



Tools and Techniques for Effective Monitoring and Auditing of Sales Agents: Insights from a New Medicare Advantage Plan

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What We Will Cover Today

- Introduction & Overview of CareSource
- Sales Processes
- Enrollment
- Sales & Educational Marketing Events
- Compliance MA Sales Proctoring Tools
- Pharmacy Information
- Sales Oversight Program
- Documentation & Record Retention Requirements
- Medicare Advantage Sales Representative Compliance Guide



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Introduction & Overview of CareSource

Our MISSION
To make a lasting difference in our members' lives by improving their health and well-being.



CARESOURCE

- A nonprofit health plan and national leader in Managed Care
- 27-year history of serving the low-income populations across multiple states and insurance products
- Currently serving over 1.5 million members in Kentucky, Ohio, Indiana, West Virginia
- Preparing to serve Indiana and Georgia Medicaid members in 2017






1.55M
members




Confidential & Proprietary **CareSource**

Fast Facts

- 2016 offered Medicare Advantage HMO in Indiana and Kentucky
- 2017 expanded coverage to Ohio and offers Advantage, Advantage Plus and Zero Premium products
- 2017 Total Enrollments 3,392

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Sales Processes

Sales Processes- Contact Activities

Acceptable Contact Activities:

- Mail (USPS) information to beneficiaries to determine their interest in CareSource Advantage plans
- Return a beneficiary's phone call
- Contact beneficiaries by phone or email who have given their permission to be contacted by providing their phone numbers or email address
 - Note: This assumes the beneficiary is aware that by providing their phone number and/or email address, they will be contacted by a CareSource Representative.
 - Note: If a potential enrollee provides permission to be called or otherwise contacted, the contact must be event-specific, and may not be treated as open-ended permission for future contacts.



Sales Processes- Contact Activities

Prohibited Contact Activities:

- Door-to-door solicitations (cold calling)
- Approaching beneficiaries in common areas such as parking lots, hallways, lobbies, sidewalks, etc.
- Contact through any other unsolicited means of direct contact, including:
 - Calling a beneficiary without the beneficiary initiating the contact or giving express permission to be called (example – contacting a beneficiary who attended a sales event and did not give permission for contact)
 - Leaving a voice-mail message or sending a text message
 - Emailing the beneficiary when he/she has not provided their email address nor given their express permission to be contacted in that manner



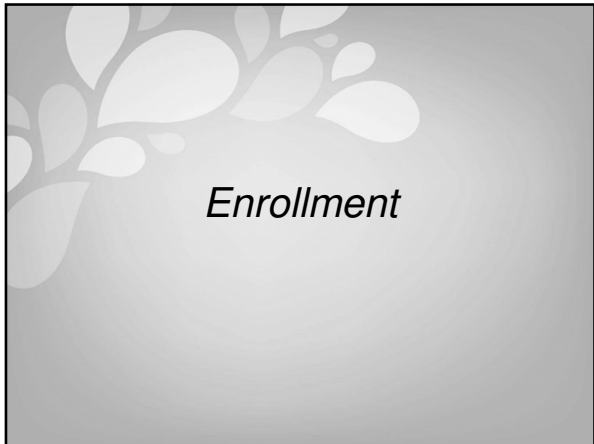
Sales Processes- Materials

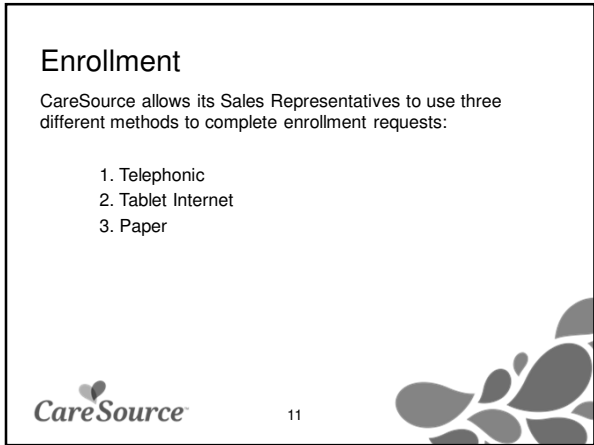
CareSource sales representatives are required to follow established policies and procedures for the use, documentation and retention of Scope of Appointment (SOAs) forms that do and do not result in a sale.

