CMS Call Center Compliance

MEDICARE ADVANTAGE SPECIALISTS
AN INTEGRITY COMPANY

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I. DEFINITIONS

Term	Definition
CMS	Centers for Medicare and Medicaid Services
Carrier	Insurance Company, or Plan Sponsor as defined by CMS
MA	Medicare Advantage
PDP	Prescription Drug Plan
Telesales	For the purpose of this policy, Telesales refers to all telephonic marketing, sales, and enrollment activities for MA/PDP products done within a call center environment
Call Center	Organizations that conduct Telesales activities (see above) under a "call center" contract

II. PURPOSE

The purpose of this policy is to ensure that all MA/PDP Telesales activity conducted in a call center setting is done so in accordance with CMS and carrier regulations.

III. POLICY

All agents and agencies conducting Telesales activities within a call center setting for federally regulated Medicare products must adhere to all CMS and carrier regulations. Demonstrated competence regarding these regulations is crucial for downline call center organizations wanting to conduct Telesales activities.

IV. PROCEDURE

Pre-Approval

Approval from each applicable carrier is required before any Telesales activities can be conducted within a call center. Each carrier has their own approval process and requirements, and the call center or Telesales agency must adhere to each carrier's pre-approval process. Medicare Advantage Specialists employees wanting to onboard a call center should contact the compliance department. Downline agencies wanting to get contracted as a call center for federally regulated Medicare products must complete the Medicare Advantage Specialists Call Center Onboarding Packet to initiate the onboarding process. Once this is complete and submitted, representatives from the Call Center organization will work directly with representatives from the applicable Carriers and Medicare Advantage Specialists to complete all requirements within each carrier's approval process.

Carrier requirements of pre-approval can include, but are not limited to: formal application requests, on-site reviews, audits (both pre-approval and annually), attestations, script submission/approval, call recording capability reviews, quality control documentation, checklists, policies and procedure documentation containing all requirements for compliant Telesales activities including TCPA (Telephone Consumer Protection Act) and CMS regulations, enrollment systems, security/privacy protocols and capabilities, agent performance tracking, and marketing and lead generation practices.

Oversight and Quality Assurance

1. Call Center organizations must have an internal oversight and quality assurance program in place to ensure compliance with Federal, State, and carrier regulations; and also to ensure that quality customer service is being provided by all call center agents.
    - Call Centers should have Policies & Procedures in place that describe how the organization will go about meeting these regulations, requirements, and standards. This documentation must be provided to Medicare Advantage Specialists during the onboarding process and should detail the processes in place to ensure the call center organization is operating compliantly.
    - As part of the quality assurance program, Call Center organizations must complete call reviews to ensure agents are operating compliantly and exhibiting quality customer service. Call Centers can use their own call evaluation forms and methods, or they can adopt Medicare Advantage Specialists's if they so choose.
    - At a minimum, Call Center organizations must review one call per agent per month per carrier, unless otherwise instructed, and have a process to address corrective actions when issues are identified during the call review process Each carrier has their own standard in regard to call reviews, so Medicare Advantage Specialists developed its minimum standard based on compilations of multiple carrier requirements.
    - Call Center organizations should have a policy and processes in place to review and monitor lead sources for compliance.
    - Call Centers should have Policies & Procedures in place that outline a process for self-reporting issues of non-compliance to applicable carriers.
2. Medicare Advantage Specialists will also maintain an effective oversight and quality assurance program to ensure downline call center organizations are operating compliantly and meeting certain minimum standards in terms of customer service. The Medicare Advantage Specialists oversight program includes:
    - Completion of the Medicare Advantage Specialists Call Center Onboarding Packet
    - Collection of call center's applicable Policies and Procedures
    - Monthly call reviews when required by the carrier
        - The number of call reviews may vary in number based on a variety of factors, but when it is required, Medicare Advantage Specialists will review three calls per month

for each carrier that requires we do so. Medicare Advantage Specialists will review the call and score/rate it using the Medicare Advantage Specialists Telesales Call Review Evaluation Form and then compare it to the downline call center's review of that same call to ensure call review effectiveness

    - Medicare Advantage Specialists will utilize secure File Transfer Protocol (FTP) to receive or transmit call recordings. Medicare Advantage Specialists will initiate the request for call recordings via email or phone call. When requested, downline call centers of Medicare Advantage Specialists shall transmit call recordings within two business days via this method

- Annual Telesales Compliance Review completed by all downline Telesales agencies.

