CY 2011 Outbound Enrollment Verification (OEV) - Model Education and Verification Script for All Plan Types

Purpose: Ensure that applicants requesting enrollment understand product type and plan rules. If during the course of the verification call there is a lack of understanding, the plan should educate the applicant about the plan that he/she has selected to enroll.

Model Script:

[Greet and identify yourself:]

Hello, my name is [caller's first and last name]. I'm calling from [insert plan name and type of plan; all but HMOs state the full name of the type plan in addition to giving the acronym, e.g., "Private Fee-For-Service (PFFS)], which is a [insert whichever is applicable: Medicare Advantage Plan or Medicare Prescription Drug Plan or Medicare Cost Plan].

[Ask for the applicant:]

We've recently received a request from [applicant first name and last name] to enroll in this plan. Is this [Mr./Ms.] [applicant last name]?

[If yes, skip ahead to "Explain purpose of the call"].

[If no, say:] May I please speak with [him/her]?

[If not available:] When is the best time to try to reach [applicant first and last name]?

(Document date and time called:)_____

[When applicant is on the line, say:] Hello, my name is [caller's first and last name from health plan]. I'm calling because we received your request to enroll in [insert plan name and type of plan; all but HMOs state the full name of the type of plan in addition to giving the acronym, e.g., "Private Fee-For-Service (PFFS)], which is a [insert whichever is applicable: Medicare Advantage Plan or Medicare Prescription Drug Plan or Medicare Cost Plan]. **[Continue with "Explain purpose of the call"].**

[Explain purpose of the call]

Because [plan name] is a [insert type of plan: HMOs say "a Medicare HMO"; all others state the full name of the type of plan], it has some rules you'll need to follow. We want to help make sure you understand these rules before your enrollment becomes final.

That's why I'm calling you today. I'd like to explain how [plan name] works and answer any questions you may have.

These calls usually take about [xx] minutes. Is now a good time to talk?

[If yes, skip ahead to "Introduction to Plan Rules"]

[If no, continue:] That's okay. When would be a better time to talk?

[Arrange and Document for a date and time to call back:]

Thank you for your time today. We look forward to speaking with you.

[If no time will work, continue as follows:]

Thank you for your time. We will send you a letter soon about your membership in our plan and how to use it. Please read it carefully and call our Member Services/Customer Service if you have any questions. The letter will give you a number to call. **[End call.]**

[Introduction to Plan Rules]

[Give assurances]

Thank you. Before we begin, I want you to know that I won't be asking anything about your health. And if you happen to give me any information about yourself, it will not have any impact on your enrollment in our plan.

[Explain type of plan:]

Okay, let's get started. You can ask questions whenever you like. As I've mentioned, we have received your application to become a member of [plan name]. Your enrollment request has/will be submitted to Medicare for final review. This is a [insert whichever is applicable: Medicare Advantage Plan or Medicare Prescription Drug Plan or Medicare Cost Plan]. [For Medicare health plans: It is not Original Medicare. And it not a Medigap or Medicare supplemental insurance plan].

Do you have any questions about this? **[Answer questions and then continue] & Document questions & answers**

[All MA plans must include the language that follows for "Using the plan's member ID card," "Cost sharing," and "Providers to use"]

[Using the plan's member ID card:]

Enrolling in [plan name] means that you will be getting your Medicare coverage through [plan name] and payment for your healthcare services will be processed through [plan name].

Once you are enrolled in our plan, we will send you a [plan name] member ID card and you must use this card whenever you get healthcare services.

During the time you are a member of our plan, you must not use your red, white and blue Medicare card because it is used only when you are getting your Medicare through Original Medicare, and our plan is different from Original Medicare.

So we tell all our new members, keep your red, white and blue Medicare card in a safe place because you might need it later on if you return to Original Medicare. But during the time you are a member of [plan name], be sure to use only your [plan name] member ID card. Otherwise, your care might not be covered and you'll have to pay for it yourself.

Do you have any questions about this? **[Answer questions and then continue.]**

[Cost sharing:]

As with any Medicare coverage, you will need to pay your share of the cost for services you receive. When you filled out the enrollment form, there should have been written information for you that tells what you must pay for services you receive as a member of [plan name].

Do you have any questions about your cost sharing as a member of our plan? **[Answer questions. If applicable, offer to mail or email a copy of the information or tell how to visit the website and get this information]**

(Dual eligible SNPs modify as appropriate)

[Providers to use:]

My next topic is which doctors, hospitals, or other health care providers you can use while you are a member of this plan.

[All PFFS plans must include the following language:]

[Plan name], the plan you are enrolling in, is a Private Fee-For-Service plan. When you are in this type of plan, you may get your covered Medicare services from any doctor, hospital, or other healthcare provider in the United States, if the provider agrees to accept our plan's terms and conditions of payment before they provide services to you and the provider is eligible to furnish services under Original Medicare.