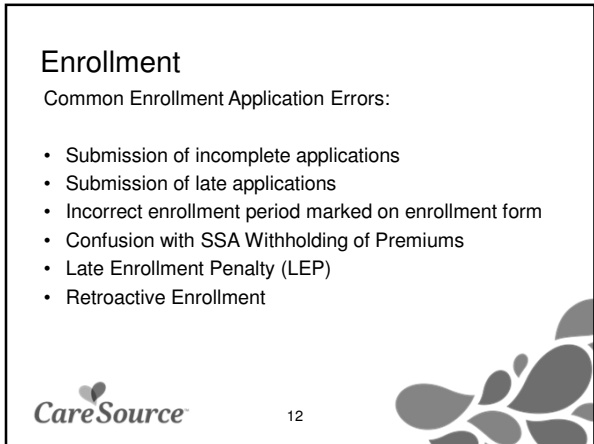
When meeting with beneficiaries, Representatives must ensure they have copies of the required pre-enrollment kit materials during and after the sales appointment, including:

1. The Summary of Benefits
2. An Enrollment Application with enrollment instructions and forms
3. CareSource's CMS Star Rating Sheet (Not Yet Applicable)
4. Provider Directory
5. Formulary











Sales Events

Marketing/sales events and appointments are **designed to steer, or attempt to steer**, potential enrollees toward a plan or limited set of plans. At marketing/sales events and appointments, plan representatives may discuss plan specific information and collect applications (*2016 Medicare Marketing Guidelines, Section 70.9 released 06.10.16*).

- Formal
- Informal

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Sales Events

During a Sales Event Representatives Must:

- Ensure all required documents are provided in the enrollment kit;
- All materials contained within the enrollment kit must be discussed
- Announce all plan types that will be covered during the presentation (e.g., Advantage, Plus and Zero Premium)
- Use CMS-approved CareSource Advantage sales presentations and materials
- Verbally discuss prescription drug benefit information, including copayments, coinsurance, costs, coverage gap or "donut hole," and formulary

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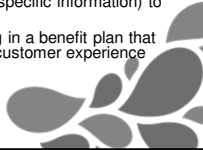
Sales Events

During a Sales Event Representatives **May**:

- Discuss information such as premiums, cost sharing and benefits
- Distribute health plan brochures and enrollment materials
- Accept and perform enrollments (Note: beneficiary must have a valid election period – ICEP, IEP, AEP, SEP)
- Deliver a formal presentation to an audience regarding CareSource Advantage plans via sales presentation, handouts, slide presentations, etc.
- Meet one-on-one immediately following a sales event with completed SOA (48-hour waiting period does not apply)
- Provide educational content (core Medicare-specific information) to an audience
- Assist the Medicare beneficiary with enrolling in a benefit plan that will meet their needs and provide a positive customer experience during the benefit year



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Sales Events

During a Sales Event Representatives **May**:

- Contribute cash towards prize money to a foundation or another entity if event is jointly sponsored
- Give a nominal gift (any item/service excluding cash items with a value not to exceed \$15 retail) and must be offered to all people, regardless of enrollment (\$75 total per person per year)
- Offer a raffle or drawing but will require the use of numbered tickets or similar approach for beneficiaries to participate in the raffle/drawing
- Provide their contact information (i.e. business card) if an individual would like to refer a friend or relative to the representative
- ***In any and all cases, a referred beneficiary must contact the representative directly;*** the representative cannot contact the beneficiary



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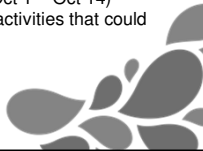
Sales Events

During a Sales Event Representatives **Shall NOT**:

- Require beneficiaries to provide ANY contact information as a prerequisite for attending the event (This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through mail)
- Require attendees to complete sign-in sheet (Representatives must use CareSource's sign-in sheet, however perspective enrollees are not required to sign in)
- Soliciting enrollment applications prior to the start of AEP (i.e. during the pre-AEP marketing period – Oct 1 – Oct 14)
- Conduct health screenings or other like activities that could give the impression of "cherry picking"



