5% Threshold):	Yes.

Appendix 1 – Standardized Pre-Enrollment Checklist (422.2267(e)(4), 423.2267(e)(4))

Instructions:
Plans must include the Standardized Pre-Enrollment Checklist with the enrollment form and the SB.

Plans may remove parts or portions of the checklist that are not applicable to a particular plan type or product. When the pre-enrollment checklist is used for multiple products, they may add additional language before or after the disclaimer to clarify or distinguish how a disclaimer applies to different products.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at [insert customer service phone number].

Understanding the Benefits

☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [insert Plan website] or call [insert plan phone number] to view a copy of the EOC.

☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

☐ In addition to your monthly plan premium [plans may delete the monthly plan premium portion for $0 premium plans], you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

> [**Note**: Fully integrated dual SNPs may elect to remove this section or modify it to convey that the Part B premium is already paid. Plans that have a Part B buy-down may alter the language to convey the amount the plan pays and the beneficiary owes.]

☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, [insert year].

☐ [For plans that do not offer out of network coverage] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

☐ [For PPO, PFFS, and other plans that offer out of network coverage] Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services [HMO-POS may insert "certain covered services"], the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. [If applicable, plans must add the following language] In addition, you will pay a higher co-pay for services received by non-contracted providers.

☐ [For C-SNP plans] This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

☐ [For D-SNP plans] This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. [D-SNPs may provide additional information if they impose restrictions to specific Medicaid eligibility category(ies)]

☐ [For I-SNP plans] This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.

☐ [For MSAs] MSA Plans combine a high deductible Medicare Advantage Plan and a trust or custodial savings account (as defined and/or approved by the IRS). The plan deposits money from Medicare into the account. You can use this money to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount, so you generally have to pay money out of pocket before your coverage begins.

Medicare MSA Plans do not cover prescription drugs. If you join a Medicare MSA Plan, you can also join any separate Medicare Prescription Drug Plan.

There are additional restrictions to join an MSA plan, and enrollment is for a full calendar year unless you meet certain exceptions. Those who disenroll during the calendar year will owe a portion of the account deposit back to the plan. Contact the plan at [insert customer service and TTY] for additional information.

Star Ratings

- The Center for Medicare & Medicaid Services (CMS) created a system to measure how well Medicare Advantage and Prescription Drug plans perform. This program was developed to help Medicare consumers compare the quality of Medicare health and drug plans being offered and thus select the best plan for their situation.
- Medicare Advantage plans are rated in five categories.
- Prescription Drug Plans are rated in four categories.
- The Star Ratings system measures, using one to five stars, the quality of health and drug services received by consumers. The results are published each year and provided in the Medicare Plan Finder alongside information about plan benefits and costs.
- The star rating determines the amount reimbursed by the federal government to the plan sponsor. The higher the rating a plan receives, the more money the carrier receives.

Medicare Advantage Star Ratings	
Summary rating of health plan quality	★★★★½
Staying healthy: screenings, tests & vaccines	★★★★
Managing chronic (long term) conditions	★★★★½
Plan responsiveness and care	★★★★
Member complaints, problems getting services, & choosing to leave the plan	★★★★★
Health plan customer service	★★★★★

Drug Plan (Part D) Star Rating	
Summary rating of drug plan quality	★★★★★
Drug plans customer service	★★★★
Member complaints, problems getting services, & choosing to leave the plan	★★★★★
Member experience with the drug plan	★★★★
Drug pricing and patient safety	★★★★☆

Within these main categories the Star Rating system measures up to 38 unique quality and performance measures on Medicare Advantage plans with prescription drug coverage (MAPD); up to 28 measures on Medicare Advantage (MA) only plans; and up to 12 measures for stand-alone Prescription Drug Plans (PDP).

If the CMS Plan Finder shows a plan with fewer than three stars for three years in a row the plan will be marked as low performing with a special symbol. Currently individuals cannot enroll in low performing plan through the Plan Finder system. They must call 1 800 Medicare or the Plan.

The methodologies used to calculate performance and factors being measured can and have changed each year. CMS is working to stabilize the measurement system and plans to implement a more demanding rating methodology over the next several years. These steps may make it difficult for plans to maintain their ratings. The companies offering Medicare Advantage and Prescription Drug plan work hard to improve their performance.

Medicare plan professionals in their work with Medicare beneficiaries also have an important role in supporting the work companies do throughout the year to improve plan performance and thus Star rating. Steps such as encouraging beneficiaries to review the welcome information after enrolling, to answer the questions when the plan sends them a survey, and to contact the plan when any questions about coverage develop. These interactions help the members know they have been heard and thus will appreciate their plan. Plans offer many available preventive services so in any conversations with clients encourage them to make an appointment and to be sure they are following, when appropriate, their chronic condition management steps. Hopefully it won't be needed but to help clients work with their plan when they have a complaint.

The Star Rating system also created a Special Enrollment Period (SEP) thus giving individuals an additional opportunity to enroll in a Five Star plan. It's a one-time opportunity and begins December 8th of the year before the plan is rated as Five Stars and lasts through November 30th of the year it is a Five Star plan. Enrollments from January through November are effective the month following the request.

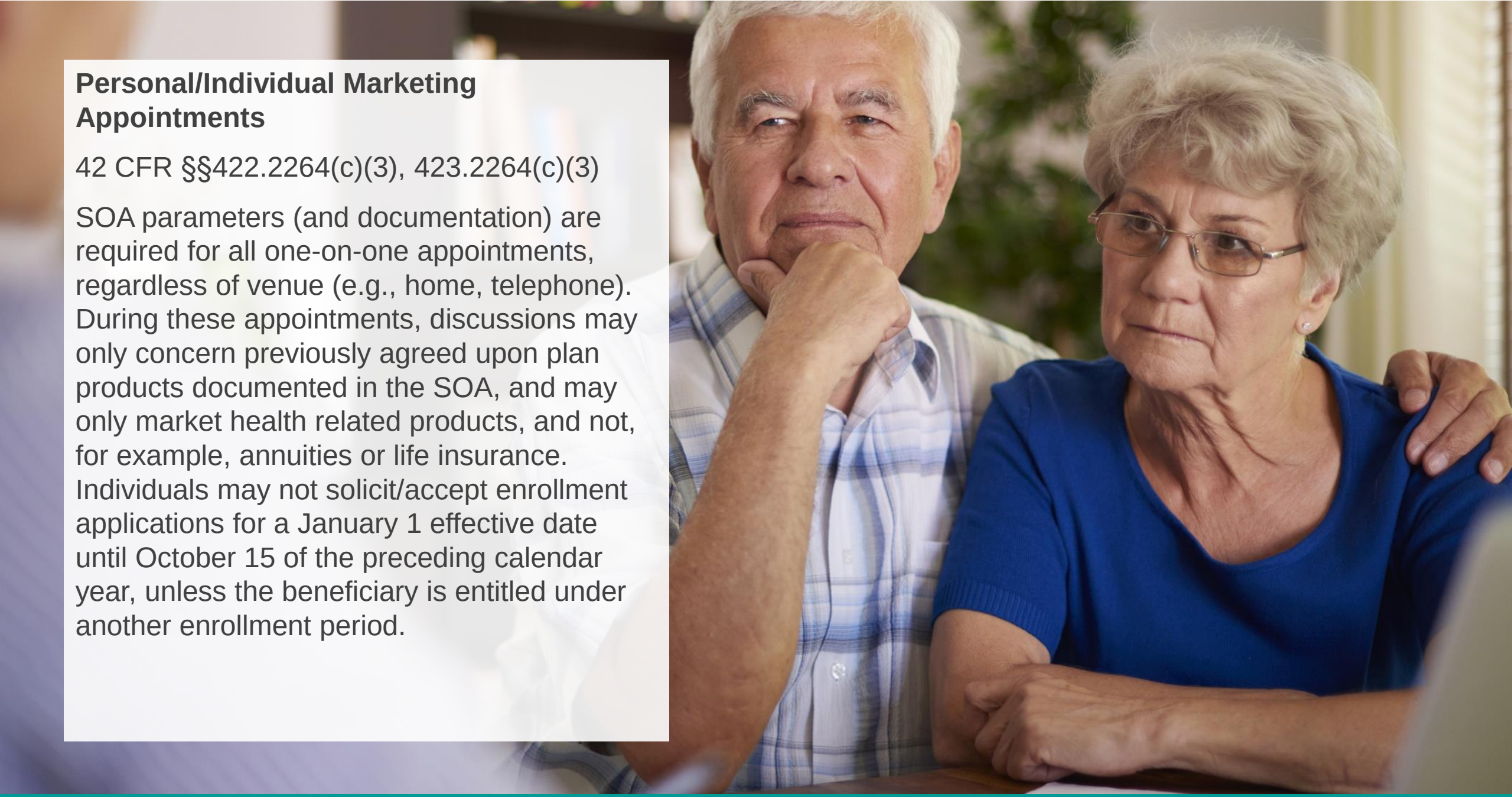
Individual Appointments

- Personal or individual appointments are considered appointments that occur in a potential client's home or some other location on a more or less one-on-one basis.
- These appointments must follow scope of appointment guidelines and follow all of the rules already outlined for MA, MA-PD and PDP sales.
- These are considered marketing events by CMS but are not required to be registered.
- There are many rules an agent must follow during an Individual Appointment.

Personal/Individual Marketing Appointments

42 CFR §§422.2264(c)(3), 423.2264(c)(3)

SOA parameters (and documentation) are required for all one-on-one appointments, regardless of venue (e.g., home, telephone). During these appointments, discussions may only concern previously agreed upon plan products documented in the SOA, and may only market health related products, and not, for example, annuities or life insurance. Individuals may not solicit/accept enrollment applications for a January 1 effective date until October 15 of the preceding calendar year, unless the beneficiary is entitled under another enrollment period.



Telesales

- Selling MAPD over the phone is allowed but has many unique rules that have to be followed along with all the same rules as Individual Appointments and other Sales Events.
- Furthermore, Carrier Approved Call Centers may run into rules set by Plan Sponsors, in addition to those specified in CMS Guidelines.
- Some notable requirements are
  - Enrollment Scripts
  - Final Rules Overseeing Recordings
  - Recording Calls

Rules

Some carriers may have additional requirements for an agency to act as a call center which could include but are not limited to:

- Additional data and physical security requirements
- Additional Monitoring and Quality Assurance
- Compliance processes and procedures
- Annual Audits

40.1.3 - Enrollment via Telephone
(Rev. 2, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

MA organizations may accept requests for enrollment into their MA plans via an incoming (in-bound) telephone call to a plan representative or agent. MAOs may also accept enrollment requests during communications initiated by the organization when, during the course of outreach to provide information about their Medicare plan offerings to individuals with whom they have an existing business relationship, the individual expresses a desire to enroll in one of the organization's MA plans.

The following guidelines must be followed, in addition to all other applicable program requirements:

- Enrollment requests from individuals with whom the organization does not have an existing business relationship may be accepted only during an incoming (or in-bound) telephone call from a beneficiary. This includes inbound calls to an incorrect department or extension transferred internally.
- For all telephonic enrollment requests, the MA organization must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his or her authorized representative.
- Individuals must be advised that they are completing an enrollment request.
- Each telephonic enrollment request must be recorded (audio) and include a statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as described in Appendix 2), and a verbal attestation of the intent to enroll. If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual's authority under State law to complete the request, in addition to the required contact information. All telephonic enrollment recordings must be reproducible and maintained as provided in section §60.9.
- Include a tracking mechanism to provide the individual with evidence that the telephonic enrollment request was received (e.g. a confirmation number).
- Optionally, organizations may request or collect premium payment or other payment information needed, such as a bank account number or credit card numbers, to process the form of premium payment requested by the individual.
- A notice of acknowledgement and other required information must be provided to the individual as described in §40.4.1.
- Telephonic enrollment requests into a plan offered by the same parent organization may be based on the model short enrollment form (Exhibit 3) or the model plan selection form (Exhibit 3a) instead of the comprehensive individual enrollment form.
- Telephonic ICEP enrollment requests from individuals enrolled in a non-Medicare plan under the same organization (or parent organization) and transitioning from the non-Medicare plan to the MA plan without a break in coverage may be based on the simplified opt-in enrollment mechanism as described in § 40.1.9.

The MA organization must ensure that all MA eligibility and enrollment requirements provided in this chapter are met. Scripts for completing an enrollment request in this manner must be developed by the MA organization. The scripts must contain the required elements for completing an enrollment request as described in Appendix 2, and must receive CMS approval in accordance with CMS Marketing Guidelines before use.