To be sure that your care will be covered, you must tell your doctors and other providers that you are a member of [plan name] by showing them your [plan name] member ID card. You must do this before you get any health care services and you must do it every single time you go. Here's why:

- With a Private Fee-for-Service plan, doctors and other health care providers are allowed to decide each time you go in for care whether they want to accept or refuse [plan name]'s terms and conditions of payment. Just because a doctor accepted our plan the last time you went in for care does not guarantee that the doctor will accept our plan the next time you go in.

- Emergency care is an exception to this rule. If it's an emergency, you can get care without having the provider agree in advance to accept our plan's terms and conditions of payment.
- To find out about our plan's terms and conditions of payment, health care providers can use the [insert as applicable: phone number or website and TTY number] on your plan member ID card.
- If a provider has agreed to accept our plan's terms and conditions of payment, they will bill [plan name] for the services you receive and you will pay your share of the costs of your care.
- If a provider does not accept [plan name]'s terms and conditions of payment, they should not provide services to you. In this case, you will need to find another provider that will accept our plan's terms and conditions of payment.

[**Partial and full network PFFS plans include:]**

Our plan has signed contracts with some providers to deliver covered services to members in our plan. These providers have already agreed to see our members. These providers are our network providers.

[**Full network PFFS plans include:]**

We have network providers for all services covered under Original Medicare [*indicate if network providers are available for any non-Medicare covered services*]. You can still receive covered services from out-of-network providers (those who do not have a signed contract with our plan), as long as those providers agree to accept our plan's terms and conditions of payment. So, be sure to show your member ID card first to be sure they will accept our plan.

[**Partial network PFFS plans include:]**

We have network providers for [*indicate what category or categories of services for which network providers are available*]. You can still receive covered services from out-of-network providers (those who do not have a signed contract with our plan), as long as those providers agree to accept our plan's terms and conditions of payment. For services for which network providers are not available, you can receive covered services from any provider who agrees to accept our plan's terms and conditions of payment. So, be sure to show your member ID card first to be sure they will accept our plan.

[Partial and full network PFFS plans should describe whether or not the plan has established any higher cost sharing requirements if the member obtains a covered service from a deemed (out-of-network) provider.] [Insert the following sentence if the plan includes such differential cost-sharing: The amount of cost sharing you pay a provider who is not one of our network providers may be more than the cost sharing you pay a network provider.]

[**Partial and full network PFFS plans include**]

For the most up-to-date information on our network providers, you can either check our website or call [Member Services/Customer Service].

Do you have any questions about what you need to do to be sure that the health care services you get are covered under [plan name]?

[All **HMO** plan types must include the following language:]

[Plan name], the plan you are enrolling in, is a [type of plan]. It has a network of doctors, specialists, hospitals, and other providers that provide healthcare services to members of our plan. You need to know which providers are part of our network because you [insert whichever is applicable: must use or may be required to use] the providers who are in our network to get your healthcare services.

There are only four situations when [plan name] will cover healthcare services you get from providers who are <u>not</u> part of the plan's network. These are:

- If you are having an emergency.
- If you have an urgent need for care and network providers are not available to give you this care.
- If you need kidney dialysis that is not available from the plan's network.
- If you have asked for and received permission from [plan name] to use a provider who is not in the plan's network.

[SNPs with arrangement with the State may revise this language to reflect, when applicable, that the organization is providing both Medicaid and Medicare covered benefits].

The health care providers in the plan's network can change at any time. For the most up-to-date information on the network of providers, check our website or call [Member Services/Customer Service].

Do you have any questions about which health care providers you can use when you are a member of [plan name]?

[All **Cost Plans and PPOs** must include the following language:]

[Plan name], the plan you are enrolling in, is a [type of plan]. It has a network of doctors, specialists, hospitals, and other health care providers you can use to get your covered services. You can also use health care providers who are <u>not</u> in [plan name]'s network, although you may have higher cost sharing if you do.

The health care providers in the plan's network can change at any time. For the most up-to-date information on the network of providers, check our website or call [Member Services/Customer Service].

Do you have any questions about which health care providers you can use when you are a member of [plan name]?

[All **Medical Savings Account Plans** must include the following language:]

[Plan name], the plan you are enrolling in, is a Medical Savings Account Plan (called an MSA). An MSA plan is a type of Medicare Advantage plan that combines a high-deductible health plan with a medical savings account. The plan will only begin to cover your costs once you meet the yearly deductible. You can choose to use the money in your savings account to help pay your health care costs before you meet your deductible. This type of plan gives you some control over your own health care dollars.

There are some important things you should know about MSA plans:

[High Deductible Health Plan:] The first part of a Medicare MSA plan is the high-deductible health plan. Let me tell you more about this.