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Sales Events

During a Sales Event Representatives Shall NOT:

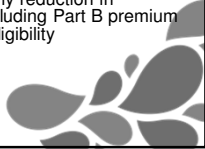
- Provide meals to attendees (light refreshments are acceptable)
- Call beneficiaries to confirm receipt of mailed information
- Use prohibited statements at sales/marketing events such as, but not limited to:
 - Using superlatives that portray CareSource and/or its networks, benefits as “the best,” “the largest,” “the highest ranked,” “one of the best” or “among the highest ranked”
- Compare CareSource’s benefits to competitors’ benefits



Sales Events

During a Sales Event Representatives Shall NOT:

- Display non-health care related materials such as information about life insurance and annuity products
- Claim that they are recommended or endorsed by CMS, Medicare, or the Department of Health & Human Services
- Market that they will not disenroll individuals due to failure to pay premiums
- Use the term “free” to describe a zero dollar premium
- Use the term “free” in conjunction with any reduction in premiums, deductibles or cost share, including Part B premium buy-down, low-income subsidy or dual eligibility



Sales Events

During a Sales Event Representatives Shall NOT:

- Engage in discriminatory marketing practices
- Offer gifts or payments as an inducement to enroll or solicit referrals
- Call former members who have disenrolled, or call current members who are in the process of voluntarily dis-enrolling to market plans
- Ask a beneficiary to provide their personal contact information in order to participate in a raffle or drawing
- Ask people for referrals



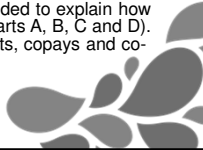
Educational Events

During an Educational Event Representatives May:

- Display a company banner with the plan name and/or logo
- Provide promotional items, including those with plan name, logo, and toll-free customer service number and/or website (Promotional items must be free of benefit information and be of nominal gift value)
- Respond to questions asked at an educational event
- Provide meals (must comply with the nominal gift requirement in section 70.1.1)
- Note: While educational events are intended to explain how the Medicare Program functions (e.g., Parts A, B, C and D). They may also be used to explain benefits, copays and co-insurance to *current members*.



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Educational Events

During an Educational Event Representatives Shall NOT:

- Discuss plan-specific premiums and/or benefits
- Distribute plan-specific materials
- Distribute or display business reply cards, scope of appointment forms, enrollment forms, or sign-up sheets
- Set up individual sales appointments or get permission for an outbound call to the beneficiary
- Attach business cards or plan/agent contact information to educational materials, *unless requested by the beneficiary*
- Advertise an educational event and then have a marketing/sales event immediately following in the same general location (e.g., same hotel)
- Invite friends, neighbors or relatives NOT enrolled in a CareSource Advantage product is prohibited

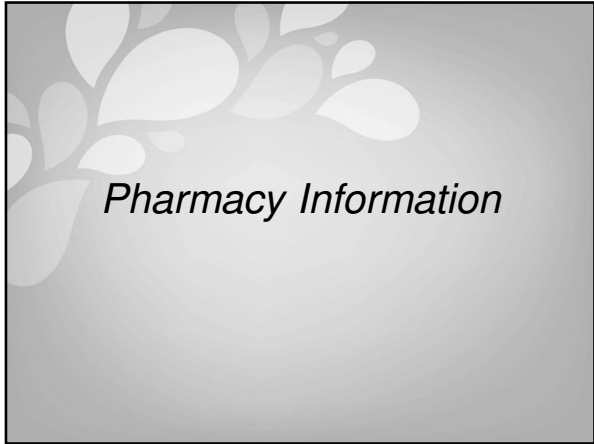


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Compliance MA Sales Proctoring Tools

1. Quick Tool- MA Sales Proctoring
2. Sales Proctoring Tool
3. MA Monitoring Report Template
4. Sales Dos & Don'ts
5. Pharmacy Dos & Don'ts