Telesales and Enrollment Scripts

Telesales and enrollment scripts are considered marketing and must be submitted to CMS. If a sales call progresses to a telephonic enrollment, the sales staff must clearly inform the beneficiary that they are enrolling into the Plan (using the specific Plan name/type).

In addition, enrollment scripts must:

- Follow all requirements described in CMS Eligibility and Enrollment Guidance (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326) (Chapter 2 of the Medicare Managed Care Manual) and Chapter 17, Subchapter D, of the Medicare Managed Care Manual, as well as Chapter 3 of the Medicare Prescription Drug Benefit Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf);
- Provide confirmation of having accepted/completed the telephone enrollment request, such as a confirmation tracking number or other tracking mechanism;
- Provide a statement that the individual will receive a notice acknowledging receipt of the enrollment (e.g., acknowledging request for additional information or denial of enrollment); and
- Provide contact information for questions including toll-free telephone and TTY numbers

Final Rules Overseeing Recordings

Medicare Marketing Rule #1:

https://www.federalregister.gov/d/2022-09375

Medicare Marketing Rule #2:

https://www.federalregister.gov/d/2023-07115

Medicare Managed Care Manual:

- 40.1.3 Enrollment via Telephone (p. 59)
- CY2021 MA Enrollment and Disenrollment Guidance (cms.gov)

Recording Calls with Beneficiaries

Effective October 1, 2022, all sales calls with beneficiaries and independent agents/brokers, or other third-party marketing organizations (TPMOs), must be recorded in their entirety when marketing plans for 2024 and subsequent years.

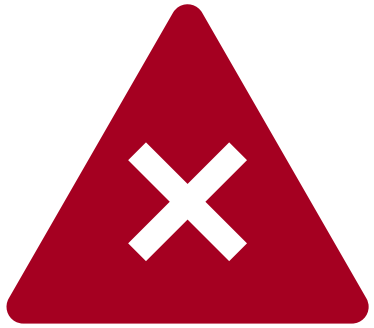
- Calls must be recorded and retained for 10 years.
  - This includes all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology, in their entirety.
- This rule includes enrollment calls.

Note: If the Part D sponsor or MA organization reaches out to the beneficiaries regarding plan business, as outlined in section 422.2264 final language, the Part D sponsor or MA organization must provide notice to all beneficiaries whom the plan contacts as least once annually, in writing, of the individual's ability to opt out of future calls regarding plan business.

Implications of Medicare Marketing Final Rules

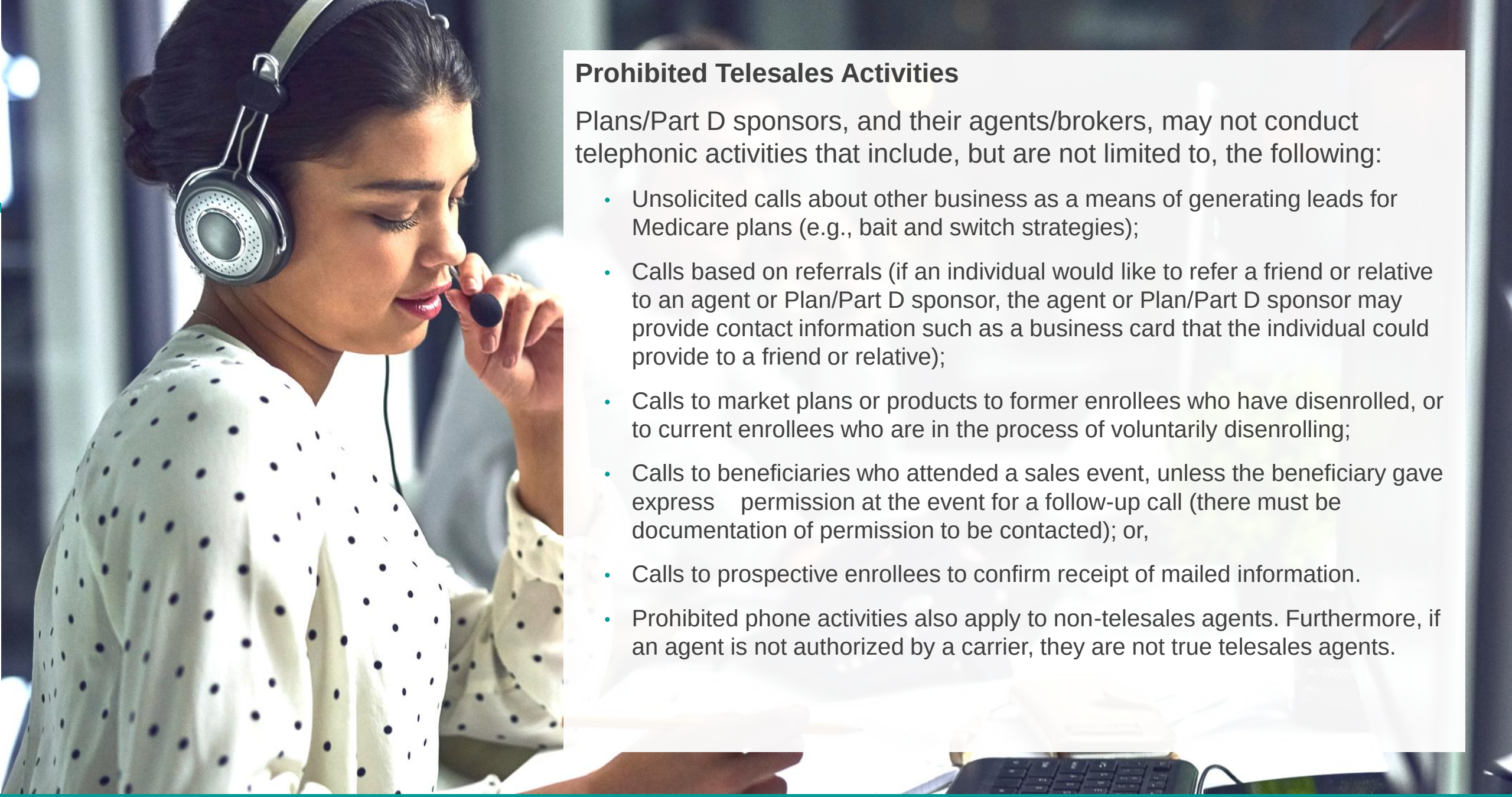
- Last year's final rule requires agents to record telephonic marketing conversations with beneficiaries beginning October 1, 2022.
- Since the first rule was released, it has been clarified that recording requirements only apply to "sales, marketing and enrollment calls."
- The recording requirement applies to all agents who enroll beneficiaries into new plans, whether they are current or new clients. Online applications that agents walk through with their clients are also subject to recording.
- Agents must disclose to beneficiaries the plans they sell and that beneficiaries "can obtain complete Medicare options/information from 1-800-MEDICARE, SHIPs or Medicare.gov."

Telesales Activities



There are many more activities that are expressly prohibited when engaging in telephonic contact.

Here is a list of activities that are allowed through telephonic contact.



Prohibited Telesales Activities

Plans/Part D sponsors, and their agents/brokers, may not conduct telephonic activities that include, but are not limited to, the following:

- Unsolicited calls about other business as a means of generating leads for Medicare plans (e.g., bait and switch strategies);
- Calls based on referrals (if an individual would like to refer a friend or relative to an agent or Plan/Part D sponsor, the agent or Plan/Part D sponsor may provide contact information such as a business card that the individual could provide to a friend or relative);
- Calls to market plans or products to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling;
- Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call (there must be documentation of permission to be contacted); or,
- Calls to prospective enrollees to confirm receipt of mailed information.
- Prohibited phone activities also apply to non-telesales agents. Furthermore, if an agent is not authorized by a carrier, they are not true telesales agents.

Allowed Telesales Activities

Plans/Part D sponsors, and their agents/brokers, may conduct the following specific telephonic activities:

- Call current enrollees, including those in non-Medicare products, to discuss plan business (examples of this include calls to enrollees aging into Medicare from commercial products offered by the same organization, calls to an organization's existing Medicaid/MMP plan enrollees to talk about its Medicare products, and calls to current MA enrollees to promote other Medicare plan types or to discuss plan benefits);
- Call beneficiaries who submit enrollment applications to conduct business related to enrollment;
- Call former enrollees after the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes (disenrollment surveys conducted telephonically, email or conventional mail may not include sales or marketing information);
- Call individuals who have given permission for a plan or sales agent to contact them (examples of permission include filling out a business reply card, emailing the Plan/Part D sponsor requesting a return call, or asking a customer service representative to have an agent contact them); and,

  Note: Permission applies only to the entity from which the individual requested contact and for the duration and topic of that transaction.

- Return phone calls or messages from individuals or enrollees, as these are not considered unsolicited contacts.

Individual Agent Selling Over Phone vs. Telesales Agent

- An individual agent selling over the phone is not a telesales agent by definition.
- Telesales agents are agents approved by a plan sponsor specifically for selling over the phone and distinct from a non-approved agent.
- Clarification between the two is a significant compliance focus among carriers.

Cross Selling

- It is not allowed to market non healthcare products during a sales event or appointment. Examples of cross-selling non-healthcare products include:
  - Life Insurance
  - Annuities
  - Securities

- Health related products can be cross sold as long as they were agreed upon in the Scope of Appointment. Examples of health-related products are:
  - Dental
  - Vision
  - Hospital Indemnity

Cross-Selling

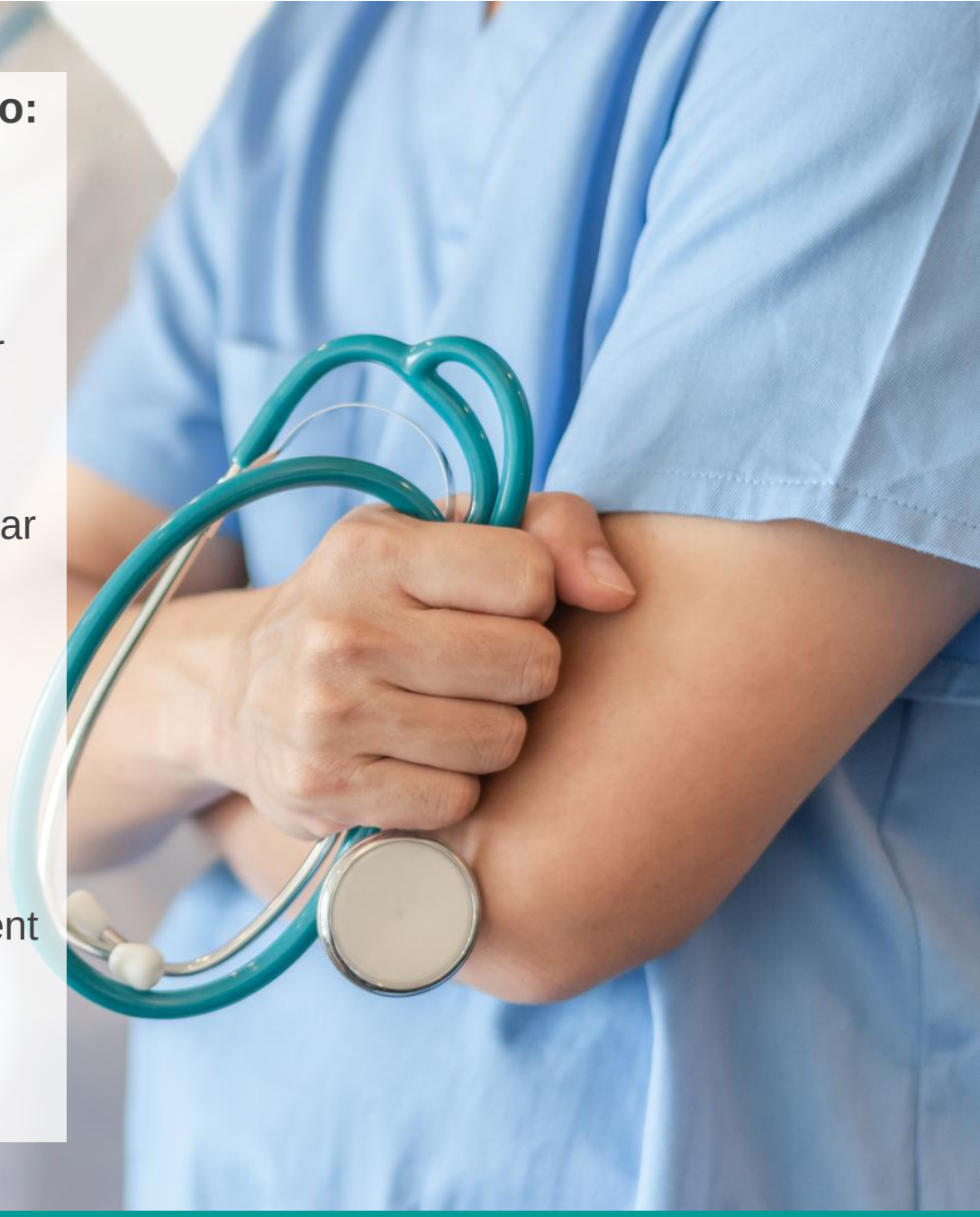
For the purposes of the prohibition on "cross-selling", CMS defines "non-health care related products" as any insurance product not involving medical / health coverage (for example, annuities and life insurance). Dental coverage is considered medical / health coverage).

