Sales and Marketing Policies for Agents and Brokers Appointed with CareOregon Advantage

POLICY AND PROCEDURES

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Procedure Number: **Sales138-001**	**Title: Sales Policies**
Department: Medicare Sales	**Unit: Sales**
Author: Stefanie Cao	**Approved by: Stefanie Cao**
Effective Date: 10/29/2012	**Revision Date: Reviewed 7/25/2018, no revisions**
Applies to: CareOregon Advantage (Medicare)	

Purpose

Medicare and Medicare Advantage (Part C) is a complex product line. CareOregon Advantage (COA) Sales Agents shall make it a priority to deliver all communications regarding plan benefits and operational procedures in a clear, concise manner while providing effective, resourceful and caring services.

The purpose of this policy is to establish the principles and guidelines that promote new member understanding, implement procedures to maintain accuracy of marketing communications and find opportunities for improvement. It is also our goal to ensure appointed Employed Agents, Independent Agents and Broker Agents submit complete and accurate enrollment applications to CareOregon in a timely manner, which will enable compliance with the enrollment timeliness requirements of CMS (Center for Medicare and Medicaid Services).

Background

As a result of regulatory guidelines and increased monitoring activities, CareOregon Advantage has revised existing Policies and Procedures, as well as developed some new Policies and Procedures for agent/brokers who sell our Medicare Advantage or Part D plans. These Policies and Procedures provide specific required processes to follow when marketing CareOregon Advantage plans to Medicare Beneficiaries, scheduling an appointment with the beneficiary, presenting Medicare Advantage or Part D plans, assisting the beneficiary with the enrollment form, and other important sales activity.

The following provides a complete description of each Policy and Procedure (PnP). It is very important that you read each PnP carefully as there are specific consequences for not working within these requirements.

Policy

This document outlines Plan responsibility for persons employed or contracted to perform marketing for Health Plan of CareOregon (DBA CareOregon Advantage) Medicare Advantage products.

Agent Training and Certification

Under CMS Guidelines, Agents and Broker much complete the training and certification process outlined as follows prior to marketing or selling any CareOregon Advantage Medicare Product.

Determine Agent/Broker Type: Depending on availability, agents may contract to sell CareOregon Advantage MAPDs either as an Independent Broker OR a Broker Agent. Please refer to the definitions below to determine which broker type best fits the situation:

- *Employed Agent* – is an individual who is employed with CareOregon Advantage.
- *Independent Agent* – is an individual who contracts with CareOregon Advantage directly.
- *Broker Agent* – is an authorized broker who is affiliated with a CareOregon Advantage contracted Sales Entity (General Agent).
- *General Agent (GA):* A General Agent is an agency contracted to provide sales of CareOregon Advantage. Typically, a GA will focus on Broker Agent recruitment and sales. Areas of support will include, but not limited to: broker certification, sales training, product training, compliance oversight and commission payout

Completing an Agent Agreement: Agent Agreements need to be submitted to CareOregon Advantage Contracting via email at: advantage@careoregon.org. Incomplete packages will be delayed and not processed. All agents seeking appointment with COA will need to submit a copy of current state insurance license and Errors and Omissions Policy along with the following based on Broker Type:

- *Independent Agent* -- A signed an Agent Agreement and W-9.
- *Broker Agent* – A signed Broker Agent Agreement and an Assignment of Commissions Form to affiliate with a GA
- *GA* – A signed General Agent Broker Agreement Advantage and W-9.

AHIP Certification: A broker is required to complete the certification before they can sell CareOregon Advantage Medicare Advantage plans.

- Agents/Brokers are required to complete the *AHIP Medicare Advantage and Part D certification course*, Gorman, or Pinpoint and pass that course with a minimum score of 90%.
- Agents/Brokers will logon to CareOregon Advantage AHIP link to transmit their AHIP certificate, final score, and number of attempts to the plan sponsor. Click on: www.ahipmedicaretraining.com/clients/CareOregon

- In addition, Agent/Brokers must complete a CareOregon product certification course on an annual basis and pass that course with a minimum score of 90%.

Product Certification: All brokers are required to complete the Product Certification on an annual basis. This content is updated yearly to reflect the new contract year benefit design.

