2011 CMS AGENT/BROKER TRAINING GUIDELINES

Introduction

Agent and broker training is one of the most critical aspects to the successful management of a Medicare Plan. Agents and brokers must possess in-depth knowledge of Medicare Advantage and Medicare Part D plan types, operation, and regulations in order to protect the beneficiary from inappropriate sales or misinformation, as well as protect the offering organization from punitive action due to improper agent/broker conduct. In order to assure consistency and quality across all agent and broker training programs, CMS offers these guidelines for creating agent and broker training for the 2011 coverage year. The following topics are covered in this document:

- Agent and Broker Requirements
- Overview of Medicare Basics
- Plan Enrollment and Disenrollment (Medicare Part C)
- Beneficiary Protections
- Medicare Marketing Regulations
- Medicare Sales and Marketing or Educational Events

Content for the these training guidelines is based on information from CMS' 2010 *Medicare & You* Handbook, CMS' Medicare Managed Care Manual (MMCM), and CMS' Medicare Prescription Drug Benefit Manual (MPDBM)[1]. Each general topic area listed below will be followed by the documents or regulatory information to reference.[2] As CMS releases frequent updates regarding its rules and requirements, the content of the 2011 training should reflect the most current guidance available.

I. Agent/Broker Requirements

- Training and testing [42 CFR 422.2274 (b) - (c), 423.2274 (b)-(c), MMCM 3: 120.3]

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1 When draft versions of manual chapters are available, the most recent final version of the chapter (as of June 30, 2010) is referenced:

- MMCM Chapter 1, dated April 25, 2007
- MMCM Chapter 2, dated August 19, 2009
- MMCM Chapter 3, frequently referred to as the Medicare Marketing Guidelines, dated June 4, 2010
- MMCM Chapter 4, dated December 18, 2009
- MPDBM Chapter 3, dated August 19, 2009
- MPDBM Chapter 5, dated December 13, 2009
- MPDBM Chapter 6, dated February 19, 2010
- MPDBM Chapter 13, dated February 5, 2010

2 When a regulatory reference cited in this document includes sub-sections, it should be assumed that all applicable subsections or cross-referenced regulations should be addressed in the educational content. For example, a reference to MMCM Chapter 2, Section 30 (Election Periods and Effective Dates) would encourage the trainer to address Chapter 2, Section 30.1 (Annual Election Period (AEP)), 30.2 (Initial Coverage Election Period (ICEP)), Section 30.2.1 (Initial Enrollment Period for Part D (IEP for Part D)), etc.

    - Agents and brokers must be tested annually on rules, regulations, and details about the products they sell
    - Agents or brokers must score 85 percent on this test to certify
- Appointment requirements [42 CFR 422.2272 (c), 423.2272 (c), MMCM 3: 120.1]

II. Medicare Basics

- Overview of Medicare
    - Description of Original Medicare [42 CFR 422.2, MMCM 1: 20]
    - Description of Medicare Advantage [42 CFR 422.1 through 422.6, MMCM 1: 10]
    - Description of Part D/Voluntary Prescription Drug Benefit [42 CFR 423.1, 423.4, 423.100, 423.104, MPDBM 5: 10, 20.1, 20.2, 20.3, 20.4, 30]
    - Eligibility requirements for Parts A, B, C, D [42 CFR 422.50 through 422.52, 423.30, MMCM 2: 20]
    - Description of Medigap [42 CFR 403.205]
    - Options for receiving Medicare:
        - Original Medicare only
        - Original Medicare + PDP
        - MA-PD
        - MA with or without stand-alone PDP

- Overview of Medicare Advantage health plans [42 CFR 422.4, MMCM 1: 30]
    - Description of Coordinated Care Plans (e.g., HMO, PSO, PPO, RPPO, SNPs) [MMCM 1: 30.2]
    - Private Fee-for-Service Plans [MMCM 1: 30.4]
    - Medicare Medical Savings Accounts (MSA) [MMCM 1: 30.3]

- Overview of Other Plan Types
    - Employer Group Plans [42 CFR 422.106 MMCM 1:20]
        - Beneficiary should check with the benefits administrator of the employer or retiree group before changing plans to keep from possibly losing coverage; or
        - Beneficiary may still be able to use employer coverage along with the plan he/she joins
    - Medicare Cost Plans [42 CFR 417, MMCM 1: 20, MMCM 17]
    - Programs of All-Inclusive Care for the Elderly (PACE) [42 CFR 460]