Activities in a Healthcare Setting

- CMS defines plan-initiated activities as those activities where either a Plan Sponsor requests a contracted provider, like a hospital, to act on behalf of the plan by engaging in marketing or referral activities.
- Providers are not allowed to engage in any marketing activities
- Including but not limited to providing plan information and benefits.
  - Here is a list of items plan sponsors cannot allow providers to engage in.
  - Here is a list of items a plan sponsor can allow providers to engage in.
- Providers are made aware of these guidelines when contracting with a Plan Sponsor.

Plans/Part D sponsors may not allow contracted providers to:

- Accept/collect scope of appointment forms;
- Accept Medicare enrollment applications;
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific Plan based on financial or any other interests of the provider;
- Mail marketing materials on behalf of Plans/Part D sponsors;
- Offer inducements to persuade their patients to enroll in a particular Plan or organization;
- Conduct health screenings as a marketing activity;
- Distribute marketing materials/applications in areas where care is being delivered;
- Offer anything of value to induce enrollees to select them as their provider; or
- Accept compensation from the Plan for any marketing or enrollment activities.



Plans/Part D sponsors may allow contracted providers to:

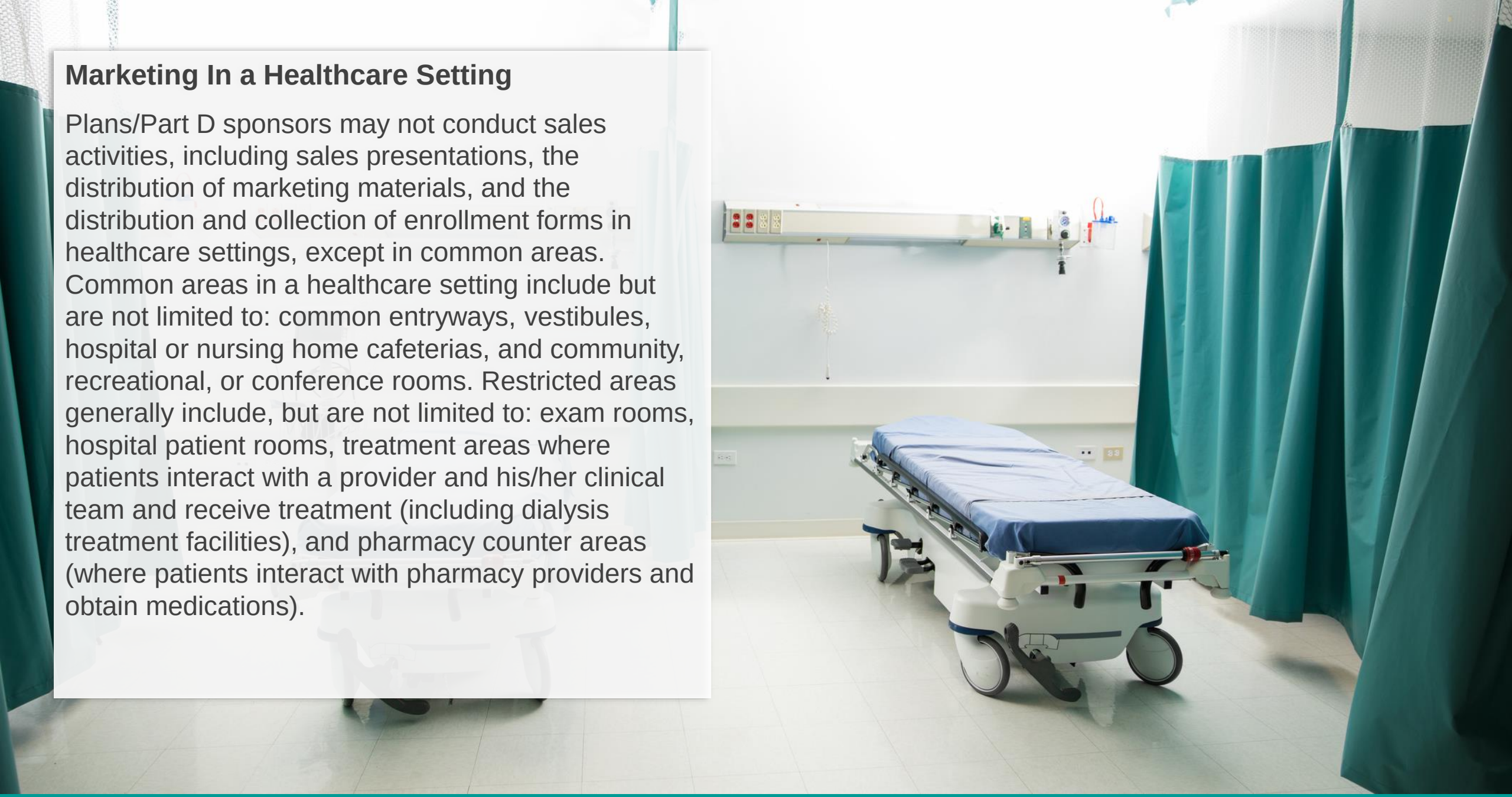
- Make available, distribute, and display communication materials, including in areas where care is being delivered; and
- Provide or make available Plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).

Activities in a Healthcare Setting (Cont'd)

- Plan Sponsors and, by extension, agents and brokers are not allowed to engage in marketing in a healthcare setting except in common areas.
- Marketing activities include but are not limited to:
  - Sales Presentation
  - Distribution of Marketing Material
  - Collection of Enrollment forms
- These rules extend to pharmacies that are in a grocery store for example or have a store front.
- However, communication materials may be distributed in a healthcare setting.

Marketing In a Healthcare Setting

Plans/Part D sponsors may not conduct sales activities, including sales presentations, the distribution of marketing materials, and the distribution and collection of enrollment forms in healthcare settings, except in common areas. Common areas in a healthcare setting include but are not limited to: common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms. Restricted areas generally include, but are not limited to: exam rooms, hospital patient rooms, treatment areas where patients interact with a provider and his/her clinical team and receive treatment (including dialysis treatment facilities), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).



Special Guidance for Institutional Special Needs Plans (I-SNPs) Serving Long Term Care Facility Residents

- Plans/Part D sponsors may provide long-term care facilities with materials for admission packets announcing all Plan contractual relationships. CMS considers these communication materials.
- CMS permits Plans/Part D sponsors to schedule appointments with residents of long-term care facilities (e.g., nursing homes, assisted living facilities, board and care homes) upon a resident's request. If a resident did not request an appointment, any visit by an agent or broker would be viewed as unsolicited door-to-door marketing.

https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/CY2019-Medicare-Communications-and-Marketing-Guidelines_Updated-090518.pdf

https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare_Communications_and_Marketing_Guidelines_Update_Memo_-_8-6-19.pdf

Educational Events

- Educational events are just what the name implies.
- These events are intended to inform the potential client or individual of their available MA, MA-PD and PDP benefits or other services and benefits related to Medicare.
- These events have to be held in a public setting with groups.
- At one of these events an agent can talk about Medicare plans in general or anything related to Medicare, but no sales or marketing can take place.

Educational Events (Cont’d)

- Providing enrollment forms, sign-up sheets and plan benefits and outlines are prohibited, though general marketing informational materials and company imprinted giveaways are allowed.
- Here are additional rules for Educational Events.

Educational events are designed to inform beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs. Educational events:

- Must be advertised as educational
- Hosted in a public venue by the Plan/Part D sponsor or an outside entity
- May include communication activities and distribution of communication materials
- May answer beneficiary-initiated questions
- May set up a marketing appointment and distribute business cards and contact information for beneficiaries to initiate contact including securing a Scope of Appointment
- Must not include marketing or sales activities or distribution of marketing materials or enrollment forms

Unsolicited Contacts and Referrals

- Agents may not reach out to a potential client without written permission or if the contact was not initiated by the potential client.
- Approved and Generic marketing materials with a call to action and proper disclaimers can be used to solicit business; however, it is still up to the potential client to reach out to the agent by replying in some fashion to the marketing piece and providing permission to contact.
- Similarly, agents may not reach out to client referrals. If a client wants to refer someone to the agent, the person being referred must reach out to the agent.

Source: 42 CFR §§ 422.2264 Beneficiary Contact

Unsolicited Contacts and Referrals (Cont'd)

- Agents may not solicit referrals, either…even from existing Medicare clients.
- If an individual would like to refer a friend or relative to an agent or Plan/Part D sponsor, the agent or Plan/Part D sponsor may provide contact information such as a business card that the individual could provide to a friend or relative.

Unit 2 Medicare Marketing Guidelines

Section 3: Marketing Requirements

Marketing Requirements

- Solicitations are allowed to prospect for potential clients.
- Some materials must be approved by a plan sponsor for use. These types of materials are usually considered non-generic because they have a carrier logo or mention plan information such as premiums or benefits.
- Generic materials do not contain plan information or premiums but usually have an attractive call to action--promising affordability or enhanced benefits beyond original Medicare, for example.

Marketing Requirements (Cont'd)

- One thing all solicitations have in common is they must contain certain standard disclaimers as well as capture Permission to Call (PTC).
- Marketing pieces cannot capture the SOA.
- Most agents will use a vendor to generate marketing materials. If these materials do not follow CMS guidelines, the agent is still at fault.
- Any marketing materials used by the agent must also have prior approval of the Plan(s) the materials represent.

Medicare Marketing Guidelines

The Marketing guidelines reflect CMS' interpretation of the marketing requirements and related provisions of the Medicare Advantage and Medicare Prescription Drug Benefit rules (Chapter 42 of the Code of Federal Regulations, Parts 422 and 423).

The Guidelines are for use by Medicare Advantage Plans (MAs), Medicare Advantage Prescription Drug Plans (MA-PDs), Prescription Drug Plans (PDPs) and 1876 Cost Plans. The guidelines allow organizations offering both Medicare Advantage and Prescription Drug Plans the ability to reference one document when developing marketing materials.

cms.gov

Marketing Requirements (Cont'd)

- Before utilizing these types of lead methods, make sure the vendor is compliant with CMS guidelines and is properly obtaining PTC as well as listing all relevant disclaimers. The agreement must be clearly laid out on the card or online registration as in the type of examples provided.
- These guidelines apply to all mediums including radio, television and print.

Where to Access Required Documents

Plans/Part D sponsors must post on their website all required documents outlined here and ensure these documents are downloadable. This includes translated documents, as applicable.

Documents to be posted on Website

Plans/Part D sponsors must post on their website all required documents outlined below and ensure these documents are downloadable. This includes translated documents, as applicable. “(M)” denotes a required marketing material, and “(C)” denotes a required communication material. If a required document is found to have errors, or is updated, the updated document must be posted on the website as soon as possible.

Required Document	Required Posting Date for Renewing Plans	Required Posting Date for New Plans
Summary of Benefits (M)*	By October 15	By October 15
Annual Notice of Change (M)*	By October 15	Not applicable
Evidence of Coverage (C)*	By October 15	By October 15
Provider Directory (C)	By October 15	By October 15
Pharmacy Directory (C)	By October 15	By October 15
Formulary (C)*	By October 15	By October 15
CMS Star Ratings Document (M)*	21 days after the release of Star Ratings on Medicare Plan Finder	21 days after the release of Star Ratings on Medicare Plan Finder
Privacy Notice under the HIPAA Privacy Rule*	Posted all year (updates as required)	By January 1
Exception Request Forms for physicians*	Posted all year (updates as required)	By January 1
Utilization Management Forms for physicians and enrollees*	Posted all year (updates as required)	By October 15

Required Disclaimer

"We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."

This disclaimer must be used by any third-party marketing organization including agents and brokers:

- On all marketing materials: print, electronically, television, and radio
- Within the first minute of all sales calls
- Prominently displayed on TPMO websites
- Verbally, electronically, or in writing, during any sales meeting with a beneficiary

When independent agents/brokers or other **TPMOs** do sell ALL commercially available MA/Part D plans in a given service area then the disclaimer is to add the addition of SHIP to the disclaimer. If a TPMO does not sell for all MA organizations and/or Part D sponsors in the service area the disclaimer consists of the statement:

"Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices".

