



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

Real Time Caption Transcript

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2010 Marketing Guidelines & AEP Surveillance Chevell Thomas, CPC/MCAG/DPAP Christine Rinehart

Chevell Thomas

Good morning. I would just like to say I'm fresh from the beach. I'm just getting back this morning. I'm just seeing my presentation. Hopefully I won't disappoint you. The trip was planned before the conference. Today I would like to talk about the what's new in Medicare and marketing and make a few clarifications. If you have an older version of the agenda you might have a third bullet. We are testing some language targeted towards SNPs. We're developing some new materials and hopefully as we get closer to their release you will hear more about that.

What is new in Medicare and marketing? Well, we made some additions to our marketing regulations found in subPart B. We put into the regulation that the marketing rules apply to 1876 cost plans. As you all know, we've kind of used the legal interpretation by our general counsel to say that most of the requirements apply, but now they're in the regulation officially, that should clear up any confusion or misunderstandings. The other important change was the definition of ad hoc communication materials. Those are informational, they're targeted, or they apply to a specific situation and do not include information about plan benefit structure. While these are not what we consider marketing materials, they are required to be submitted in HPMS. They may show up in a retrospective review. There's a couple of examples for you on the slide, shortage of formulary drug, refund information. These are just examples.

The next important change, we added some language around standardized marketing materials. Now when CMS provides standardized language, we will provide a standardized document, it is mandatory to be used without modification. Currently the only two documents that are standardized are the summary of benefits, the annual notice of change, and evidence of coverage.

Next, updates to the marketing guidelines. The first of which is the material ID requirement. In the past when you submitted documents for file and use you had to enter the date when you expected to send them out, typically that was the five days prior to use. Now what you will find is that after you get the acceptance from HPMS you have to go back in and list the actual date that you send out the document, or make the document available.

In section 50 we consolidated all of the disclaimer requirements. Many of you can probably remember the old guidelines where we had disclaimers everywhere. So now we have a section 50 that includes the disclaimers that will you use, it describes when and where they should be place. We also have a couple new, these apply to full and partial network plans.

We also have included update s on the plan mailing requirements. There are four statements that must be on documents that the plan sends out. This is on advertisements, important plan information, health and wellness information, or nonhealth or nonplan information. These should



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

be displayed on all mailings prominently. If you include information on your envelope that is not one of these four statements then you need to submit that information into HPMS, it will require a 45-day review. I just want to point out that envelopes should not resemble official government mailings, plans should place their logo or their name on all mailings. This is something that your delegated entities must also adhere to. If you have a subcontractor that does your pharmacy benefit information, for example, and they have -- they put it into the envelope and mail it, your plan name or logo must be on that document so that beneficiaries will know that it's associated with your plan.

Promotional activities, events and outreach. We added an update to our outbound enrollment verification guidance. These calls must be made for enrollments effect waited by brokers, except in two cases, when a member switches within a plan, within the same plan type. Say they switch from an HMO to a PPO, then the outbound verification call is required. If you have reps collecting information, those are not required to have the outbound verification calls either. In section 100 we talk about plan website requirements, we've updated it to include social media. I just want to make clear that plans are allowed to use social media to promote their plans. We will monitor the activities on these sites and based on our findings we may have additional guidance. Also, plan materials that are included on social media sites must have been approved by CMS and must be in HPMS. If you have an ad that pops up based on key words that advertisement must be an approved advertisement in HPMS, it should have the appropriate material IDs to identify it.

Okay. Moving on to policy Claire of clarifications. The use of med gap data, plan sponsors may not conduct outbound calls for MA, MAPD, activities based on their med gap data. Marketing must be all current enrollees and not just the subsets, and in the case of MA, cost plan or Part D products, they may be discussed in their outbound call in the beneficiary initiates the question. For instance if you are calling about something else, some other med gap plan business and the beneficiary has a question, while I have you on the phone can you tell me about your MA products? Then you are allowed to continue that dialogue with the beneficiary. Section 30. We updated our guidance on nonEnglish speaking. It's the plan sponsor's material to make sure that -- sponsor's responsibility to make sure that materials are available in other languages. Translated versions, in the case where you have populations that do exceed the 10% threshold, those documents must be posted on your plan sponsor website. Regardless of whether the amount of nonEnglish speakers reaches the 10% threshold, for call centers you must be able to accommodate nonEnglish speaking beneficiaries.