- Overview of Medicare Prescription Drug Coverage
    - Plan types (MA-PD, Stand-alone PDP) [42 CFR 423.4, MMCM 1: 20]
    - Standard benefit [42 CFR 423.100, 423.104, MPDBM 5: 10.2, 30, 20.3]
    - TrOOP, coverage gap, catastrophic coverage

- Part D utilization management [42 CFR 423.4, 423.100, 423.104, MPDBM 6: 30.2, 30.3, 30.4]
    - Formulary and formulary requirements
    - Co-pay tiers
    - Step therapy
    - Prior authorization
- Help for lower-income individuals [42 CFR 423.900 through 423.910, MPDBM 13: 70]
    - Low-income subsidy (LIS), state pharmacy assistance programs (SPAPs)

III. Medicare Part C Enrollment and Disenrollment

- Enrollment procedures [42 CFR 422.50, 422.60, 422.66, 423.30, 423.32, MMCM 2: 40.1, MPDBM 3: 30.1]
    - Format of enrollment requests (use of approved enrollment mechanism such as enrollment via internet or enrollment via telephone). NOTE: if enrollment mechanism being used is for a PFFS or MSA plan use appropriate language for these plan types.
    - Enrollment mechanism used requires beneficiary to acknowledge the following:
        - Understanding of the requirement to continue to keep Medicare Part A and Part 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; and
        - Understanding of the right to appeal service and payment denials made by the organization.

- Processing the Enrollment request [42 CFR 422.60, 422.66, 423.32, MMCM 2: 40.2, MPDBM 3: 30.2]
    - Who may complete the enrollment request

- Non-discrimination requirements [42 CFR 422.2268 (c), 423.2268 (c), MMCM 3: 30.6, MMCM 4: 10.6]
    - Plan sponsors may not discriminate based on race, ethnicity, religion, gender, sexual orientation, disability, health status, or geographic location within the service area.
    - All items and services of a plan sponsor are available to all eligible beneficiaries in the service area with the following exceptions:
        - Certain products and services may be made available to enrollees with certain diagnoses (e.g., medication therapy management program for

individuals with chronic illnesses or medically necessary coverage provisions).
        - Enrollment in the low-income subsidy (LIS), as there may be additional eligibility standards.
    - Plan sponsors may not engage in discriminatory practices including:
        - Targeting marketing to beneficiaries from higher income areas;
        - Stating or otherwise implying that plans are available only to seniors rather than to all Medicare beneficiaries.
        - Only organizations offering SNPs may limit enrollment to dual-eligibles, institutionalized individuals, or individuals with severe or disabling chronic conditions and/or may target items and services to corresponding categories of beneficiaries.

- Enrollment Process [42 CFR 422.62, 422.68, 423.38, MMCM 2: 30, MPDBM 3: 20]
    - Clarify that there are very limited circumstances under which a beneficiary can make a mid-year change in enrollment (exceptions are ICEP, SEPs for moves or other such circumstances, and LIS-eligible beneficiaries, who can switch plans month-to-month).
    - Initial Coverage Election Period (for people newly eligible for Medicare)
    - Annual Election Period
    - Open Enrollment Period
        - LIS and dual-eligible individuals have a special continuous enrollment period
    - Special Election Period
    - Changes to Enrollment Periods with Affordable Care Act
        - No more Open Enrollment Period
        - 2011 will have an Annual Disenrollment Period (ADP) from January 1, 2011 to February 14, 2011 during which a beneficiary can disenroll from an MA plan into FFS Medicare
        - Annual Enrollment Period (AEP) for 2011 will be November 15th to December 31st, 2010.
    - Outbound Education and Verification to New Enrollees [42 CFR 422.2272 (b), 423.2272 (b), MMCM 3: 70.6]
        - After sale has been made, to ensure beneficiary understands the plan rules
        - Calls will come from someone other than agent
        - Exceptions