- All agents/brokers must complete training and product testing through the Plan's training portal located at: https://sentinelelite.com. If the agent/broker does not complete the product certification before the onset of the new contract year selling period, they will not be able to order the necessary supplies and materials to sell CareOregon Advantage products or collect future renewals.

- After training course is completed, agents/brokers will complete the certification exam will be required to achieve an 85% success rate or higher in order to sell Medicare Advantage products.

- A confirmation email will be sent by COA Medicare Broker Contracting with email subject line: "Welcome to CareOregon Advantage**!" <u>Independent Agents and Broker Agents cannot conduct COA sales presentations or submit member applications until you receive your writing number and confirmation email from COA.</u>**

No Engagement in Activities which Mislead, Confuse, or Misrepresent Policy and Procedure

CareOregon Advantage ensures all marketing related complaints are reviewed and appropriately investigated. CareOregon Advantage also ensures the marketing activities of its Brokers, Agents, and marketing contractors are monitored. CareOregon Advantage ensures that the following activities are prohibited.

<u>Discriminatory Activities:</u> These include attempts to discourage participation on the basis of actual or perceived health status, such as:

- Attempts to enroll beneficiaries from a high income area if you are not making comparable effort to enroll beneficiaries from lower income areas in your service area; or

- Attempts to give enrollment priority to those in your service area who are newly eligible for Medicare for over other beneficiaries, unless those newly eligible are 'age-ins', i.e., members of your plan prior to Medicare entitlement.

<u>Activities Which Mislead, Confuse, or Misrepresent</u>: Activities that could mislead or confuse beneficiaries or activities that misrepresent the organization, its Agents and Brokers, or CMS are prohibited. The following are examples of activities considered to fall within these categories:

- Claiming recommendation or endorsement by CMS of the plan or claiming that CMS recommends that beneficiaries enroll in the plan;

- Using terms such as 'Official U.S. Government' or 'Medicare' on envelopes or in other marketing materials in ways likely to result in beneficiary confusion;

- Using terms such as 'Medicare Substitute' or 'instead of Medicare' which imply that Medicare entitlement does not continue once a beneficiary is enrolled in the plan;

- Using coupons or cards seeming intended for requesting additional information for enrollment and/or enrollment screening
- Agents identifying themselves as representatives of Medicare or the Federal government. You may, however, explain that CareOregon Advantage has a contract with CMS or the Medicare program;
- Omitting information necessary for the beneficiary to make an informed choice, whether or not the beneficiary specifically requests the information;
- Making inaccurate statements about fee-for-service Medicare;
- Making overstatements about the plan's coverage;
- Using enrollment forms which are not accompanied by sufficient other information to allow for an informed choice;
- Incorrectly describing Medicare covered services; and
- Not offering benefits approved by CMS as part of the bid submission.

Gifts or Payments to Induce Enrollment: Offers of gifts or payments as an inducement to enroll in CareOregon Advantage are prohibited. However, CMS does allow plans to give Medicare beneficiaries nominal value gifts, provided that the plan offers these gifts whether or not the beneficiary enrolls in the plan. For example, agents/brokers may give nominal value gifts to all beneficiaries who attend a marketing presentation. We define nominal value as an item having little or no resale value and which cannot be readily converted to cash. Generally, nominal value gifts are work less than $15.00.

Although, agents/brokers may describe legitimate benefits the beneficiary might obtain as a managed care enrollee, CareOregon Advantage is prohibited from offering or giving rebates, dividends or any other incentives, especially those that in any way compensate for lowered utilization of health services by beneficiaries. You may not tie lowered or reduced premium costs for the beneficiary to the beneficiary's decreased utilization of health services.

Door-to-Door Solicitation: Door-to-door solicitation of beneficiaries who have not contacted the agent/broker or who have not invited a CareOregon Advantage presentation in their residence is prohibited. This applies to any personal residence, including non-common areas of nursing or rest homes.

Marketing through Unsolicited Contacts: The prohibition on door-to-door solicitation now extends to other instances of unsolicited contact that may occur outside of the advertised sales or educational events. Prohibited activities include, but are not limited to, the following:

- Outbound marketing calls, unless the beneficiary requested the call. This includes contacting existing members to marketing other Medicare products.
- Calls to former members who have disenrolled, or to current members that are in the process of voluntarily disenrolling, to market plans or products.
- Calls to beneficiaries to confirm receipt of mailed information.
- Calls to beneficiaries to confirm acceptance of appointments made by third parties or independent agents.

