DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: August 13, 2014

TO: Medicare Advantage-Prescription Drug Plans, Prescription Drug Plan Sponsors, Medicare-Medicaid Plans, Section 1876 Cost Plans

FROM: Kathryn A. Coleman
Acting Director

SUBJECT: Clarification of Medicare Marketing Guidelines and Additional Agent/Broker Compensation Guidance

The Centers for Medicare & Medicaid Services (CMS) has received inquiries regarding the Medicare Marketing Guidelines (MMG) released June 17, 2014 and the new Agent/Broker Compensation regulations. The purpose of this memorandum is to clarify these provisions to ensure consistent and correct implementation of CMS' requirements.

Medicare Marketing Guidelines

Section 70.6 Telephonic Contact

Section 70.6 of the MMG outlines permissible and prohibited telephonic activities of both agents/brokers and Plans/Part D Sponsors. We are clarifying that "plan business" means the member's current plan. Agents may not contact members, via the telephone, to discuss other plan options. This is considered an unsolicited contact.

Section 70.7 Outbound Enrollment and Verification Requirements

Section 70.7 currently states that Outbound Enrollment and Verification (OEV) Requirements "…must be maintained for all enrollments…" To clarify, the OEV process applies exclusively to enrollments in which employed, captive, and independent agents/brokers were involved.

Section 120.2 Plan Reporting of Terminated Agents

CMS requires that Plans/Part D Sponsors report terminated agents to the State and CMS if state law requires. We are clarifying that Plans/Part D Sponsors should adhere to the state requirements for reporting terminated agents to the state. Plans/Part D Sponsors must report for-cause terminations to CMS. These terminations should be reported to your Account Manager, via email or letter. Plans/Part D Sponsors must also report to CMS all sales made by agents without a valid license.

Section 120.4.2 Referral Fees
Section 120.4.2 of the MMG limits referral fees paid to agents/brokers to $100. Since the referral fee must be part of the total compensation, a $100 referral fee would exceed the current fair market value (FMV) for stand-alone Prescription Drug Plans (PDPs). Therefore, we are modifying this section to limit referral fees for PDPs to $30. The referral fee for other plan types remains at $100.

Additional Agent/Broker Compensation Guidance

Effective Dates
Enrollments effective on January 1, 2015 and after are subject to the new compensation requirements, even if the beneficiary signed up for the plan during the CY2015 AEP (October 15, 2014 through December 7, 2014). Enrollments effective prior to January 1, 2015 are subject to the compensation requirements found in the 2014 MMG.

Payment of Compensation
CMS' revised regulations require that Plans/Part D Sponsors make payments for the current year enrollment. Plans/Part D Sponsors may not pay compensation until January 1 and must pay in full by December 31 of each year. Therefore, for all January 1, 2015 enrollment effective dates (including AEP applications), Plans/Part D Sponsors must wait until January 1, 2015, to make compensation payments. CMS recognizes that retroactive enrollments/disenrollments may cross contract years. Payment/recoupment for these instances is exempt from the requirement to make payments between January 1 and December 31 of the enrollment year.

Renewal Compensation
CMS' revised regulations state that renewal compensation is applicable for all years following the initial year enrollment. The renewal payment is up to fifty (50) percent of the current Fair Market Value (FMV). The new requirements are effective for all renewals, regardless of when a member enrolled. For example, a beneficiary enrolled in an MA plan as an initial enrollee in May 2012 would be in the 3rd renewal year in Contract Year (CY) 2015. The MA organization should pay the agent up to 50% of the CY 2015 FMV, not 50% of the initial (CY2012) FMV.

Administrative Fees
Administrative fees (training, testing, and advertising) that are paid to downstream entities such as Field Marketing Organizations may be paid prior to January 1, 2015. These fees are not considered compensation and thus are not subject to the January 1 through December 31 payment requirements.

Initial Enrollment Chargeback

Plans/Part D Sponsors have the option to pay either full or pro-rated compensation for initial enrollments that are effective later than January 1 and have no prior plan history. However, if the Plan/Part D Sponsor pays a full initial compensation and the member disenrolls during the contract year, the Plan/Part D Sponsor must recoup a pro-rated amount for all months the member is not enrolled. This would include months prior to the enrollment.

> For example, a member ages into Medicare and elects an MA-PD plan (Plan A), effective April 1. The member moves and is eligible for a special enrollment period. The member elects a new MA-PD (Plan B), effective November 1. Plan A must recoup 5/12ths of the initial compensation (January through March and November through December) to account for the months the member was not enrolled in Plan A. Since the member had prior plan history when the member enrolled in Plan B, Plan B many only pay a pro-rated initial compensation equal to 2/12ths (November through December).

For additional questions, please contact your CMS Regional Office account manager, if applicable, or submit them to the marketing mailbox at Marketing@cms.hhs.gov.