MAPD Formulary

- A formulary is a list of drugs that are covered by the plan; this is also known as the Drug List
- Five tier plan
- The drugs listed are only those covered under Medicare Part D
- The Formulary is updated monthly
- Few changes occur during the year
- If a member is negatively impacted by a change, the member is notified at least 60 days prior to the change
- The MA Formulary is specific to the MA product and is different than the formularies used by our other products

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Tier Levels

Medicare Advantage:

- **Tier 1** Preferred Generic drugs
- **Tier 2** Generic drugs
- **Tier 3** Preferred Brand drugs
- **Tier 4** Non-preferred Brand drugs
- **Tier 5** Generic and Brand Specialty drugs

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Coverage Determination (CD)

- Any decision made by or on behalf of a Part D plan sponsor regarding payment or benefits to which a member believes he or she is entitled.
- Example: Itraconazole



Levels of CD's

- **Exception Request:** A type of coverage determination made in response to a request
- **Prior authorization:** A process whereby certain designated preferred drugs must meet established criteria before the prescription can be covered
- **Redetermination:** The first level of the appeal process, which involves a Part D plan sponsor reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained



Quantity Limits

- For safety and cost reasons, plans may limit the amount of prescription drugs they cover over a certain period of time
- This is part of Utilization Management along with Step Therapy
- Example: Metoprolol



Step Therapy

- Certain drugs may require a member to try another drug before getting coverage approved
- Example: Uloric

Step Therapy Group	ULORIC
Drug Names	ULORIC
Step Therapy Criteria	Coverage will be provided if allopurinol has been tried (at least a 30-day supply in the prior 180 days)



What is Transition?

- Per CMS rules, CareSource MA provides a transition fill of most covered drugs for new enrollees
 - Member and prescriber are sent a letter within 3 days of a transition fill
- **Retail setting pharmacy-** Up to 30 day supply
- **LTC setting pharmacy-** At least 91 day supply, up to 98 days
 - Plans must allow up to 98 day supplies in LTC setting due to dispensing increments in LTC settings



Who is eligible for Transition?

- Drugs Eligible for Transition Include:
 - Non-formulary
 - Drugs that require a Prior Authorization
 - Drugs that have Step Therapy Rules
 - Drugs that have Quantity Limits
- Drugs/Conditions that **do not** apply to Transition are:
 - Drugs that are excluded (non Medicare Part D, OTC, Enhanced medications)
 - B vs D Drugs
 - Drugs that require a Diagnosis to determine D eligibility (e.g. Cialis, TIRF)

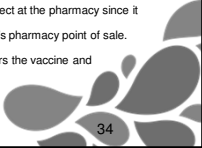


Additionally:

- **B vs D** -Part B medications are medications that are paid under the medical benefit. Some examples are:
 - Inhalants
 - Injections
 - Vaccines
 - DME (ex. Diabetic supplies)
 - Medications used in conjunction with organ transplants
- **Hospice**- Members enrolled in Hospice have all (with very few exceptions) drugs covered under the Hospice Benefit, Part-A, so are not covered under the Part-D benefit
 - All pharmacy claims for Hospice members will reject at the pharmacy
- **ESRD**- Members with ESRD have some drugs covered under the ESRD benefit, Part-B. If covered under Part-B, they will not be paid under Part-D

For example:

 - If member is receiving dialysis that is paid under Part-B directly to the dialysis center, then the ESRD drugs are paid in a bundle payment to facility. Items and services include supplies and equipment used to administer dialysis in ESRD facility or at patient's home, drugs, lab tests and supportive services
 - If an ESRD drug is on the "always" list, the claim will reject at the pharmacy since it is paid under Part-B
- **Vaccines** - CareSource allows vaccines to be covered at member's pharmacy point of sale, including seasonal influenza and pneumonia vaccines
 - Most vaccines are covered under the Part B benefit, this covers the vaccine and administration cost