- Approaching beneficiaries in common areas (i.e. parking lots, hallways, lobbies, etc.).
- Calls or visits to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call or visit.

Distribution of Unapproved Marketing Materials: You are prohibited from distributing marketing materials which have not been approved by CareOregon Advantage's Medicare Marketing Department. Similarly, you are prohibited from distributing marketing materials which CMS has disapproved in writing within 45 days after your submission of them.

Pre-production and post-production materials are required for review:

- Independent agents appointed under GAs must discuss with their upline to ensure they understand:
    - The distribution channel and intended use of the material
    - They have reviewed the material with the Agent
    - The material is compliant with CMS Medicare Marketing Guidelines including appropriate disclaimers
- The GA will then submit the pre-production marketing piece for review to the Medicare Marketing Manager.
- The Medicare Marketing Manager will then review scope, distribution channel and piece before submitting to Medicare Program Manager for Marketing ID and CMS Approval.
- If the piece is misleading, not compliant with Medicare Marketing Guidelines, or missing disclaimers, the Medicare Marketing Manager will return to the GA for corrections.
- The Medicare Program Manager will notify Medicare Marketing Manager once the piece has been approved and Marketing ID has been issued.
- The Medicare Marketing Manager will notify GA of approved status: Medicare Marketing ID number, Approval Date
- The GA will provide a copy of the Final Production Marketing Piece to Medicare Marketing Manager so a hard copy can be filed with the GA's file.
- CareOregon Advantage has a zero tolerance policy for use of unapproved Medicare marketing materials. If an agent or GA uses unapproved materials in the marketplace and is discovered by CareOregon Advantage, an immediate contract termination will occur as well as a commission chargeback.

Allowable Actions for Medicare Advantage/Medicare Part D Organizations:

Agents/brokers contracted to represent CareOregon Advantage in the marketplace are considered and extension of the plan sponsor. Please note the following allowable and not allowable actions:

- Medicare Advantage/Medicare Part D Organizations and appointed sales agents or brokers **may do** the following:
    - Assist in the planning of local health fairs

- Distribute health plan brochures and application forms, while at the health fair if reported to CMS as a sales/marketing event. They may also include in their handouts a reply card which may be given to interested beneficiaries for return to the organization via mail.

- Collect enrollment applications at sales/marketing events.

- Have a booth at the health fair. Sales/marketing events must be submitted to CareOregon Advantage and CMS for approval.

- Distribute items with a total retail value of no more than $15.00. These items MUST be offered to everyone (i.e. organizations cannot give gifts to only those individuals who show interest)

- Have personnel present (i.e. marketing personnel, customer services personnel) as long as they adhere to these guidelines

- Contribute funding for any health fair costs (i.e. purchasing of food, drawings, raffles, or door prizes which exceed $15.00 nominal value requirement) as long as the recognition of the donation is to a number of entities (not just one particular MA/or Part D organization)

- Market multiple lines of business in MA/Medicare Part D if event has been reported to CMS as a sales/marketing event.

- Medicare Advantage/Medicare Part D Organizations **<u>may not do</u>** the following:

    - Collect names/address of potential enrollees as a requirement to attend events. However, as noted above, they may distribute application forms and reply cards.

    - Compare their benefits against other health plans. However, they may use comparative information which has been created by CMS (such as information from CMS' Website) or information/materials which have been approved by CMS (i.e., the standardized Summary of Benefits)

    - Third party created materials may not be used, unless they have been approved by CMS in advance.

    - Give individuals gifts with a retail value of more than $15.00

    - Cross-sell non-health care related products (such as annuities and life insurance) to prospective enrollees during any MA or Part D sales Activity or presentation

    - Conduct sales activities in health care settings except in common areas.

    - Conduct sales activities at educational events

Prohibition on the Provision of Meals: MAPDs may not allow prospective enrollees to be provided meals or have meal subsidized at any event or meeting in which plan benefits are being discussed and/or plan materials are being distributed.