Definition of TPMO (Why Agents are Impacted)

Third Party Marketing Organizations are defined as “organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision).

Marketing Plans with an Overall 5-Star Rating

- For most agents, what is important to remember is that 5 Star plans have an 11-month SEP, a continuous SEP all year, and are not limited to the AEP changes. This means new members may enter the plan at any time during that period.
- If a plan is going to lose its 5-star rating, the plan sponsor has to quit marketing it as such and taking new enrollments on that basis by November 30th of the current plan year.

Websites and Social/Electronic Media

- Electronic material such as social media advertising and websites must follow the same rules and restrictions as print media.
- They also fall into the same categories as Generic and Branded materials.
- Any materials that meet the definition of marketing and are not generic must be submitted to the plan sponsor for approval with CMS.

Enrollment Process

- For Medicare Part C and D the enrollment process is the same.
- There are required items that must be provided at different stages of the enrollment.
  - Pre-Enrollment
  - Enrollment
  - Post Enrollment
- The required enrollment materials are provided to the agent by the Plan Sponsor
- Plan sponsors are required to provide training on their enrollment tools and documents.

https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

Enrollment in an MA/MAPD/PDP Plan

Upon request. All organizations/sponsors must have available a paper enrollment form in addition to any other acceptable enrollment mechanisms. Paper enrollment forms may be in hard copy or electronic format (e.g., PDF file) and must be provided via email, online portal for current members, and upon request (e.g., if beneficiary does not want to enroll telephonically or electronically). Any enrollment mechanism outlined in enrollment guidance is acceptable for an enrollment request. Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted.

- Includes all enrollment processing notices (acknowledgement, confirmation, denial, rejection, request for more information, attestation of creditable coverage, cancellation, reinstatement, etc.).
- Includes all enrollment adjustment notices (700-series transaction reply code notices, Part D late enrollment penalty notices, etc.).
- Includes all disenrollment notices (advance warning, research of possible ineligibility, disenrollment, cancellation, request for more information, etc.).
- Plans must maintain copies of required notices, as outlined in enrollment guidance. Eligibility, Enrollment, and Disenrollment – Medicare Managed Care Manual-Chapters 2 and 17D and Medicare Prescription Drug Manual-Chapter 3.
- Creditable Coverage Determinations and Late Enrollment Penalty
  - Medicare Prescription Drug Manual – Chapter 4.
- Non-renewal and Service Area Reduction Guidance.

https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

Enrollment Materials

Enrollment materials are materials used to enroll or disenroll a beneficiary from a plan, or materials used to convey information specific to enrollment and disenrollment issues such as enrollment and disenrollment notices.

https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

Enrollment Process (Cont'd)

- Enrollments can be done in a few ways.
  - Face-to-Face
  - Web-based
  - Telephonic
- Any enrollment method a Plan Sponsor offers must be approved by CMS and the agent approved by the Plan Sponsor to use the specific enrollment method.
- The most common enrollment method for agents is face-to-face.

Enrollment Options

Medicare beneficiaries have options outside of agent assisted enrollment including:

- Using Medicare's Plan Finder.
- Visiting the plan's website to see if they can enroll online.
- Filling out a paper enrollment form. Contact the plan to get an enrollment form, fill it out, and return it to the plan. All plans must offer this option.
- Calling the plan with whom they wish to enroll. Call 1-800-MEDICARE (1-800-633-4227).
- Seamless Conversion

https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan

CMS previously allowed health insurance companies to enroll individuals covered by their medical plan into one of the companies Medicare Advantage plans when first eligible for Medicare. The process was called Seamless Conversion. CMS modified the regulations for this type of enrollment in contract year 2019 and began to use the default enrollment program. This change was made at the same time regulations were issued for the MA OEP program.

Regulations now say a default enrollment can only be used for dully eligible beneficiaries. The Medicare Advantage company wishing to begin using the optional default enrollment process, must have, or be affiliated with a Medicaid Managed Care company. The company must request and obtain approval from CMS prior to effectuating and default enrollments from their Medicaid Managed Care company, or affiliated organization, into their Medicare Advantage dual eligible special needs plan (D-SNP). One requirement is the MA organization these individuals will be enrolled in must have a minimum 3-star quality rating.

When approved the Medicaid Managed Care company must identify individuals, in their plan who are becoming Medicare-eligible because of age and disability. The company then must issue these individuals a written notice, at least 60 days before being default-enrolled. The notice explains their right to opt out, their other Medicare coverage options, and the process for obtaining care in the D-SNP.

https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

Pre-Enrollment

Prior to completing an enrollment an agent must provide a Summary of Benefits and a Pre-Enrollment Checklist which advises the beneficiary to review the following:

- ❑ Evidence of Coverage
- ❑ Provider Directory
- ❑ Pharmacy Directory
- ❑ Important Plan Rules

Pre-Enrollment Checklist

- Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at [insert customer service phone number]

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit [insert Plan website] or call [insert plan phone number] to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Source: Medicare Communications and Marketing Guidelines (MCMG)

Evidence of Coverage

To Whom Required	Must be provided to all enrollees of plan. October 1, November 1, and December 1 enrollees must receive the current EOC and the next calendar year EOC.
Timing	Must be provided to current enrollees of plan by October 15 of each year. Must be provided to new enrollees within ten (10) calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
Method of Delivery	Hard copy; made available electronically, as permitted; or electronically, if enrollee has opted into receiving electronic version as permitted.

Provider Directory

To Whom Required	Must be provided to all current enrollees of the plan.
Timing	Must be provided to current enrollees of Plan by October 15 of each year.
	Must be provided to new enrollees within ten (10) calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
	Must be provided to current enrollees upon request, within three (3) business days of the request.
	Must update directory information any time they become aware of changes. All updates to the online provider directories are expected to be completed within 30 days of receiving information. Updates to hardcopy provider directories must be completed within 30 days, however, hardcopy directories that include separate updates via addenda are considered up-to-date.
Method of Delivery	Hard copy; made available electronically, as permitted in; or electronically, if enrollee has opted into receiving electronic version as permitted.

Pharmacy Directory

To Whom Required	Must be provided to all current enrollees of the plan.
Timing	Must be provided to current enrollees of Plan by October 15 of each year.
	Must be provided to new enrollees within ten (10) calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
	Must be provided to current enrollees upon request, within three (3) business days of the request.
	Must update directory information any time they become aware of changes. All updates to the online provider directories are expected to be completed within 30 days of receiving information. Updates to hardcopy provider directories must be completed within 30 days, however, hardcopy directories that include separate updates via addenda are considered up-to-date.
Method of Delivery	Hard copy; made available electronically, as permitted; or electronically, if enrollee has opted into receiving electronic version as permitted.

Important Plan Rules

Guidance Comparison Between Marketing/Sales and Educational Events

The purpose of this document is to provide a reference summary of key event guidelines, highlighting the difference between Education and Marketing/Sales Events. Use it to ensure you are scheduling and conducting the appropriate event type. The list of guidelines is not exhaustive and additional information about the parameters of what is required and allowed for each activity can be found in the most current agent guides or compliance guidelines. Guidance is subject to change. Effective June 2023

Guidance	Marketing/Sales	Educational Event
Report and/or cancel event according to carrier policy	Required	Required
Host the event at a public venue	Required	Required
Advertise as an Educational Event	Not Allowed	Required
Display disclaimer: *For accommodations of persons with special needs at meetings call [insert consumer contact phone number] TTY: 711* on all Event advertising.	Required	Required
Expect secret shoppers	Allowed	Allowed
Invite a provider to speak on general health topics	Allowed	Allowed
Conduct health screening or genetic testing	Not Allowed	Not Allowed
Provide meals (Maximum $15 combined nominal retail value)	Not Allowed	Allowed
Serve light snacks/refreshment within combined $15 nominal value.	Allowed	Allowed
Provide gift cards, gift certificates, or cash giveaways.	Not Allowed	Not Allowed
Provide giveaways with agent contact information	Allowed	Allowed
Provide plan giveaways containing logo, toll-free number and/or carrier website	Allowed	Allowed
Conduct lead generating activities; request members to schedule a future meeting.	Allowed	Not Allowed
Request or accept a referral	Not Allowed	Not Allowed
Post an approved carrier sign-in sheet, labeled "Optional"	Allowed	Allowed
Collect or accept lead cards/business reply cards	Allowed	Allowed
Attach a business card to materials with a single staple or a piece of tape. * Note: at Educational Events, only educational materials may be distributed.	Allowed	Allowed *
Provide a business card if consumer requests one	Allowed	Allowed
Provide a business card to attendees, regardless if asked	Allowed	Allowed
Discuss specific carrier plans/products/benefits	Allowed	Not Allowed
Respond beyond a specific question a consumer asks	Allowed	Not Allowed
Provide educational materials on health care topics	Allowed	Allowed
Distribute plan materials	Allowed	Not Allowed
Distribute or collect enrollment Applications	Allowed	Not Allowed
Schedule a follow-up in-home or one-on-one appointment with a consumer.	Allowed	Not Allowed
Obtain compliant Permission to Contact that is not open-ended and is event-specific. BRCs allowed in common areas.	Allowed	Allowed
Collect a Scope of Appointment form for a future appointment	Allowed	Not Allowed

Part D Formulary

- Must be provided to all enrollees of plan.
- Must be provided to current enrollees of plan by October 15 of each year.
- Must also provide to new enrollees within ten (10) calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.
- Hard copy; made available electronically, as permitted; or electronically, if enrollee has opted into receiving electronic version as permitted.

Source: Medicare Communications and Marketing Guidelines (MCMG)

Star Ratings

Medicare Plan professionals have a role in helping MA and PDP companies improve star ratings.

Conversations with clients about the value gained from screenings, annual vaccines and colonoscopies, and how they contribute to their overall health are essential.

When members use these services, it contributes to the plan's Star Ratings. Then too, if not explained correctly, the beneficiary may not seek these services and have unexpected costs prompting complaints and calls to customer service, which can impact star ratings negatively.

Agent/Brokers play an important role.

Star Ratings Document

- Must be provided to all prospective enrollees when an enrollment form is provided. For online enrollment, Star Ratings document and SB must be made available electronically (e.g., via link) prior to the completion and submission of enrollment request.
- Must be provided prior to enrollment as a hard copy.
- All Plans/Part D sponsors must provide the Star Ratings document.
- New Plans/Part D sponsors that have no Star Ratings are not required to provide until the following contract year.
- Updated Star Ratings must be used within 21 calendar days of release of updated information on Medicare Plan Finder.
- Updated Star Ratings must not be used until CMS releases Star Ratings on Medicare Plan Finder.
- Only the Plan logo may be added to the document (no other changes or alterations are permitted).

Source: Medicare Communications and Marketing Guidelines (MCMG)

Explanation of Benefits

Explanation of Benefits – Part D	To Whom Required	Must be provided anytime an enrollee utilizes their prescription drug benefit.
	Timing	Sent at the end of month following the month when benefit was utilized.
	Method of Delivery	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in 100.2.2.
Explanation of Benefits – Part C	To Whom Required	Must be provided anytime an enrollee utilizes a Part C benefit.
	Timing	Plan may send monthly or per claim with a quarterly summary.
	Method of Delivery	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted.

Enrollment Mechanisms

Enrollment mechanisms must include the applicant's acknowledgement of the following:

- Understanding of the requirement to continue to keep Medicare Parts A and B
- Agreement to abide by the MA plan's membership rules, as outlined in member materials
- Consent to the disclosure and exchange of information necessary for the operation of the MA program
- Understanding that he/she can be enrolled in only one Medicare health plan and that enrollment in the MA plan automatically disenrolls him/her from any other Medicare health plan and prescription drug plan.
- Understanding of the right to appeal service and payment denials made by the organization
- Multi Language Options

https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

Enrollment Forms

- Upon request, all organizations/sponsors must make available a paper enrollment form or packet, in addition to any other acceptable enrollment mechanisms.

- To enroll, a beneficiary needs:
  - Medicare Card
  - Medicaid Card (when applicable)

- The Enrollment Packet/Form must include a number of items, such as:
  - Attestations
  - Acknowledgements
  - Conditions for Enrollment and Disenrollment

Membership ID Cards

Must be provided to all plan enrollees.

Must be provided to new enrollees within ten (10) calendars days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later. Must also be provided to all enrollees if information on existing card changes.

Must be provided in hard copy. In addition to the hard copy, plans may also provide a digital version (e.g., app).