    - Medicare Advantage Specialists compliance personnel will initiate the review, and they will work with representatives from the call center throughout completion of the review. The review will consist of various compliance questions, the request for certain compliance metrics and reports, and an attestation of compliance. Once completed, the call center representative should return it within the specified timeframe given by the Medicare Advantage Specialists representative

- Oversight will also include continued monitoring and ongoing support by Medicare Advantage Specialists representatives which can include:

    - Review of complaints and violations received by the carrier
    - Identification of coaching opportunities and/or possible risk areas that need addressed
    - Ongoing support with compliance and marketing strategies
    - Communication of compliance requirements
    - Support with audits and call reviews/investigations

3. When carriers allow a downline call center of Medicare Advantage Specialists to contract call center agencies underneath their hierarchy, said call center must have an appropriate oversight plan in place to ensure compliance standards are being met by those downline agencies. Call center entities can adopt the Medicare Advantage Specialists oversight plan or utilize their own. If using their own, the call center should be prepared for reviews or audits to prove the effectiveness of their oversight plan.

CMS Telephonic Contact Rules

1. Pursuant to Section 40.3 of the Medicare Communications and Marketing Guidelines, Telesales agents must have compliant "Permission to Contact" prior to making outbound calls to prospective clients in regard to federally regulated Medicare products (i.e. Medicare Advantage and Prescription Drug Plans, and certain Carrier's Medicare Supplement Plans). Examples of permission to contact include Business Reply Cards (BRC) including electronic submissions via a website or some other electronic or online form, emails requesting a return call, or recorded requests for agent contact made by

the consumer. Verbal requests to be contacted via inbound calls must be recorded and stored for a duration of 10 years. Permission to contact applies only to the individual that made the request and only to the entity from which the individual requested contact from; for the duration of that transaction, and for the scope of the product indicated. Each telephonic enrollment request must be recorded (audio) and include a statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as described in Appendix 2 of the Managed Care Manual), and a verbal attestation of the intent to enroll. If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual's authority under State law to complete the request, in addition to the required contact information. All telephonic enrollment recordings must be reproducible and maintained as provided in section §60.9 (Medicare Managed Care Manual).

2. Telesales agents are allowed to contact current customers at any time to discuss their current plan business per Medicare Marketing Guideline regulations. Calls to current customers can be made to discuss plan business, promote other Medicare plan types, and conduct normal business activities related to enrollment; as well as to discuss benefits, plan information, upcoming plan changes, AEP dates, conduct disenrollment surveys (after the disenrollment date), and other related activities that meet CMS standards.

3. Telesales agents are prohibited from using bait and switch strategies, making outbound calls based on referrals, calling former customers who have disenrolled or are in the process of disenrolling (disenrollment surveys are permitted), calling customers from a sales event (unless express permission is given with documentation of permission), and calling customers to confirm the receipt of mailed information. Calls to former enrollees after the disenrollment effective date are permitted in order to conduct disenrollment surveys for quality improvement purposes (disenrollment surveys conducted telephonically, email or conventional mail may not include sales or marketing information)

Sales Script and Telephonic Enrollment

1. Only pre-approved telephonic scripts can be used for the purposes of marketing and/or enrollment into federally regulated Medicare products.

2. Sales and Enrollment scripts must be reviewed and approved annually and/or when CMS guidance is updated to ensure compliance.

3. A thorough needs assessment must be completed and a complete sales presentation covering all necessary elements of a plan must be given prior to enrollment, in order for the consumer to make an informed and educated decision. Agents should also fully review the Summary of Benefits with each client in order to ensure understanding.

4. Call center agents should not discriminate based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, medical history, genetic information, evidence of insurability, or geographic location.

5. If the consumer requests an in-home appointment for further information, pursuant to Section 50.3, Telesales agents should record a verbal Scope of Appointment for the future in-home appointment. If any revisions or amendments to the SOA are needed in the field, the agent may need to complete a paper form at that time.