- Items considered acceptable:
    - Fruit
    - Raw Vegetables
    - Pastries

- Cookies or other small dessert items
- Crackers
- Muffins
- Cheese
- Chips
- Yogurt
- Nuts

Rapid Disenrollment/Chargeback Policy and Procedures:
Any MAPD member disenrollment of three months or less of coverage will result in rescinding the annualized 1st year commission of the broker from the date of disenrollment. For agents/brokers with higher than average rapid disenrollment, corrective action will be implemented.

- The Medicare Marketing Manager will review the Rapid Disenrollment Report in SASBI to identify agents/brokers that have excessive amounts of Rapid Disenrollment.
- The Medicare Marketing Manager will notify agents/brokers that they must reduce Rapid Member Disenrollment or they will be required to repeat the Agent Certification Course
- If the Rapid Member Disenrollment has not been reduced, the Medicare Marketing Manager will revoke the agent's/broker's privilege to sell CareOregon Advantage Plans.

Enrollment Form Submission Policy and Procedure: The agent/broker must submit complete Enrollment Forms for Medicare Advantage within 48 hours upon receipt from beneficiary ensuring that CareOregon Advantage is positioned to comply with CMS guidelines for timely handling of beneficiary enrollment applications.

Each beneficiary application requires a Confirmation/Acknowledgment letter from CareOregon Advantage. The Confirmation/Acknowledgment letter is required to be received by the beneficiary within 7 calendar days from the date CMS approves the enrollment.

In addition, the agent/broker must ensure that the Enrollment Form is complete and all of the information is accurate.

- The agent/broker must review the Enrollment Form, including online Enrollment forms, with the applicant to ensure that the form is complete and the information provided is accurate before the applicant signs the form.
- All Enrollment Forms received by home visits, mail, seminar, walk-ins or other means are submitted within 48 hours following the receipt of the enrollment form. This can be accomplished by overnight mail, faxing the enrollment form to (503) 416-8117, or send via secure, encrypted email to enrollmentmaterial@careoregon.org.
    - Immediately upon receipt of completed Enrollment Form from the Medicare beneficiary, the agent/broker enters the date received in the Plan use only section of the Enrollment Form.

- All Enrollment forms must include the respective Scope of Appointment Form to CareOregon Advantage. If no Scope of Appointment is included, please state the reason on the coversheet (i.e. – application received via mail).

Holding Enrollment Forms

- An Enrollment Form cannot be held for any period of time that results in the plan not receiving it more than 48 hours from the agent received date. If the beneficiary wants a Broker to hold an Enrollment Form, the agent/broker must explain that he/she can either submit or cancel the Enrollment Form following established procedures.

Monitoring

- The Medicare Marketing Manager monitors the agent/broker for accuracy/completeness and timeliness issues. This will be monitored over a 12 month rolling period.

- A monthly report will detail accuracy/completeness (dirty application) and timeliness issues by offending agent/broker.

    - Monthly report showing agent/broker with the first occurrence with 3 or more dirty and/or late applications will receive a verbal warning and be advised that the next step will result in a written warning where corrective action may be required i.e. mandatory training.

    - The Medicare Marketing Manager will continue to monitor the agent/broker for timeliness and completion of the enrollment applications

    - If no improvement is shown, the agent/broker will be suspended from selling MAPD Plans.

    - Agents/brokers can be reinstated to sell plan once they have completed retraining. Reinstatement must be approved by the Medicare Program Manager.

Scope of Appointment (SOA) Policy and Procedure

Agents/brokers must not market any health care related product during a marketing appointment (in-person or telephonic) beyond the scope agreed upon by the beneficiary, and documented by the Broker, prior to the appointment. Any such marketing must be done at a separate appointment that can occur no earlier than 48 hours after the initial appointment.

- When the Broker schedules the appointment (in-person or telephonic) with the beneficiary, they must review all of the health plan options they will be discussing at the appointment and obtain agreement from the beneficiary prior to the appointment.

- The Broker may obtain this agreement using a CMS approved Scope of Appointment Form signed by the beneficiary, or a recorded oral agreement. Any technology (e.g. conference calls, fax machines, designated recording, line, pre-paid envelopes, and email) can be used to document the scope of appointment.