Sales Oversight Program

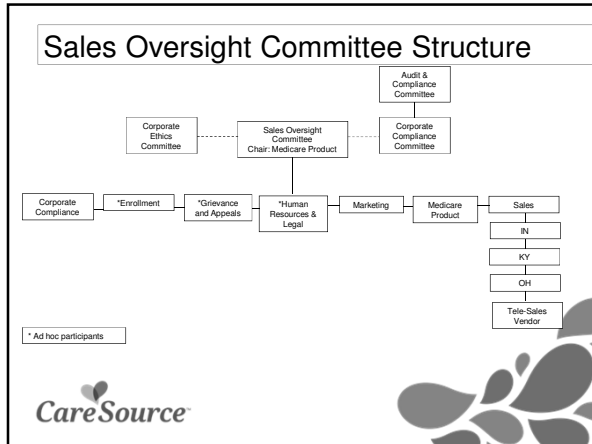


Sales Oversight Program

Some of the greatest compliance deficiencies CMS has found based on their secret shopping activities include:

- Failing to prepare prior to a sales event
- Injecting personal opinion
- Making absolute statements (e.g., "CareSource is the best," "No paperwork," "No claim forms" or use of the word "free" to describe zero premium plan)
- Making inaccurate statements (e.g., Drugs covered on the formulary)
- Not covering the entire presentation
- Not reviewing the Part D benefit thoroughly
- Failing to explain the eligibility requirements
- Not verifying participating providers





- ### Sales Oversight Committee Structure Key Activities
- **Sales**
 - Events Calendar Review: Next 30, 60 and 90 Days
 - Confirmation on venues: Signage, Parking, Light Refreshments, Enrollment Kits, Primary and Backup Presenter
 - Cancellation of events: Advance notification
 - Technology enhancements: IVR Scope of Appointment, IPAD Enrollment Application
 - **Materials**
 - Collaterals, flyers, presentations
 - Do materials require a 45-day review with CMS; create a calendar to back-in to the presentation dates
 - Status with Marketing review and submission to Compliance
 - **Training**
 - CareSource new product training
 - CMS required annual training to sell for Annual Election Period (AEP)
 - CareSource Compliance Manual training
 - Secret Shopper Audits
 - **Discipline – Marketing Misrepresentation (Internal or Broker)**
 - Employee: gather facts, conduct interviews, review policies/procedures, internal action
 - Broker: gather facts, conduct interviews, review contractual requirements, legal action
 - **Reporting**
 - Collect data to report CMS elements for Sales Oversight of Agents
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Documentation & Record Retention Requirements

Documentation & Record Retention Requirements

General Record Retention Requirements

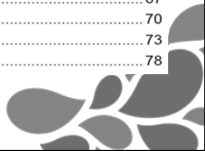
- CMS requires sales and marketing information be retained for a period of 10 years plus the current year for a total of eleven (11) years and will be the subject to an audit as required by Medicare regulations
- CareSource expects sales Representatives to document all sales appointments and maintain thorough and auditable records for a period of 11 years



Medicare Advantage Sales Representative Compliance Guide

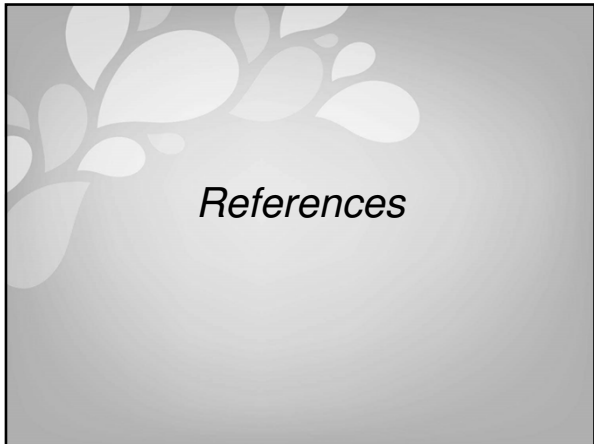
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Questions?





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- CMS Medicare Managed Care Manual, Chapter 3 – Medicare Marketing Guidelines (for CY2017); Updated June 10, 2016
- CMS Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections; Updated April 24, 2016
- CMS Medicare Managed Care Manual, Chapter 13 – Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans); Rev. 105; Issued: April 20, 2012
- CMS Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual Chapter 9 – Compliance Program Guidelines; Updated: January 11, 2013
- Medicare & You handbook; Updated September 2015
- Sales Agent Oversight Program – CareSource, July 2015

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