Source: Medicare Communications and Marketing Guidelines (MCMG)

Enrollment

- The beneficiary is not required to provide any health information to complete the enrollment.
- If it is determined during the course of the enrollment that a beneficiary has Medicaid or is eligible for LIS, their eligibility status needs to be verified prior to submitting the enrollment.
- Usually, Plan Sponsors provide tools or a hotline for verifying LIS and Medicaid eligibility.
- Agents must review the enrollment form with the client in its entirety and ensure they agree to all the acknowledgments and disclaimers prior to submitting the enrollment.
- Following a Plan Sponsor’s provided CMS-approved presentation will usually cover all of the required items that must be reviewed during an enrollment, including the Summary of Benefits.
- For telesales agents, all the necessary items are usually covered by the enrollment script provided by their Lead Plan Sponsor.
- No enrollments may be submitted without the permission of the beneficiary.

Summary of Benefits

- Must be provided to all prospective enrollees when an enrollment form is provided.
- Must be available by October 15 of each year.
- Hardcopy or electronic, depending on the format of the enrollment mechanism.

Model Summary of Benefits Instructions

Plans must reflect Part C and Part D benefits and cost sharing in the SB. If there is no cost sharing, plans must notate no costs (e.g., $0 cost for day six (6) and beyond). If the benefit is not offered, then notate that it is not offered. Part C benefits and cost sharing must be in the following order:

- Monthly plan premium (Part C and D premium combined);
- Part B premium buy-down, if applicable;
- Deductibles, including plan level and category level deductible;
- Maximum Out-of-Pocket Responsibility (does not include prescription drugs);
- Inpatient Hospital coverage;
- Outpatient Hospital coverage;
- Ambulatory Surgical Center (ASC) Services;
- Doctor Visits (Primary Care Providers and Specialists);
- Preventive Care;
- Emergency Care;
- Urgently Needed Services;
- Diagnostic Services/Labs/Imaging (include diagnostic tests and procedures, labs, diagnostic radiology, and X-rays);
- Hearing Services (Include mandatory and optional supplemental benefits);

- Dental Services (Include mandatory and optional supplemental benefits);
- Vision Services (Include mandatory and optional supplemental benefits); and,
- Mental Health Services.

In addition to the benefits in §§ 422.2267(e)(5)(ii), plans should include the following five (5) benefits in the SB under Part C:

- Skilled Nursing Facility;
- Physical Therapy;
- Ambulance;
- Transportation; and
- Medicare Part B Drugs.

Part D benefits must include:

- Cost sharing for deductible, the initial coverage phase, coverage gap, and catastrophic coverage. Cost sharing must be broken down by the tier number/name (e.g., tier 1 generic).

When applicable, a notation that costs may differ based on pharmacy type or status (e.g., preferred/non-preferred, mail order, long-term care (LTC), and 30- or 90-day supply).

To avoid beneficiary confusion when comparing plans, plans must maintain the above order of the data elements. The monthly premium, deductible and the maximum out-of-pocket cost must always be displayed first. Plans may then decide whether to display drug or health benefits next.

If any of the benefits are not offered (e.g., transportation), indicate them as “not covered.” Plans may remove certain benefits if they are not applicable to a particular plan type (e.g., Part D only plan removes Part C benefits).

Additional benefits may be listed after all the required elements are provided in the SB. They may be listed after Part C or after Part C and D benefits.

Plans may list supplemental benefits for the chronically ill (SSBCI) in addition to Part C benefits and Part D.

When adding Value Added Items and Services (VAIS) in the SB:

- They should be placed in a separate section, distinguishable from the benefits;
- Services/items should not be called benefits as they are not part of the Medicare plan benefit package; and,
- Plans should provide language in the SB to make it clear that these additional services/items are not part of the plan benefit package or the Medicare benefit.

Please refer to Medicare Managed Care Manual, Chapter 4, Section 80 for additional information on VAIS.

Other required information in the SB:

- The document must be labeled as “Summary of Benefits” noting the plan year;
- The plan name and type must be clearly labeled for all Plans in the SB. For example, <Plan name, HMO or PPO, SNP, MSA, etc.>;
- Service area and eligibility requirements, including the Medicaid eligibility criteria applicable to Dual Eligible Special Needs Plans (D-SNPs);
- Phone number, including TTY/TDD;
- Days and hours of operation;
- Website address;

- In-network and out-of-network cost-sharing information for applicable plan types;
- Applicable disclaimers;
- Language stating that the complete list of services is found in the Evidence of Coverage (EOC), as well as language directing readers how to access or order the EOC;
- Language that directs readers how to access or order the "Medicare & You" handbook;
- If the SB includes plans with and without Part D prescription drug coverage, the distinction between plans must be clear;
- Notate services that require a physician referral or prior authorization; and
- If offering optional supplemental benefits, plans must include the additional premium amount.

D-SNPs

We encourage FIDE SNPs to work with their contracted State Medicaid agencies in developing an SB that displays integrated benefits.

Medicare Premium and Deductible:

Plans that use Medicare premium, deductible, or cost sharing amounts (e.g., inpatient hospital) must insert the current year's Medicare amounts. In addition, the category must also note that these amounts may change for the following year and the plan will provide updated rates at [insert website] as soon as Medicare releases them.

Overall design and layout:

Plans may present multiple plan benefit packages (PBPs) in the same document by displaying the benefits in separate columns. Plans using this option may include similar or different plan types (e.g., HMO to HMO, or HMO to PFFS, or HMO to PPO). Plans may also:

- Make use of colors to enhance the ability to navigate the document, or
- Incorporate various icons/graphics to help locate important information, such as how to complete an application online or contact customer service (e.g., phone number).

Note: SNPs must remain separate from non-SNP plans to avoid confusion for beneficiaries.

Recommendations:

The following recommendations are based on consumer testing:

- Avoid the use of multiple folds and large charts as it may make it cumbersome and difficult to use;
- Include definitions and purpose of the document;
- Avoid using dimensions that are too large as it could diminish the usefulness of the SB; and,
- Avoid the use of footnotes. If necessary to include footnoted information, visually emphasize (e.g., larger or bold font) the inclusion of superscripts in coverage charts.

HPMS Submission Process:

The SB is a File & Use document, and therefore must be submitted in HPMS under “CMS Required” as one document.

Post Enrollment

- After the enrollment is submitted the beneficiary must be provided with details on what to expect next.
  - When they will receive their welcome package
  - Outbound Enrollment Verification
  - Plan Sponsor information
  - Agent contact information

- All Enrollment information including Medicaid and LIS status must be confirmed and the plan approved by CMS prior to the policy being issued.

Outbound Enrollment Verification

- Must be provided for all agent/broker assisted enrollments
- Must be conducted within 15 calendar days following the receipt of the enrollment request.
- Hard copy, telephonic, email.
- Communication must address enrollment into Part C or Part D Plan and provide customer service number for beneficiary questions regarding costs, benefits, rules, or any other question about the Part C/Part D Plan.
- May be completed via phone call (including during welcome call) or via email, if email is requested by an enrollee.
- Must send a written communication if the Plan/Part D sponsor fails to speak with the individual within 15 calendar days of enrollment requests.
- Agent/brokers are not permitted to be part of the enrollment verification call.
- Enrollment verification processes must stop if Plan/Part D sponsor is notified that beneficiary is ineligible to enroll in plan or if beneficiary has canceled the enrollment.
- Method and timing of the enrollment verification must be documented (date, time, and method of contact).

Source: Medicare Communications and Marketing Guidelines (MCMG)

Low Income Premium Subsidy Notice

Must be provided to potential enrollees of what their plan premium will be once they are eligible for Extra Help and receive the low-income subsidy.

Must be provided prior to effective date of enrollment.

Low Income Subsidy (LIS) Rider Notice

Must be provided to all current enrollees who qualify for Extra Help. Enrollees will get a LIS rider from the Plan telling them how much help they will receive in the benefit year toward their Part D premium, deductible, and copayments.

Must be provided at least once per year by September 30.

Must be sent to enrollees who qualify for Extra Help or have a change in LIS levels within 30 days of receiving notification from CMS.

Member Cards and Additional Notices

- Membership ID cards are provided within 10 calendar days of the receipt of CMS confirmation of enrollment.
- A hard copy must be provided by the Plan Sponsor however, they may also make electronic copies available.
- There are a number of notices that could be received by the beneficiary after their enrollment and during the plan year such as:
  - Non-Renewal Notice
  - Part D Transition Letter
  - Prescription Transfer Letter
  - Termination Notices

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c17d.pdf

Mid-Year Change Notification to Enrollees

- Must be provided to all applicable enrollees when there is a mid-year change in benefits, plan rules, formulary, provider network, or pharmacy network.
- Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted.
- Notices of changes in plan rules unless otherwise addressed in a regulation must be provided 30 days in advance.
- For changes in provider network and/or pharmacy network, see 42 CFR 422.111 and 422.128.
- National Coverage Determination (NCD) changes announced or finalized less than 30 days before effective date, notification required as soon as possible.
- Mid-year NCD or legislative changes must publish no later than 30 days after the NCD is announced. Plans may include change in next plan mass mailing (e.g., newsletter), provided it is within 30 days and must be reflected on Plan/Part D website.
- Plan/Part D sponsor developed letter/communication. Required elements must be included in letter/communication.

Non-Renewal Notices

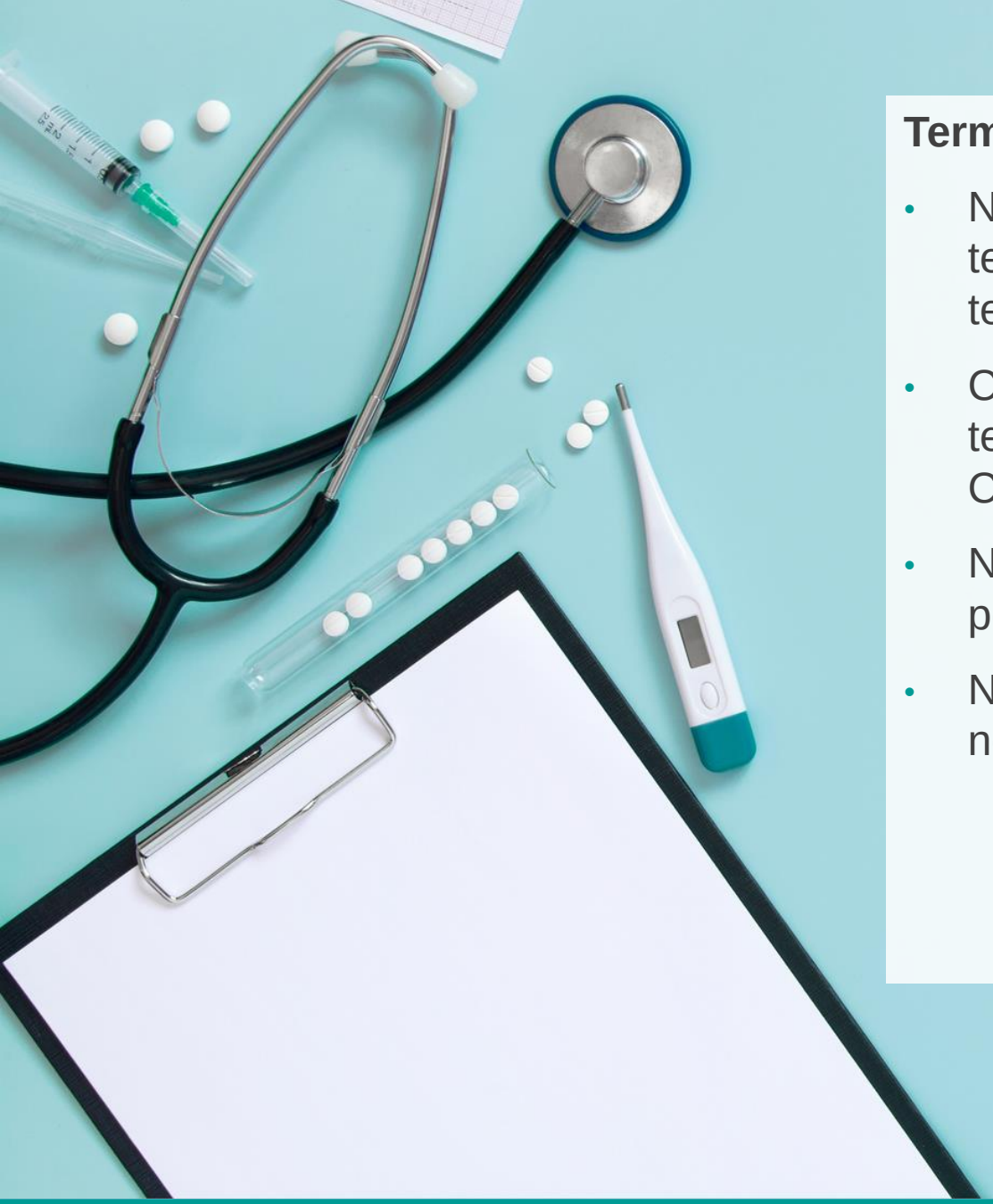
- Must be provided to each affected enrollee after the Plan/Part D sponsor decides to non-renew or reduce their plan's service area.
- At least 90 days before the end of the current contract period. Cost Plans (without Part D) provide notice at least 60 days before the end of the current contract period.
- Notices must be hard copy and sent via U.S. mail. First class postage is recommended.
- Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until notice is received from CMS.
- Medicare Advantage Organizations (MAOs) may elect to share Non-Renewal and Service Area Reduction (NR/SAR) information only with first tier, downstream, and related entities (FDRs) or anyone that the MAO does business with (i.e., contracted providers).
- Additional NR/SAR notice information can be found in the annual "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models" HPMS memo.