- The scope of appointment must meet the following requirements:

    - Date of appointment

    - Beneficiary contact information (e.g., name, address, telephone number)

    - Written or verbal documentation of beneficiary or appointment/authorized representative agreement

- The product type(s) (e.g., MA, MAPD, MMP) the beneficiary has agreed to discuss during the scheduled appointment

- Agent information (e.g., name and contact information)

- A statement clarifying that:
  - beneficiaries are not obligated to enroll in a plan
  - current or future Medicare enrollment status will not be impacted
  - that the beneficiary is not automatically enrolled in the plan(s) discussed

- Copies of the Sales Appointment Authorization will be maintained by the agent/broker for 10 years and will be available upon request.

- If during the appointment, the beneficiary expresses an interest in non-health related plans or products outside the scope of the agreed upon topic, the agent/broker can set another appointment for 48 hours later and may leave the beneficiary with a copy of the Marketing Brochure for the product, but may not leave the enrollment form.

- If the beneficiary requests information on another health related MA plan, collect a new scope outlining the plans of interest and notate, why the scope was collected at the time of the appointment if under 48 hours.

- Agents/brokers will be required to waiting at least 48 hours before meeting with the beneficiary to discuss new plan(s) or product(s).

- When an Agent/broker contacts a beneficiary in response to a reply card, the representative may only discuss the products that were indicated on the advertisement.

Sales Event Report Policy and Procedure
All agents/brokers conducting a CareOregon Advantage brand MAPD sales presentation must report that event to their GA prior to the scheduled event. The GA will then provide the sales event reports to the Medicare Marketing Manager at least 10 days to the scheduled event.

The GA will send a completed Event Matrix Marketing Events CareOregon Advantage to the Medicare Marketing Manager on behalf of their appointed agent to ensure all fields have been completed and the nature of the event has been discussed.

- The completed Template must include the following:

  - Contract Number (H5859)

  - Presentation Language

  - Presentation Language if Other

  - Event Type (Formal vs. Informal)

  - Event Date MUST be in the following format: mm/dd/yyyy

  - Event Time MUST be in the following format: hh:mm AM/PM should be in capital letters and standard time; not military time

  - Brokerage Firm/Agency

  - Facility Type (drop down menu of choices)

- Facility type if Other
- Representative Agent National Producer Number (NPN)
- Representative/Agent Name
- Venue Name
- Venue Phone format: 999-999-9999. Nothing but dashes can be used
- Venue Address 1
- Venue Address 2
- Venue City
- Venue State
- Venue Zip Code format: 99999 or 99999-9999
- Event Contact: First and Last Name
- Contact Phone for Event format: 999-999-9999. Nothing but dashes can be used
- Other requirements:
  - Only one contract number can be entered on a single event in the upload file.

If a sales event is cancelled within 48 hours of its originally scheduled date and time, the agent/broker must:

- Notify the Medicare Marketing Manager of the cancellation.
- Ensure that a representative is present at the site of the cancelled sales event for 15 minutes, at the time the event was scheduled to occur, to inform attendees of the cancellation and distribute information about the plan.

If a sales event is cancelled more than 48 hours of its originally scheduled date and time, the agent/broker must:

- Notify the Medicare Market Manager of the cancellation; and
- Notify the beneficiaries of the cancellation by the same means used to advertise the event.

Notification of cancelled sales events should be made, whenever possible, more than 48 hours prior to the originally scheduled date and time of the event. If the beneficiaries are notified of a cancellation more than 48 hours before the event, then there is no expectation that a representative will be present at the site of the event.

Event Evaluation and Call Monitoring

- Internal Audit and Compliance Specialist will formally attend a scheduled sales/marketing event or home visits to evaluate the agent/broker. The Internal Audit and Compliance Specialist can schedule the evaluation or attend unannounced.

- The Internal Audit and Compliance Specialist will ensure, through monitoring of these events that the agent/broker is not offering gifts or pays as inducement to enroll in an organization.

Sales Incident Policy and Procedure

Every sales incidence will be documented and reported through Sales Incident Investigation Form. The Medicare Marketing Manager will investigate the agent/broker and complete Sales Incident Investigation Form. The Medicare Marketing Manager will take the appropriate corrective action with the agent/broker based on the findings of the completed investigation. The Medicare Marketing Manager may also discuss agent/broker issues with the Medicare Compliance Manager.