6. Sales calls must include a privacy statement clarifying that the customer is not required to provide any health-related information to the plan representative unless it will be used to determine enrollment eligibility.
7. **May only enroll consumers telephonically as a result of an inbound call.**
8. Inbound calls made directly to a sales department or a sales agent must clearly inform the customer if/when the nature of the call moves from a sales presentation to telephonic enrollment. This must be done with the full and active concurrence of the customer, ideally with a yes/no question.
9. Once an enrollment request has been identified and recorded, the Telesales agent will transition from the approved Telephonic Sales Script to an approved Telephonic Enrollment Script which is to be utilized verbatim.
10. Each telephonic enrollment must be recorded (audio) and include a statement of the individual's agreement to be recorded, along with all required elements necessary to complete the enrollment and a verbal confirmation of the intent to enroll ("Statement of Understanding" must be read verbatim from the CMS approved enrollment application). If the request is made by someone other than the consumer, a recording of the individual's such authority under State Law along with their contact information is required.
11. All telephonic enrollment recordings must be reproducible and maintained in a manner that meets CMS and carrier standards.
12. Consumers must be advised they are completing an enrollment into a Medicare Part C or Part D plan.
13. Collection of financial information (i.e. credit card number or bank account) is prohibited at any time during the call.
14. Upon completion of the telephonic enrollment, the Telesales agent must provide the consumer with a confirmation number for tracking purposes.
15. A notice of acknowledgement and any other required information must be provided to the consumer.

Operational Standards and Reporting Requirements

1. Certain operational standards must be met in order to be approved for Telesales activities and to maintain good standing and the ability to continue Telesales activities. These standards can be dependent upon the individual carrier and can include, but are not limited to the following:
    - The use of alternative technologies such as voice-mail or an answering service for weekends, holidays, and off business hours is permitted/required. Must indicate the voicemail is secure
    - Provide free interpreter services to all non-English speaking and LEP consumers or have the ability to transfer such calls to the carrier for interpreter services

- Provide TTY service to all hearing impaired current or potential customers or have the ability to transfer such calls to the carrier for TTY services
- Establish and follow an explicitly defined process for handling member complaints
- Secret Shopper compliance (standard threshold set by each applicable carrier)
- Call Centers cannot use non-licensed customer service representatives to perform functions that require State marketing licensure
- Call Centers are allowed to use non-licensed administrative support staff to conduct certain customer service activities such as:
    - Conducting Plan Changes
    - Answering Calls
    - Setting Appointments
    - Providing Information as outlined in this policy
    - Providing factual information
    - Fulfilling material requests
    - Taking Demographic Information for the purpose of enrollment when initiated by enrollee
    - "For-Cause" review of materials and activities for complaint investigation
    - "Secret shopper" activities where CMS requests materials such as enrollment packets
    - In the event the call center uses licensed benefit advisors and/or Telesales agents as customer service representatives to answer inbound calls or make outbound calls, sales management ensures (when/if applicable):
    - The licensed benefit advisors and/or Telesales agents are trained on customer service processes and systems
    - The licensed benefit advisors and/or Telesales agents are removed from inbound sales queues that are assigned in the phone system
    - The phone queue supervisor is provided a list of benefit advisors and/or Telesales agents' names via email to remove agents from sales queues
        - Confirm benefit advisors and/or Telesales agents have been removed by receiving a screen print of their active queue list.
    - Benefit advisors and/or Telesales agents are added back to assigned sales queues once the customer service project has been completed

2. Telesales organizations must also be able to track certain metrics for reporting purposes. Each Carrier may have its own set of metrics it requires to be tracked for those reporting purposes. These metrics can include, but are not limited to the following, and must be **reproducible for a period of ten (10) years** upon request:

    - Average hold times
    - Average ring times / # of rings
    - Disconnect rates
    - Abandoned/Dropped call rates
    - Average “handle” or “talk” time
    - Total calls handled
    - Enrollments (both total and per agent)
    - Call to Enrollment ratio
    - Call volume data
    - Adherence %
    - Quality measurement

V. DISCIPLINARY ACTION / SANCTIONS

Those who violate this policy are subject to discipline up to and including termination in accordance with the Medicare Advantage Specialists Sanctions and Disciplinary Action Policy. Furthermore, corrective actions can include, retraining, suspension of marketing privileges, termination, and/or reporting of misconduct to the respective State Departments of Insurance.