- Your MSA plan has a yearly deductible of [insert deductible amount]. Until you have paid [insert deductible amount], you must pay the full cost of your covered services. Only covered Medicare Part A and Part B services count towards the MSA plan deductible.

- Even if you haven't met your deductible yet, you should ask your provider to submit a claim to the plan. If your provider doesn't submit a claim, you should report your Medicare expenses to the plan yourself to make sure that your expenses are counted toward your deductible.

- Once you meet your yearly deductible, the plan will pay 100% of the costs for covered Medicare services for the rest of the calendar year. Your MSA plan must cover the full cost of all covered Medicare Part A and Part B services.

- You should never be asked to pay more than the Medicare allowed amount for Medicare Part A or Part B covered services.

- The plan covers costs beyond an out-of-pocket spending limit (also known as catastrophic coverage).

- You do not pay a monthly plan premium to be a member of an MSA plan. However, you are still required to pay your monthly Medicare Part B premiums to Medicare.

Do you have any questions about your costs for the high-deductible health plan?

- [Insert if appropriate: [Insert plan name] has signed contracts with some providers to deliver covered services to members in our plan. These providers are our network providers. However,] You are not required to use network providers. You can receive care from any provider in the United States who is eligible to provide services under Original Medicare.

Do you have any questions about which health care providers you can use when you are a member of [plan name]?

[The Medicare MSA Savings Account:] The second part of a Medicare MSA plan is the MSA account. The MSA account is a special type of savings account. Let me tell you more about the account.

- An MSA account must be opened in your name as part of the enrollment process so that it can be funded with your yearly deposit

- The plan deposits money from Medicare into the savings account at the beginning of each year. You cannot deposit your own money into the account.

- If you leave our plan in the middle of the year, part of the current year's deposit will be refunded to Medicare. The amount recovered and refunded to Medicare depends on the number of months left in the current calendar year.

- You can use the money in your account to pay for medical expenses, but only Medicare Part A and Part B covered services count toward your deductible.

- To avoid taxes and penalties, you must use the money in your account for Qualified Medical Expenses. Qualified Medical Expenses are the same types of services and products that could be deducted as medical expenses on your yearly income tax return. (See IRS Publication 969.) You need to keep track of your medical expenses during each calendar year.

Do you have any questions about the MSA account?

[MSAs and Prescription Drug Coverage:] You should also know that:

- MSA plans do not offer Medicare Part D prescription drug coverage.

- You can join a stand-alone Medicare Prescription Drug Plan (PDP) where MSA savings account withdrawals for Part D drug co-pays will count towards the Part D's out of pocket limit.

[**All PDPs** and all other plan types offering Part D coverage must include the following language:]

[Plan name] has a network of pharmacies. In most situations, we will pay for your prescriptions only if you use a pharmacy in our network. To get more

information, including the most up-to-date list of pharmacies in the plan's network, you can either check our website or call Member Services/Customer Service.

If you have limited income and resources, you may be able to get extra help to pay for your prescription drug premiums and costs. If you want to learn more about this, and see if you qualify for getting extra help, I have some phone numbers you can call. Would you like me to give those phone numbers to you?

[If yes:] You can call Medicare. That number is 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week. Or, call the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778. You may also call your State Medicaid Office.]

[All plans must include the following language:]

[Any questions?:]

Do you have any questions about the things I've been explaining?

[If yes, answer the questions. Repeat explanations as needed until the applicant understands.]

If you have questions later on, after we finish talking, you can always call our Member Services/Customer Service. Would you like to have the number to call?

[If yes, give the phone number (give TTY number if applicable). Include the calling hours and days of operation]

[Enrollment cancellation policy:]

We will now proceed with your enrollment in our plan unless you changed your mind. If you decide that you do not want us to finish enrolling you as a new member, you have the right to cancel your enrollment request. If you already know that you do <u>not</u> want to become a new member of [plan name], you can tell me now and we'll stop processing your enrollment. It's important for you to know that in order for us to cancel your enrollment, you must call us at [Member Services/Customer Service] at [phone number] no later than [insert date (date must be either 7 calendar days from the date of this phone call or the last day of the month in which the enrollment request was received, whichever comes later)]. If you decide you want to cancel your enrollment request and you don't call us before [insert date used in previous sentence], we will not be able to cancel your enrollment. You can call [insert calling hours and days of operation]. You may also call 1-800-Medicare for assistance in exploring other enrollment options.

Should I repeat any of the numbers to call so you can write it down?

Unless you call to cancel your enrollment, you will be enrolled in our plan. You will receive a letter shortly confirming your enrollment.

Do you have any questions about this? **[Answer questions and then continue.]**

[Close:]

[Mr/Ms] [applicant last name], thanks for talking with me today. **[End call.]**

[Material ID#]