- The Medicare Marketing Manager will send the form to the agent/broker.
- The agent/broker will complete and return the form the Medicare Marketing Manager.
- The Medicare Marketing Manager will review the form for the completeness.
- Under no circumstances may a agent/broker contact the enrollee, member or any other individual involved in the investigation.
- At the conclusion of the investigation, the Medicare Marketing Manager will complete the Sales Violation Information section of the Sales Incident Investigation Form with the following information:
    - Violation type:
        - Major Sales Violations:
            - Theft
            - Failure to provide written description of Medicare Advantage rules at the time of enrollment.
            - Threatening, coercing, intimidating or abusive (verbal or physical) behavior.
            - Distribution of unapproved marketing material.
            - Discriminatory activities.
            - Activities which mislead confuse or misrepresent.
            - Falsifying signatures or participating in falsifying signatures.
            - Ignoring or delaying an enrollees request for cancellation or disenrollment.
            - Referring to enrollment form as an information card to trick individuals into enrolling.
            - Using gifts or payments to induce enrollment.
            - Door-to-door solicitation, marketing through unsolicited contacts.
            - Collection of monies from enrollees other that required plan premiums. Agent/broker may not collect money at the time of the appointment for premiums. Leave an ACH form or advise beneficiary they will receive a bill via mail.
            - Sales of Medicare Advantage plans by non-licensed individuals, as required by each state.
            - Splitting of commission with another person.
            - Knowingly enrolling a beneficiary who does not meet eligibility criteria, or knowingly falsifying beneficiary information on an enrollment application.

- Holding a signed enrollment form past the allowed time frame.
- Failure to follow the do not call registry rules.
- Providing meals.
- Other Major sales violations.

▪ Minor Sales Violations:
- Enrollee did not understand lock-in; failed outbound verification.
- Enrollee did not understand plan benefits.
- Unintentionally enrolled an individual of questionable competence.
- Failure to follow established enrollment procedures, i.e., did not copy of POA papers if required.
- Other minor sales violation.

o Violation Description – A brief description of the violation.

▪ Finding:
- Founded (F) – There is clear evidence that the agent/broker violated MA and CMS sales policies.
- Unfounded (U) – There is clear evidence that the Sales Representative did not violate any sales policies.
- Inconclusive (I) – It cannot be conclusively established whether or not a sales policy was violated.

o Corrective Action – The Medicare Marketing Manager will discuss all findings with the agent/broker. The guidelines below list the potential administrative outcomes. These guidelines will apply in most cases:

• Founded Major Violation – Termination and Commission Chargeback.

• Inconclusive Major Violation:
- First incident – discussion with Medicare Marketing Manager and respective GA, appropriate coaching and training plan will be determined by GA and Medicare Marketing Manager.
- Second incident within 90 days – Verbal Warning issue, additional coaching and training provided.
- Third incident within 90 days – Written Warning Issued, additional coach and training provided.
- Fourth incident within 90 days – Revocation of privileges to sell MA products. Commission chargeback.

• Unfound Major Violations – No action.

• Founded Minor Violation:
- First Incident – Discussion with Medicare Marketing Manager and respective GA. Verbal warning issued. At least 2 additional call audits, ride-alongs or meeting monitoring in the next 30 days with GA participation. Appropriate coach and training provided. Commission chargeback.
- Second incident within 90 days – Written warning issued, additional coaching and training provided. Continue increased call audits, ride-alongs and meeting monitorings with GA participation. Commission chargeback.

    - Third incident within 90 days – Revocation of privileges to sell MA products. Commission chargeback.

- Inconclusive Minor Violation
    - First incident – Discussion with Medicare Marketing Manager, appropriate coaching and training provided.
    - Second incident within 90 days – Verbal warning issued, additional coaching and training provided.
    - Third incident within 90 days – Written Warning Issued, additional coach and training provided.
    - Fourth incident within 90 days – Revocations of privileges to sell MA products. Commission chargeback.

- Unfounded Minor Violation – No action

RELATED POLICIES AND PROCEDURES

OTHER RELATED DOCUMENTS

Scope of Appointment Form
Sales Incident Investigation Form