- Disenrollment [42 CFR 422.74, 423.36, 423.44, MMCM 2: 50, MPDBM 3: 40]
    - Voluntary Disenrollment [42 CFR 422.74, 423.36, 423.44, MMCM 2: 50.1, MPDBM 3: 40.1]
        - MA plan only
        - Original Medicare and a PDP
        - Original Medicare without a PDP
        - MA and MA-PD exceptions

- Involuntary Disenrollment [42 CFR 422.74, 423.36, 423.44, MMCM 2: 50.2, 50.3, MPDBM 3: 40.2, 40.3]
    - Plan Types: MA and MA-PDP, PDP, Medicare Cost Plans, SNP
    - Falsifying and withholding information
    - Paying plan premiums
    - Enrollee rights
        - Enrollees in all plan types have the right to make a complaint if the plan ends their membership
        - If a plan ends an enrollee's membership, the plan will tell the enrollee the reason in writing and explain how the enrollee may file a complaint against the plan

IV. Beneficiary Protections

- Guaranteed rights of the beneficiary include:
    - Choose health care providers within the plan [*Medicare & You* Handbook]
    - Get a treatment plan [*Medicare & You* Handbook]
    - Know how doctors are paid [*Medicare & You* Handbook]
    - Grievance and Appeal Rights Under Medicare Part C [42 CFR 422.560 through 422.626]
        - An appeal can be filed if plan does not pay for, allow or ends a service that should be covered
        - Appeal process should be provided to beneficiary in writing by the Medicare health plan
    - Grievance and Appeal Rights Under Medicare Part D [42 CFR 423.564 through 423.638]
        - An appeal can be filed if beneficiary believes a Part D prescription drug should be paid for by the plan
        - Appeal process should be provided to the beneficiary in writing by the Medicare prescription drug plan
    - Explain plan specific member complaint process in the product specific training

V. Medicare Part C and D Marketing and Educational Events

- Sales Events [42 CFR 422.2260, 423.2260, 422.2264, 423.2264, 422.2268, 423.2268, 422.2268 (b), 423.2268 (b), 422.2268 (p), 423.2268 (p), MMCM 3: 20, 50.1.8, 70.1, 70.2, 70.8]
    - Definition (i.e., marketing to potential members), how different from educational events
    - Promotion (including use of appropriate disclaimers, identification of the types of products that will be discussed, etc.)
    - Dos and Don'ts
        - Locations [42 CFR 422.2268 (j) and (k), 423.2268 (j) and (k), MMCM 3: 70.8.1, 70.8.2, 70.8.3]
            - Community-sponsored health fairs

        - Health care settings, including restricted areas
        - Provider settings
        - Long-term care facilities
      - Topics (Medicare, plan-specific premiums and/or benefits, etc.)
      - Display and/or distribution of advertising and explanatory materials
      - Use of sign-up sheets (and requiring certain fields), unsolicited contacts with beneficiaries, etc.
      - Provision and examples of refreshments, snacks, and meals [42 CFR 422.2268 (p), 423.2268 (p), MMCM 3: 70.2.1]
        - Meals cannot be provided, subsidized, or served at any event where plan benefits are discussed or materials distributed
        - Light snacks and refreshments are acceptable
        - See MMCM 3: 70.2.1 for complete details and examples
  - Notification requirements for cancelled events

- Educational Events – definition (i.e., provide objective information), how different from sales events [42 CFR 422.2264, 423.2264, 422.2268, 423.2268, 422.2268 (l), 423.2268 (l), MMCM 3: 50.1.7, 70.1, 70.7]
  - Definition (i.e., provide objective information), how different from sales events
  - Sponsorship, promotion (including use of appropriate disclaimers, identification of the types of products that will be discussed, etc.), and use of multiple vendors
  - Dos and Don'ts
    - Topics (Medicare, plan-specific premiums and/or benefits, etc.)
    - Display and/or distribution of advertising and explanatory materials
    - Sales activities
      - Use of sign-up sheets, business cards, and plan or agent/broker contact information
      - Further contact with beneficiary (setting up personal sales appointments, permission for an outbound call, etc.)
      - Distribution of sales/marketing materials, including business reply cards and scope of appointment forms
      - Distribution/collection of plan applications
    - Provision and examples of refreshments, snacks, and meals [42 CFR 422.2268(p), 423.2268(p), MMCM 3: 70.2.1]
      - Meals worth $15 or less, based on the retail value of the food, may be provided at educational events