The summary of benefits is now a required document in the enrollment kit. This is a slight change. We're now making this mandatory, it was optional. For dual eligible special needs plans you must include your SB with section 4 to meet your comprehensive written statement requirement. That includes section 4, requires a 45-day review, just a reminder.

Okay. Section 80. The customer service number requirements for plan sponsors are a little different for 2011. So I want to point out that you must operate your customer service center from 8:00 a.m. to 8:00 p.m. for the 2011 contract year. Compensation, section 120, in addition to plan sponsors must withhold and recover agent/broker payments. This is new included in the marketing guidelines. We define a rapid disenrollment, it occurs within the first three months of an enrollment. There's one exception, if a beneficiary enrolls in November and then in the following January they change plans that's not a rapid disenrollment, all beneficiaries are allowed the opportunity to change plans for the next contract year. If you have a member enroll in October, November, or December and they remain through December and change in January



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

that is not a rapid disenrollment, you should not be recovering funds from agents who sold those plans. The payments should go with the agent who is providing the services to the beneficiary. An agent should not be able -- an agent cannot make claims on payments when they are no longer with the beneficiary. Then the third situation where you need to recover or not pay funds is other times when members are not in your plan. Say someone joins your plan midyear, say in June, you are not responsible for paying the agent for January-May, they were in another plan, that plan should have been paying the agent. Say they stay in the plan from June-October, you would be responsible for paying the agent from June-October. After November if they move to a different plan then whatever plan is receiving that beneficiary would be responsible for November and December's payment.

Third party marketing organizations, which include field marketing organizations, general agents, brokers and other third party entities that may be providing marketing services for you. It is your responsibility to ensure that they are complying with our marketing rules and requirements. This is very important because as we've done some monitoring in the past we have noticed that some plan sponsors have allowed their contracted entities to set their own requirements. One that comes to mind is FMO was paying agents 25% of the initial amount for renewals. Renewals are 50% of initials. That plan sponsor was out of compliance, their contractor was not following those rules. It's important to make sure that your contracted entities are making sure their people are tested annually, they pass the testing score, that they are continuing to be licensed in the state when the states require those licenses and that they're paying according to our rules for payment. This is really important. When we do our audits, or whatever other marketing monitoring activities, we will look at you when your contractors are not following our rules.

I'm going to turn the mic over to Christine to talk about surveillance. Thank you. [Applause]

Christine Rinehart

Thank goodness for bosses, thank you. I was also at the beach this weekend, I just got back last night. It's good to be here, it's good to see everyone. It's a wonderful turn out. I will talk about the contract year 2011 marketing surveillance area. 2011 surveillance activities, we will continue secret shopping. We will continue to use contractors and regional office staff to conduct these events, we will be using surveillance [Indiscernible] as our primary means of communication. It was used last year, we will continue to use it this year. There will be one major difference that I'm sure you will appreciate, instead of having three business days to respond, we heard your concerns and will increase the amount of time to respond concerning issues to five business days. I am sure that will be a little bit easier on you to do a proper investigation and provide us with a response.

When we tell you that [Indiscernible] is going on, although you do have five days to respond, we expect that you start taking actions upon initial disclosure of information to you through that console. Your organizations will be on notice of the violations when we tell you in the beginning, not after you have responded. We will continue our secret shopping and use the console. We will also do individual shopping. We will continue to do clipping of unreported marketing events. We will use a contract to clip items from newspapers and ensure that they're in HPMS. We're also looking at the nonrenewal rededuction oversight. We want to make sure that plans are providing accurate information. We want to make sure that the plans that are marketing in the service areas are doing so appropriately.