Part D Transition Letter

- Must be provided when a beneficiary receives a transition fill for a non- formulary drug.
- Must be sent within three (3) days of adjudication of temporary transition fill.

Prescription Transfer Letter

When a Part D sponsor requests permission from an enrollee to fill a prescription at a different network pharmacy than the one currently being used by enrollee.



Termination Notices

- Notice must be provided to affected enrollees before the termination effective date or the end of services for provider terminations.
- CMS and MAO initiated terminations and provider terminations require enrollee notices be sent as specified in CFR Title 42.
- Notices must be hard copy and sent via U.S. mail. First class postage is recommended.
- Notice to the general public requires publishing in one or more newspapers of general circulation.

Voluntary Disenrollment

- When a beneficiary makes a choice to change plans during voluntary enrollment or SEP, that is considered a Voluntary Disenrollment.
- The current plan must be disenrolled before the new plan can take effect.
- Examples of Voluntary Disenrollment Include
  - AEP
  - OEP
  - Certain SEPs

Involuntary Disenrollment

- Involuntary Disenrollment is due to an SEP being triggered for various reasons including, but not limited to:
  - Moving to a new zip code
  - Loss of LIS or Medicaid Status
  - A Plan Sponsor discontinuing a plan
  - A Plan Sponsor voluntarily or involuntarily ceasing participation in the federal Medicare program.

- A notice will be sent to the beneficiary of involuntary disenrollment by the plan sponsor

Required Involuntary Disenrollment

The MA organization **must** disenroll a member from an MA plan in the following cases. Refer to §50.6 for some exceptions to required disenrollment for grandfathered members.

1. A change in residence (includes incarceration –see below) makes the individual ineligible to remain enrolled in the plan (§50.2.1);
2. The member loses entitlement to either Medicare Part A or Part B (§50.2.2.);
3. The SNP enrollee loses special needs status and does not reestablish SNP eligibility prior to the expiration of the period of deemed continued eligibility (§20.11).
4. The member dies (§50.2.3); or
5. The MA organization contract is terminated, or the MA organization reduces its service area to exclude the member. There is an exception to this rule, which is described in §50.2.4.

Incarceration – A member who is incarcerated is considered to be residing outside the plan's service area, even if the correctional facility is located within the plan's service area. However, plans must disregard past periods of incarceration that have been served to completion if those periods have not already been addressed by a plan or by CMS (see §50.2.1.3).

https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

Involuntary Disenrollment Notice Requirements

In situations where the MA organization disenrolls the member involuntarily on any basis except death or loss of entitlement, notices of the upcoming disenrollment meeting the following requirements must be sent. All disenrollment notices must:

1. Advise the member that the MA organization is planning to disenroll the member and why such action is occurring;
2. Be mailed to the member before submission of the disenrollment transaction to CMS; and
3. Include an explanation of the member's right to a hearing under the MA organization's grievance procedures. (This explanation is not required if the disenrollment is a result of the MA plan termination or service area or continuation area reduction, since a hearing would not be appropriate for that type of disenrollment. There are different notice requirements for terminations and service area reductions, which are provided in separate instructions to MA organization

https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

Effective Date of Coverage

The effective date of coverage for MA/MAPD/PDP plans varies by election period such as:

- **IEP** - First day of the month of entitlement to Medicare Part A and Part B or the first of the month following the month the enrollment request was made, if after entitlement has begun
- **SEP** - Varies
- **OEP** - First day of the month after the month the MA organization receives an enrollment request
- **AEP** - January 1 of the following year

Effective Date of Coverage

- With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their enrollment effective date. Furthermore, except for EGHP enrollment requests, the effective date is generally not prior to the receipt of an enrollment request by the MA organization.
- An enrollment cannot be effective prior to the date the beneficiary or his/her legal representative signed the enrollment form or submitted the enrollment request. §40.2 includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined in this section.
- To determine the proper effective date, the MA organization must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the enrollment request is received by the MA organization.
- Once the election period is identified by the MA organization, the MA organization must determine the effective date. Refer to §60.8 to determine the effective date for a continuation of enrollment. In addition, EGHP enrollments may be retroactive (refer to §60.6 for more information on EGHP retroactive effective dates)

Model and Short Enrollment Form

These are special versions of enrollment forms for making specific types of plan changes with the parent organization/plan sponsor

Model Enrollment Form

Switch from Plan to Plan within a parent organization/Plan Sponsor

Short Enrollment Form

These forms may be used in place of the model individual enrollment form when a member of a MA plan is enrolling into another MA plan offered by the same parent organization. This form is not applicable to MSA.

https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf

Open Enrollment Period

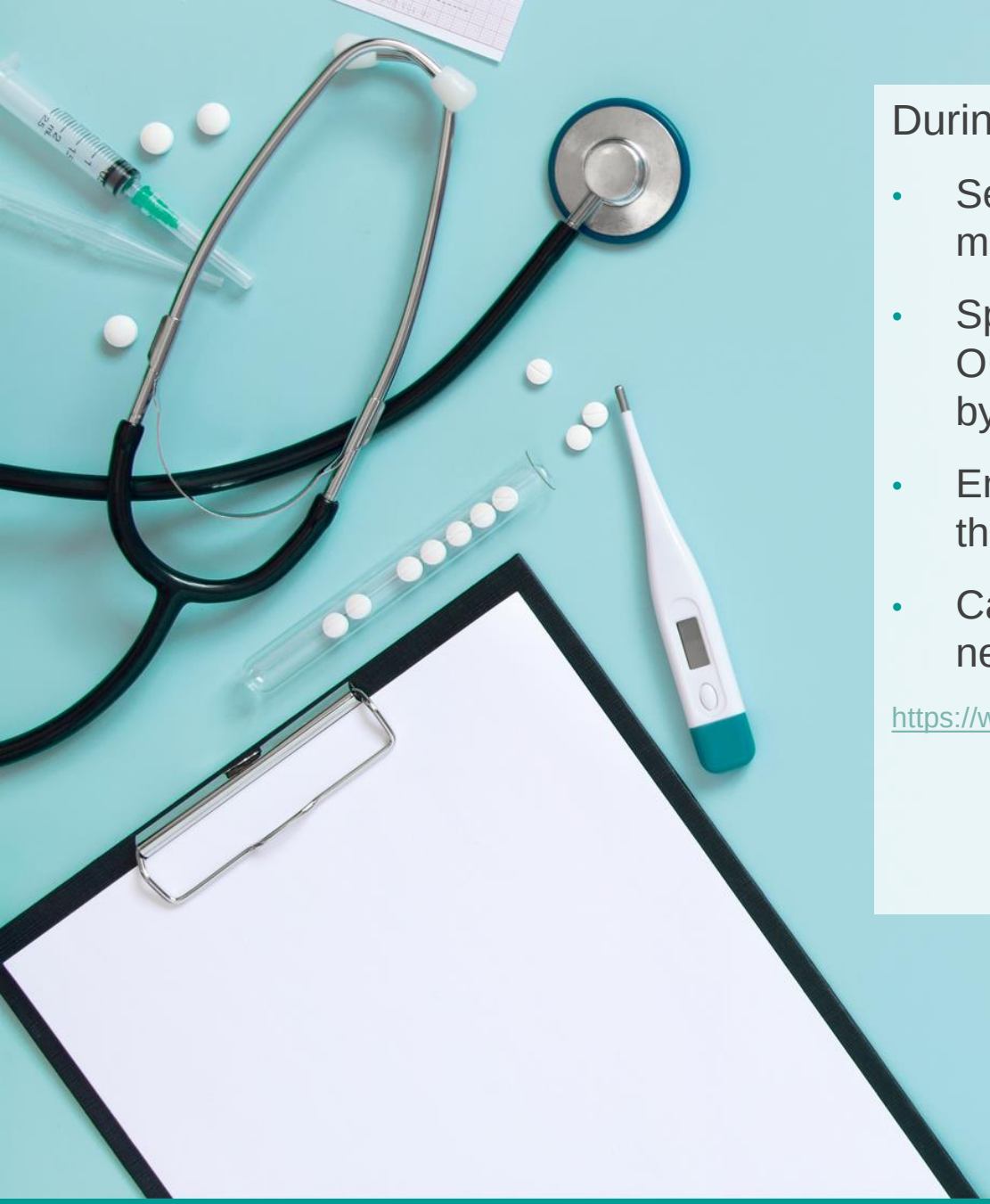
- The Medicare Advantage Open Enrollment Period (MA OEP), implemented January 1, 2024, is from January 1st to March 31st
- The reinstatement of the Open Enrollment Period (OEP) is not an opportunity for agents or carriers to solicit new clients.
- The period is purely intended for clients who wish to make a change based on what they chose to do during the AEP.
- Agents and Plan Sponsors cannot market to potential or existing clients specifically targeting the MA OEP.
  - Here is a list of approved OEP marketing activities
  - Here is a list of more prohibited OEP activities

During the MA OEP, Agents and Plan sponsors may:

- Conduct marketing activities that focus on other enrollment periods, including but not limited to:
  - Age-ins (who have not yet made an enrollment decision),
  - 5-star plans regarding their continuous enrollment SEP, and
  - Dual-eligible and LIS beneficiaries who, in general, may make changes once per calendar quarter during the first nine months of the year.
- Send marketing materials when a beneficiary makes a proactive request;
  - At the beneficiary's request, have one-on-one meetings with a sales agent; and
  - At the beneficiary's request, receive information on the OEP through the call center.

Note: The unintentional receipt of other marketing materials by beneficiaries who have already made an enrollment decision is not considered knowingly targeting. For example, if a Plan sends mailers to a list of age-ins discussing the Initial Coverage Election Period (ICEP), it is possible that some recipients may have already made an enrollment decision; however, the content of the message to the intended audience of age-ins is not prohibited OEP marketing.

https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf



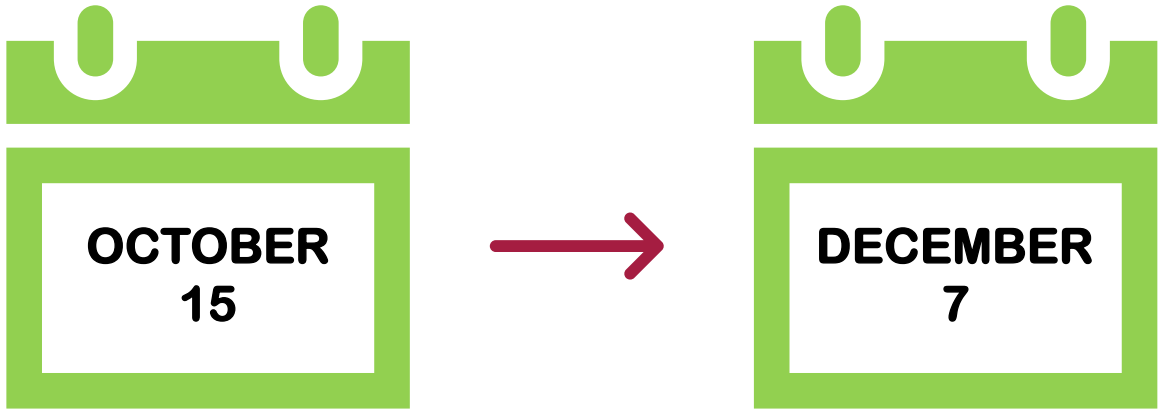
During the MA OEP, Plans/Part D sponsors may not:

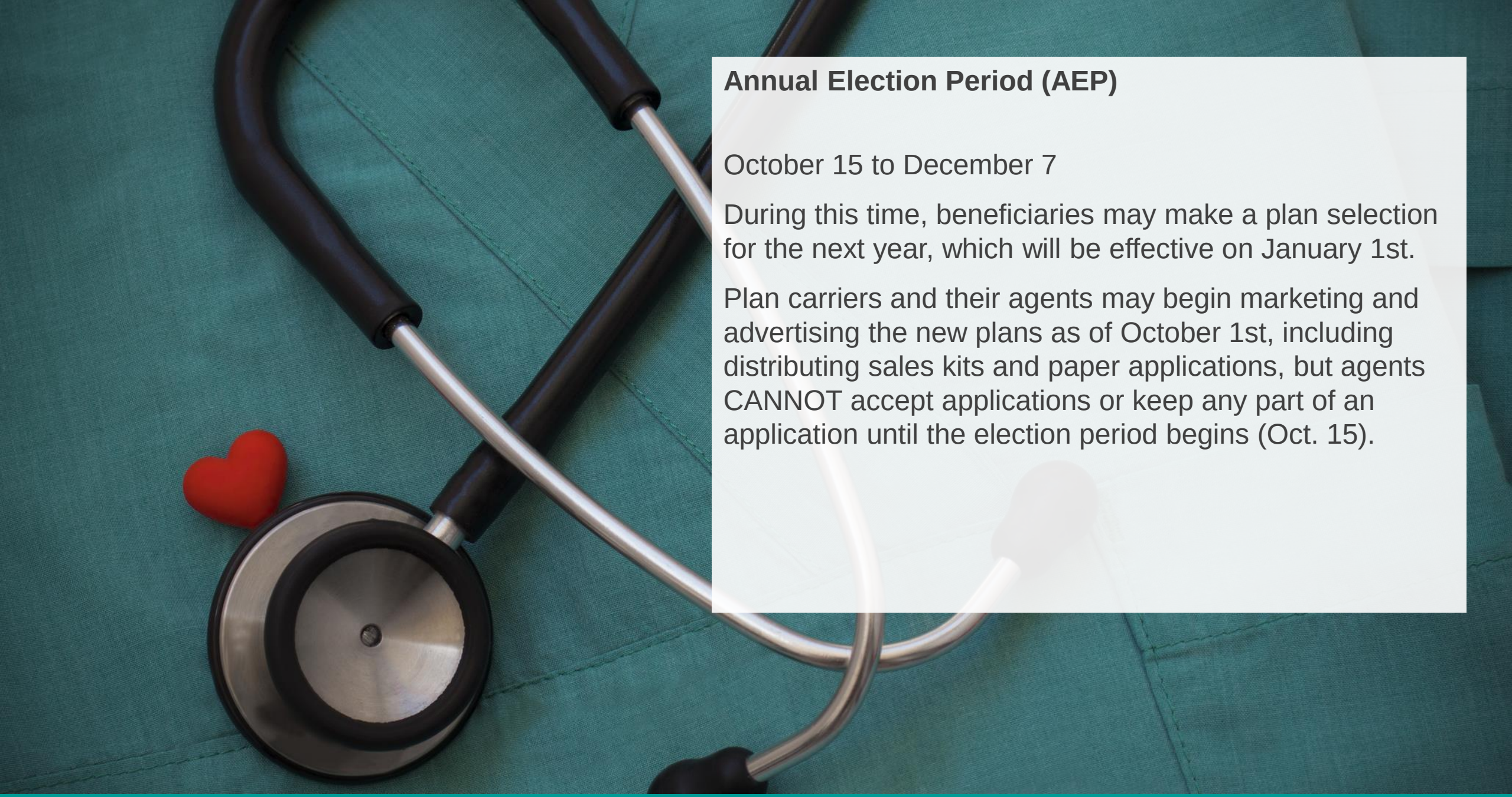
- Send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the MA OEP;
- Specifically reference the MA OEP to beneficiaries, during the MA OEP, who made a choice during Annual Enrollment Period (AEP) by purchase of mailing lists or other means of identification;
- Engage in or promote agent/broker activities that intend to target the OEP as an opportunity to make further sales; or
- Call or otherwise contact former enrollees who have selected a new plan during the AEP.

https://www.cms.gov/files/document/medicare-communications-marketing-guidelines-2-9-2022.pdf

Annual Enrollment Period

- The period lasts from Oct 15 to Dec 7 each year.
- During this period beneficiaries may change MA, MAPD, and PDP plans to any plan of their choice available in their area.
- In general, agents are free to market during this period as long as they are using approved and compliant methods; however, there are restrictions.
- Here are some guidelines for marketing activity during AEP.





Annual Election Period (AEP)

October 15 to December 7

During this time, beneficiaries may make a plan selection for the next year, which will be effective on January 1st.

Plan carriers and their agents may begin marketing and advertising the new plans as of October 1st, including distributing sales kits and paper applications, but agents CANNOT accept applications or keep any part of an application until the election period begins (Oct. 15).

Initial Enrollment and Other SEP Marketing

There are additional enrollment periods such as:

- The Initial Enrollment Period for those newly eligible for Medicare
- There are also Special Enrollment Periods that are triggered when someone has a life event, meets certain requirements or events out of their control cause them to lose coverage.
- Here is a list of SEP scenarios.
- All compliant marketing activities are allowed for these periods.
- Agents need to be sure to get a scope of appointment and have proper permission to contact prior to enrolling individuals during these marketing periods.

Eligibility for ISNP Plans

There are a number of other SEPs available in specific circumstances:

- *If you joined a Medicare Advantage plan during your initial enrollment period when you turned 65, your first year in the plan* counts as a trial period. You can change to Original Medicare at any time within these 12 months. And you have a guaranteed right to buy medigap supplemental insurance within 63 days of your plan coverage ending.
- *If you gave up a medigap policy to join a Medicare Advantage plan*, and this is your first year ever in such a plan, the first 12 months also counts as a trial period. Within that timeframe you can switch back to Original Medicare and get your Medigap policy back.
- *If you are receiving Extra Help to pay for your prescription drugs*, you can change your drug plan once per quarter in the first 3 quarters of each year. Coverage in the new plan begins the month after you enroll in it.
- *If you live in a nursing home*, you can change your drug plan the month you move into the home and any month while you're living there. You also get a two-month SEP to switch to another plan after you move out.
- *If you have access to a Medicare Advantage or Part D drug plan that has earned Medicare's top quality rating of five stars*, you can switch to that plan at any time of the year.
- *If you move out of your plan's service area*, you have the right to change to a new plan in your new area. (But if you're in a drug plan that serves an entire state, and you move within that state, your coverage will continue and you won't be entitled to an SEP.)
- *If your plan withdraws from your service area, leaves Medicare or is closed down*, you will receive a letter explaining how long your coverage will last and when you can switch to a different plan of your choice.
- *If you were tricked or misled into joining a Medicare Advantage plan*, you can ask Medicare to investigate and grant you a SEP to change to another plan.
- *If your plan breaks its contract with you* — for example, by denying promised benefits — you can ask Medicare to investigate and grant you a SEP to change to another plan.
- There are also SEPS for disasters that can be declared by FEMA. Examples may include, wildfires, floods, hurricanes, etc. These are event specific and generally short in duration.

Open Enrollment Period for Institutionalized Individuals (OEPI)

- The OEPI allows eligible individuals continuous and unlimited enrollments into MA plans.
  - Eligible is defined as an institutionalized individual who moves into, resides in, or moves out of an institution.
  - Individuals who qualify for a MA SNP for institutionalized individuals (I-SNP) can also use the OEPI.
- MA plan companies are not required to accept OEPI requests to enroll, but if the company has a plan open for enrollment, it must accept all OEPI requests to enroll.
- The OEPI has continuous enrollment thus original Medicare is also open continuously. Therefore, MA organizations must accept OEPI requests to disenroll from their MA plans whether or not their MA plan is open to accept enrollment.
- When an individual moves out of the institution the OEPI is available for two months after the month the individual left the institution.

For I-SNP plans the ability to enroll will be based on verification that the member, for 90 days or longer, has had or is expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility. A member's ability to enroll can also be based on verification that their condition makes it likely that either the length of stay or the need for an institutional level of care would be at least 90 days.

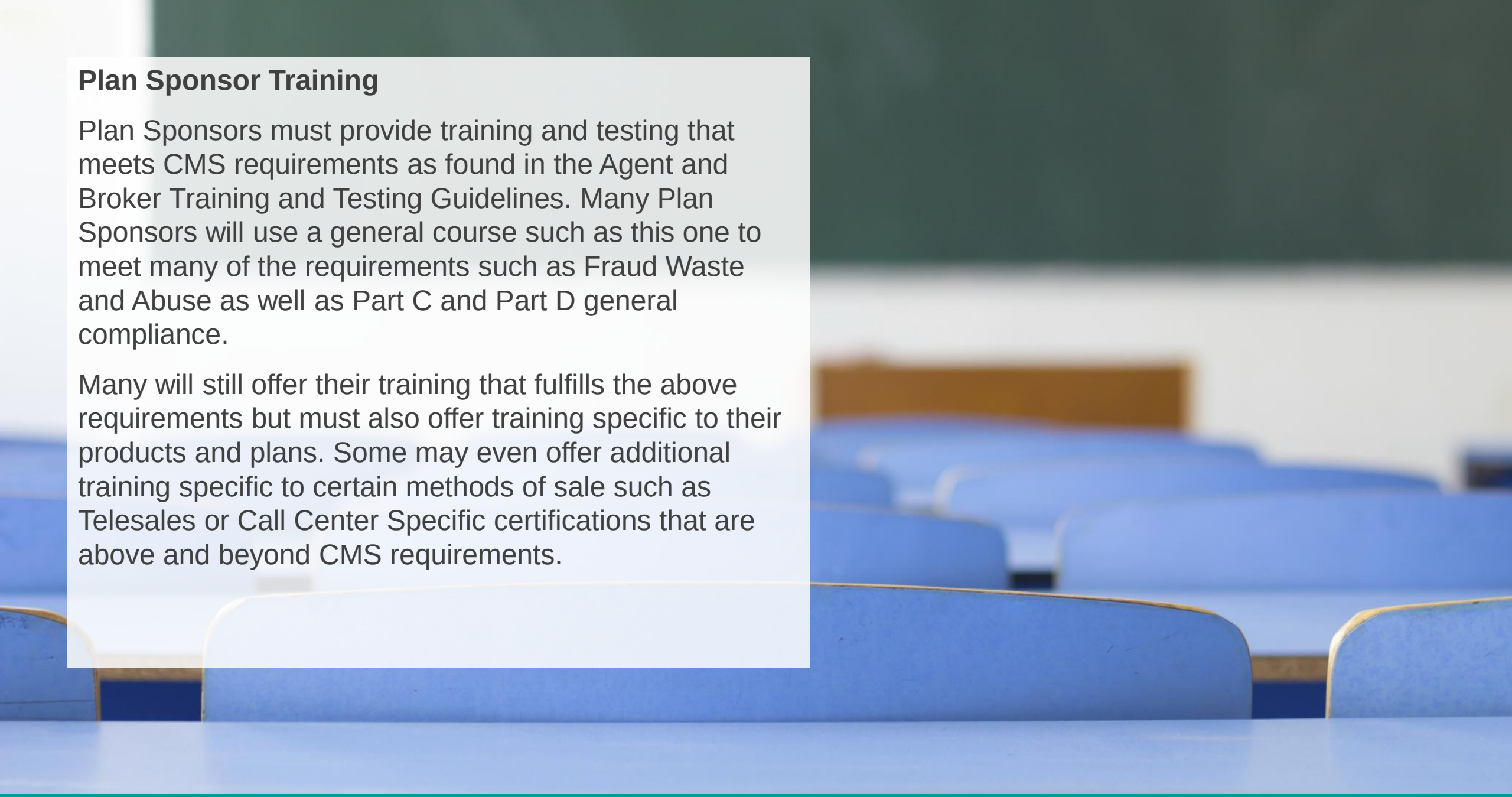
Nominal Gifts

- These are small gifts not in excess of $15.00 per person (up to $75 annual aggregate) that may be offered to potential enrollees. If offered, the potential enrollee cannot have the gift rescinded if they do not enroll in the plan.
- Nominal gifts cannot be in the form of cash or other monetary rebate, like a gift card.
- Nominal gifts cannot be used to provide a meal or collection of smaller items that could be perceived as a meal.
- Nominal gifts are based on the retail purchase price of the item.
- Nominal gifts can be combined (monetarily) for a larger gift but the total value of the larger gift cannot exceed more than $15.00 per attendee at an event. For example, if an agent rents a particular venue and the total cost is $150.00, the agent would have to have a minimum of 10 attendees.

https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm

Agent Requirements

- There are a number of rules that must be followed by agents when engaging in Broker Activities involving Medicare Advantage, Part D and Cost Plans.
- Marketing activities can be broken into two categories:
  - Permitted Activities
  - Restricted Activities
- There are also Certification and Training Requirements such as:
  - Plan Sponsor Training
  - Medicare General Certification



Plan Sponsor Training

Plan Sponsors must provide training and testing that meets CMS requirements as found in the Agent and Broker Training and Testing Guidelines. Many Plan Sponsors will use a general course such as this one to meet many of the requirements such as Fraud Waste and Abuse as well as Part C and Part D general compliance.