- Personal/Individual Marketing Appointments [42 CFR 422.2268, 423.2268, MMCM 3: 70.1, 70.9]
  - Scope of Appointment for Medigap, MA, and PDP products [42 CFR 422.2268 (g) and (h), 423.2268 (g) and (h), MMCM 3: 70.9.1, 70.9.2]
    - Scope must be agreed to prior to any face-to-face personal/individual marketing appointment
      - Documented in writing, via a Scope of Appointment Form

            - Documented in call recording, placed by the plan sponsor (and not agent/broker)
            - If during the appointment the beneficiary requests to discuss a product not included in the initial Scope of Appointment, a second Scope of Appointment must be signed before the meeting can continue/the product can be discussed
        - Acceptable technologies include conference calls, fax machines, designated recording lines, pre-paid envelopes, e-mail, etc.
    - Dos and Don'ts
        - Discussion of educational content
        - Discussion of plan options (as agreed to in the Scope of Appointment)
        - Discussion/marketing of non-health care products
        - Solicitation of referrals

- Nominal Gifts/Give-aways/Promotional Activities [42 CFR 422.2268, 423.2268, 422.2268 (b), 423.2268 (b), 422.2268(p), 423.2268(p), MMCM 3: 50.1.9, 70.1, 70.1.2, 70.2, 70.2.1, 70.2.2]
    - Promotion (including use of applicable disclaimers, inclusion/exclusion in certain pre-enrollment advertising and explanatory materials, etc.)
    - Must be
        - Offered to all people eligible to enroll
        - Provided whether or not the individual enrolls in the plan
        - Nominal value (worth $15 or less)
            - If a nominal gift provided is one large gift that is enjoyed by all in attendance (for example a concert or a magician) the total retail cost must be $15 or less when it is divided by the estimated attendance (for planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation)
        - Tracked and documented during the contract year
    - May not be:
        - Cash or readily convertible to cash (i.e., rebate, lowering or waiving co-pays)
        - Items otherwise available, to the general public, for free
        - Gift cards or gift certificates to a restaurant or any place where food is served
        - Items that are considered a health benefit (e.g., a free checkup)
        - Tied directly or indirectly to the provision of any other covered item or service
        - Structured to steer enrollees to particular providers, practitioners, or suppliers

- Cross-selling – definition [42 CFR 422.2268, 423.2268, MMCM 3: 70.8, 70.9]
    - Non-health care related products – definition
    - Dos and Don'ts

- Unsolicited contact, outside of advertised sales or educational events or mailings [42 CFR 422.2268, 423.2268, 422.2268 (d), 423.2268 (d), MMCM 3: 70.1, 70.3, 70.4, 70.5, 70.5.1]
    - Door-to-door solicitation
    - Referrals
    - Approaching beneficiaries in common areas (i.e., parking lots, hallways, lobbies)
    - Use of old lists or consents, except for agents/brokers contacting their own clients and/or plans contacting their current members (includes individuals aging-in to Medicare from commercial products agents/brokers previously sold to individual)
    - Use of telephonic or electronic solicitation, including leaving electronic voicemail messages on answering machines, text message, or e-mail contact (unless the beneficiary agrees to receive e-mails from the plan sponsor and the beneficiary has provided his/her e-mail address to the plan sponsor)
    - 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
    - Calls to market plans or products to former members who have disenrolled
    - Calls to market plans or products to current members in the process of voluntarily disenrolling
    - Calls to beneficiaries to confirm receipt of mailed information

- Referrals – solicitation of leads from members for new enrollees [42 CFR 422.2268, 423.2268, MMCM 3: 30.14]
    - May only request names and addresses (cannot request phone numbers)
        - May use member provided referral names and addresses to solicit potential new members by mail only
    - Any solicitation for leads, including letters sent to members, cannot announce that a gift will be offered for a referral
    - Gifts for referrals must be available to all members that provide a referral (cannot be conditioned on actual enrollment of the person being referred)
        - Limited to one gift per member, per calendar year
        - Gifts must be of nominal value ($15 or less, based on retail purchase price of item)
        - Cannot use cash promotions as part of referral program