We will still have two contractors and offices doing surveillance activities. Some of the initiatives



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

that will be lead will be calls to local agents, calling to shopping event coordinators, we will be shopping events and also have personal appointments. The ROs will be very active, as in the past.

One of the things that we're doing this year is we will use a true risk-based approach for surveillance. When your organization, we will look at different types of data to determine if you are a high risk organization, high risk organizations will be shopped for frequently than lower risk organizations. We will look at the 2010 secret shopping events. If you were an outlier for 2010 we will consider that a factor and you be placed in the high risk category. If you have had actions that dealt with marketing, if you have had penalties that deal with marketing issues that will be factored into high risk. Clipping service, if we determine there's a number of events that have not been reported in HPMS that will also factor into it.

Complaint performance, the higher rating -- the more complaints you have the higher risk you will be considered. Explosive growth, some organizations have grown extremely fast, we consider that could be more of a high risk situation. That also be looked at for this risk model. If you are a new organization for 2011 that will be considered into the factors of the high risk. After we perform the secret shopping if you have to deal with actions we will follow up with the models, a number of organizations may have received notices last year for surveillance activities, warning letters, the progressive module. When we do the progressive compliance module this year if you received notices last year that will be factored into what type of action you receive this year. When we do shopping in October of 2010 for the 2011 year if you already received a notice last year and you did not improve your performance in October of 2010 we will factor in last year's notice of noncompliance into the compliance action this year. We're holding you accountable for the actions from last year.

As I mentioned, we will be doing personal and individual marketing appointments. That's defined by the personal nature of the beneficiary encounter. When agents go to homes that's a personal event, we will do shopping in that way. Last year we piloted that type of agent communication, this year it's not a pilot but will actually be in effect. We did -- from feedback we received from you we've heard that last year you were concerned if CMS or a contractor -- individual agents often it could affect their income stream, because they have a high number of sales, they don't have a high number of enrollments, we've heard the concerns. We will take into account with our secret shopping this year.

Unreported marketing events and our clipper service. We will be scanning newspapers, other print advertisements for marketed events, we will be checking them to make sure they're in HPMS. It's a reminder to make sure that all events are in HPMS. If you have cancellation make sure to update that in HPMS. You will be held accountable if it's not kept up to date.

New for 2011, we will be looking if he the social -- we will be looking at the social media sites that plans and agents use. As Chevell mentioned, this is a new area. There are some guidelines associated with that. Once we start looking at these social media sites if we determine additional guidelines are necessary we will be -- we will provide additional guidance. Again, ensure that social media sites are reviewed, sent into HPMS, it requires a 45-day review appropriate.

Nonrenewal service area. We have two main goals. First, plans that are potentially gaining beneficiaries we want to ensure those plans that are in position to gain beneficiaries are using CMS approved materials, are using appropriate marketing practices, and are adhering to our



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

guidelines. We will be on the lookout for that. We also want to ensure there's a continuity of service and operations with nonrenewing plans. We will respond as quickly as possible for violations. We want to ensure that further violations are not performed by organizations, we will catch you early and get that violation to stop. The surveillance team will be reporting results to the nonrenewal coordination team. CMS understands the impact of new renewals. Our goal is to respond to problems quickly and also to ensure beneficiaries are safe, that they receive appropriate materials and are treated properly.

When secret shoppers shop events they will pay attention to inappropriate statements. Your agents should be speaking about your plans, benefits, costs. They should not be inappropriate statements concerning other organizations and other service areas.

There was a readiness assessment to make sure that organizations are ready. This includes nonrenewal process requirements, sending the letter timely, it includes complying with marketing requirements such as making statements in sales presentations and continuing operations such as processing claims even though they've been nonrenewed in that service area.

Complaint report activity. We want to make sure that a nonrenewal is not a major source of complaints. We also are going to determine if particular plans are generating exceptional volume. We will highlight certain areas if we see more issues occurring in certain areas than others.

Call centers. We are going to make sure that call centers are still accessible to beneficiaries during the timeframes that they're supposed to be accessible. We want to make sure that the centers provide access responses to questions. We will work to ensure that call centers are working appropriately.