Many will still offer their training that fulfills the above requirements but must also offer training specific to their products and plans. Some may even offer additional training specific to certain methods of sale such as Telesales or Call Center Specific certifications that are above and beyond CMS requirements.

§422.2274, §423.2274 Broker and agent requirements.

(c) Annual training. The MA organization/Part D sponsor must ensure that all agents and brokers selling Medicare products are trained annually on the following:

(1) Medicare rules and regulations.

(2) Details specific to the plan products they intend to sell.

(d) Annual testing. The MA organization/Part D sponsor must ensure that all agents and brokers selling Medicare products are tested annually, to ensure the following:

(1) Appropriate knowledge and understanding of Medicare rules and regulations.

(2) Details specific to the plan products they intend to sell.

Plan Sponsor Oversight and Corrective Actions

- Plan Sponsors are responsible for enforcing CMS Marketing Guidelines.
- Additionally, carriers can establish their own guidelines that may even go above and beyond what is required by CMS to regulate agent behavior.
- When agents are found to be in violation of the guidelines, plan sponsors institute various levels of corrective action including, but not limited to:
  - Corrective Action Plans
  - Additional Training and Certification
  - Termination of the agent's appointment

Corrective Action Plans

A corrective action plan (CAP) is a step by step plan of action that is developed to achieve targeted outcomes for resolution of identified errors to correct errors and non-compliant behavior. These are generally issued by a plan sponsor to an agent when they have been found at fault of a minor or serious violation and should be considered more severe than standard coaching.

Plan Sponsor Oversight and Corrective Actions (Cont'd)

- Depending on the seriousness of the violation, the plan sponsors may not have a choice other than termination.
- Most violations result from client complaints to plan sponsors.
- Some complaints are made directly to CMS. These are referred to the Medicare Complaints Tracking Module (CTM) and are generally considered more severe than other complaints because they reflect more heavily on the plan sponsor, although, all complaints are reported to CMS by plan sponsors.

Plan Sponsor Oversight Responsibility and Agent Compensation

- Plan Sponsors for MA and Part D are required to ensure certain behaviors and activities by agents.
- Which include but are not limited to :
  - Enforcing CMS guidelines
  - Approving Marketing Materials
  - Applying corrective action to agents who violate CMS guidelines.
- Compensation requirements, unless otherwise noted, only apply to independent agent/brokers.

Behaviors and Activities

Plans/Part D sponsors must oversee all downstream entities (including agents/brokers) to ensure those entities abide by all applicable state and federal laws, regulations, and requirements. CMS requires Plans/Part D sponsors to:

- Ensure agents/brokers are properly licensed and appointed, per individual state requirements;
- Report to the state (in those states where agents must be appointed) the termination of an agent/broker, including the reason for termination if state law requires;
- Report to CMS Account Managers all enrollments made by unlicensed agent(s) and report for-cause terminations of an agent/broker to CMS.
- Provide training and testing that meets CMS' requirements as found in the Agent and Broker Training and Testing Guidelines;
- Report annually to CMS whether the Plan/Part D sponsor intends to use employed, captive, or independent agents or brokers in upcoming plan year and, if applicable, the specific amount or range of amounts the Plan/Part D sponsor intends to pay the agents/brokers;
- Submit agent/broker marketing materials to CMS through HPMS prior to use;
- Ensure agents do not charge beneficiaries a marketing fee; and
- Ensure agents complete SOAs as required

Plan Sponsor Oversight Responsibility and Agent Compensation (Cont’d)

Compensation Guidelines

Compensation requirements only apply to independent agent/brokers. Plans/Part D sponsors must ensure the following requirements are met in order to pay compensation:

- Plans/Part D sponsors may only pay agents/brokers who meet state licensure/appointment requirements.
- Agents/brokers who represent the Plan/Part D sponsor must be trained and tested to receive compensation; representation includes:
    - Selling products;
    - Outreach to existing or potential beneficiaries; and
    - Answering or having the capability and authority to answer questions from existing or potential beneficiaries.
- Unless otherwise noted, compensation is governed by terms of the contract between the Plan/Part D sponsor and the agent/broker and must comply with regulations at 42 CFR 422.2274 and 423.2274.
- A contract, including re-negotiating of any contract, is an issue between the Plan/Part D sponsor and the agent/broker.
- Plans/Part D sponsors may pay initial compensation at or below the fair market value (FMV) as published annually by CMS.
- For each enrollment in Year 2 and beyond, Plans/Part D sponsors may pay renewal compensation at an amount that is up to fifty (50) percent of the current FMV a published annually by CMS. Plans/Part D sponsors may pay Renewal Compensation:
    - In any year following the initial year compensation.
    - When a beneficiary enrolls in a new “like plan” within the same Parent Organization or between two (2) different Parent Organizations; or
    - When a beneficiary who is a member of an MMP switches to an MA plan with a PDP or an MA-PD plan (and vice versa), if applicable per state MMP policy.

Other Compensation Scenarios

- For MA-PD enrollees, Plans/Part D sponsors may pay only the MA compensation.

- When a beneficiary enrolls in both a Section 1876 Cost Plan and a stand-alone PDP, the Cost Plan must pay compensation for the Cost Plan enrollment and the Part D sponsor must pay compensation for the Part D enrollment.
- For enrollees in an MA-only plan and a standalone PDP, each plan should pay compensation only for enrollment in that particular plan; i.e., the MA-only plan pays compensation only for the MA-only enrollment, and the PDP pays compensation only for the PDP enrollment.
- *A "like plan type" enrollment includes:*
    - A PDP to another PDP;
    - An MA, MA-PD, or MMP to another MA, MA-PD, or MMP; or
    - A Section 1876 Cost Plan to another Section 1876 Cost Plan.
- *An "unlike plan type" enrollment includes:*
    - An MA or MA-PD plan to a PDP or Section 1876 Cost Plan;
    - A PDP to a Section 1876 Cost Plan or an MA (or MA-PD) plan; or
    - A Section 1876 Cost Plan to an MA (or MA-PD) plan or PDP.

Plan Sponsor Oversight Responsibility and Agent Compensation (Cont'd)

- Compensation includes monetary or non-monetary remuneration relating to the sale or renewal of a policy including, but not limited to:
  - Commissions
  - Bonuses
  - Gifts/prizes
  - Awards
  - Referral/finder's fees.

- Compensation can be paid if plans are sold following the correct guidelines, and they can also be charged back for plans disenrolled prematurely.

Compensation Recovery Requirements (Chargebacks)

Plans/Part D sponsors must recover compensation when:

- A beneficiary disenrolls from a plan within the first three (3) months of enrollment (rapid disenrollment); or
- Any other time a beneficiary is not enrolled in a plan, but the Plan/Part D sponsor paid compensation for that time period. CMS expects Plans/Part D sponsors to retroactively pay or recoup funds based on retroactive beneficiary changes for the current and previous calendar years. Plans/Part D sponsors may choose to recoup or pay compensation for years before the previous calendar year. However, if a Plan/Part D sponsor chooses to recoup payments from a prior calendar year, it must also pay funds retroactively that would have been due during that same year.

https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare_Communications_and_Marketing_Guidelines_Update_Memo_-_8-6-19.pdf

Agent Compensation

- Compensation DOES NOT include:
  - The payment of fees to comply with state appointment laws
  - Costs associated with training/testing
  - Certification costs
  - Reimbursement for actual costs (e.g., mileage to and from appointments with beneficiaries, venue rent, snack, materials).

- Compensation and how it is paid can be broken into a few categories:
  - Initial Compensation
  - Renewal Compensation
  - Referral/Finders Fees
  - Other Compensation Scenarios

Initial Compensation

42 CFR §§ 422.2274(d)(2), 423.2274(d)(2)

Plans/Part D sponsors may pay initial compensation at or below the fair market value (FMV) as published annually by CMS.

Renewal Compensation

42 CFR §§ 422.2274(d)(3), 423.2274(d)(3)

For each enrollment in Year 2 and beyond, Plans/Part D sponsors may pay renewal compensation at an amount that is up to fifty (50) percent of the current FMV a published annually by CMS.

Referral/Finder's Fees

42 CFR §§ 422.2274(f), 423.2274(f)

Payments may be made to individuals for the referral (including a recommendation, provision, or other means of referring beneficiaries), recommendation, provision, or other means of referring beneficiaries to an agent, broker or other entity for potential enrollment into a plan. The payment may not exceed $100 for a referral into an MA or MA-PD plan and $25 for a referral into a PDP plan.

Other Compensation Scenarios
42 CFR §§ 422.2274, 423.2274

For MA-PD enrollees, Plans/Part D sponsors may pay only the MA compensation.

- When a beneficiary enrolls in both a Section 1876 Cost Plan and a stand-alone PDP, the Cost Plan must pay compensation for the Cost Plan enrollment and the Part D sponsor must pay compensation for the Part D enrollment.
- For enrollees in an MA only plan and a PDP plan, compensation for both the MA plan and the PDP plan is paid.

A "like plan type" enrollment includes:

- A PDP to another PDP;
- An MA, MA-PD, or MMP to another MA, MA-PD, or MMP; or
- A Section 1876 Cost Plan to another Section 1876 Cost Plan.

An "unlike plan type" enrollment includes:

- An MA or MA-PD plan to a PDP or Section 1876 Cost Plan;
- A PDP to a Section 1876 Cost Plan or an MA (or MA-PD) plan; or
- A Section 1876 Cost Plan to an MA (or MA-PD) plan or PDP.

Note: For enrollees who change from two plans (e.g., MA and a stand-alone PDP) (dual enrollments) to one plan (MA-PD), compensation is at the renewal rate for the MA-PD product.

Agent Compensation (Cont'd)

- On top of paying compensation, plan sponsors can charge back compensation under certain conditions such as:
  - Rapid Disenrollment
  - Change of Member eligibility

- Payments other than Compensation
  - Payments made to third parties for actual costs must not exceed fair market value (FMV) or an amount that is commensurate with the amounts paid to a third party for similar services during each of the previous two (2) years. Administrative payments to third parties can be based on enrollment, provided payments are FMV.

Rapid Disenrollment

Rapid disenrollment applies when an enrollee makes any plan change (regardless of Parent Organization) within the first three (3) months of enrollment. Additionally, rapid disenrollment compensation recovery applies when a beneficiary uses OEP to make an enrollment change. Rapid disenrollment compensation recovery does not apply when a beneficiary enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1. Exceptions to the requirement for a Plan/Part D sponsor to recover compensation because of a rapid disenrollment may be granted when CMS determines that recoupment is not in the best interests of the Medicare program. CMS has made that determination for changes in enrollment made for the following reasons:

- Other creditable coverage (e.g., employer plan);
- Moving into or out of an institution;
- Gains/drops employer/union sponsored coverage;
- Plan termination, non-renewal, or CMS imposed sanction;
- To coordinate with Part D enrollment periods or State Pharmaceutical Assistance Program;
- Becoming LIS or dual (Medicare and Medicaid) eligible;
- Dual eligible beneficiaries moving from an MA-PD to MMP;
- Qualifying for another plan based on special needs;
- Due to an auto, facilitated, or passive enrollment;
- Death;
- Moves out of the service area;
- Non-payment of premium;
- Loss of entitlement or retroactive notice of entitlement; and
- Moving to a 5-star plan or from an LPI plan into a plan with three or more stars.

Agent Compensation (Cont’d)

- Compensation year is Jan. 1 through Dec. 31, regardless of beneficiary enrollee date.
- Initial members (New to MAPD/PDP) are paid either a pro-rated amount or the full compensation.
- Payment must be pro-rated for mid-year enrollments

Agent Compensation (Cont’d)

- Compensation is forfeited under certain scenarios such as writing without being licensed or properly appointed.
- Additionally, being terminated by a plan sponsor usually results in the forfeiture of future compensation in the form of renewals.
- If agents neglect to recertify year to year, they may also forfeit future renewals.
- Some plan sponsors may have the option for agents to enter into what is called a Servicing Status.
- Usually, a Servicing agent is still required to complete some form of certification, but it is usually substantially less involved than requirements for an active writing agent.

Proceed to the Next Module