CMS and external partnerships, we will continue the use of on the ground resources. We include departments of insurance and [Indiscernible], we're also using the senior Medicare patrol and other groups. We have more people on the ground, a lot of different entities. We continue to share information with our external partners, those include adjudicated enforcement actions, those include use of aggressive marketing tactics, misleading advertising and phone calls. If we find out you are offering inducements to enroll we will let others know about that. We are working with our partners closely, they're also working with us, to provide information that is found in the marketplace.

As I mentioned before, CMS had an industry call with you a while back to look at issues with our HPMS console. We've made some changes based on that industry call. First, we have increased the timeframe for responses from three to five business days. We've are weighting issues, administrative issues will receive a lower weight than a marketing representation. When you look in the console you will see more data, you will be able to compare your data against the industry averages, that will be able to be done after the AEP season is over. You will able to see how you perform against others. You will also be able to download reports and send them internally. You will be able to take reports, ship them off to people. We are also in the process of moving the console into HPMS. So we are hopeful that should be done for the next surveillance season.

To do a quick summary of the changes for 2011, again, a true risk model. Higher risk organizations will be shopped more. Appropriate corrective action. We will look at social media.



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

We will be using on the ground resources. The surveillance console will have increased functionality, you now have five days to respond. Here's my contact information. Right now I think we have some time for some questions.

Does anyone have a question? There we go.

My question is for Mr. Thomas. Could you elaborate on the dedicated customer service hours from April 1-October 15 from 8:00 a.m. to 8:00 p.m.

What exactly?

You mentioned in the slides about the first three months of the year. There was nothing from April 1-October 14.

The normal customer service hours would apply during those times.

Okay.

There is a period of time that we've not really addressed, which was -- let me find the slide real quickly. After December 7, we didn't have an -- haven't addressed that. We haven't decided how to apply the rules at that point in time. Since it's not affective until 2011 you will get an update.

Thank you.

We have another question over here. Your name and who you work for.

Good morning. My name is Rita. According to the regulations plans are required to be open from January 1-March 1 from 8:00 to 8:00. Can you tell us if there's a reason, or it requires for the SNPs to have a live person answering the phone during this period?

Unfortunately I can't answer for SNP plans today, so my recommendation is to submit that question. Do we have a place to submit that?

All questions are to be referred to the CMS account managers.

Thank you.

Question over here.

Hi, good morning. Kevin Gray from American healthcare care. Agent compensation. The question is why are plans not able to resubmit a compensation structure annually? The programs went into effect last year, while MA plans are required and are able to adjust most other components. Why can't we adjust based on business needs?

The current regulation specified 2009 as the base year from which other all other adjustments will be made. In order to change that we will have to do a regulatory change. So, um, what I can offer to you is that the current regulations are interim final. And so we have three years from the date of publication to either accept them or propose new regulations. We're coming up on that date pretty soon here. They were published in the fall of 2008. In the fall of 2011 we will have to decide on that. I say all of that to say there may be an opportunity for you to provide comment



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

about those requirements. That input will be taken at that time and used either to change or not.

A follow-up question. In one of your slides you mentioned with regard to recovering compensation -- to a change in agent. I'm not familiar how that would work where the agent is not really providing customer service, they are the enrollment broker, but no longer really have -
- I'm not sure how somebody would change their agent.

We don't have a process specified. That would be up to all to determine. We have received questions in the past from beneficiaries and from agents in which a beneficiary is unhappy with their agent, they get another one. Then when the plan sponsor stops payment the agent has come to us asking why they're no longer being paid. If you are not servicing the beneficiary annually then there is no reason for you to continue to be paid.

Okay, thank you very much.

[Captioner One more question.

I am [indiscernible], last year in the console we had access to the CMS tool, both -- secret -- as well as individual home -- secret shopper tool for our training purposes. Would that be available before marketing season starts?

I wish I could provide you an answer. E-mail me and I will respond back. I don't know that right off hand.

All right.

Thank you.

Thank you very much for your presentation Chevelle and Christine.
[Applause] >