Plan Specific Training
2016

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WELCOME!

The entire Sales Team and Agent Services welcome you to the 2016 Season. Our goal is to provide exceptional service. Please contact us for any assistance you may need. It is important to us that you can find helpful support and find it easily!

Agent Services

1-877-877-0539

Agent Service team members are happy to assist and whenever possible, our goal is one call resolution. If further research or coordination with another department is necessary, we will follow up in a timely manner.

AEP Hours

August 1st – December 7th

Monday – Friday from

8am – 8pm

Saturday & Sunday from
8:30am – 5:00pm

Regular Hours

December 8th – August 2015

Monday – Friday from
8:00am – 8:00pm

Agent Services

Other ways to contact us:

https:vipagentsupport.com

Use our 24/7 Answers Online inquiry feature on your homepage. The VIP Agent Support site is a secure site for sending and receiving general, member or commission inquiries/responses when the content of the inquiry contains member protected health information (PHI).

By Email:
salesinfo@vipagentsupport.com
Please remember, do not include any prospect or member information that would be considered (PHI) via email.

Our local area Sales Managers are happy to assist you. For contact information in your local area click https://vipagentsupport.com/PublicPages/MarketAreaPublic.**aspx**

VIP Agent Support Portal

After you have completed certification, you will be taken to your homepage where you will have access to the full site that includes the following features:

- ✓ Your Clearance to Market Status
- ✓ Commission statement reporting for direct pay agents
- ✓ Important announcements and information updates
- ✓ View & download sales training materials such as plan presentations, provider directories, & video links
- ✓ Update your profile information or change your password

- ✓ Send and receive general, member or commission inquiries (if a direct pay agent)
- ✓ Review frequently asked questions
- ✓ Visit the Agent Tools & Resources pages on the outside of the site to find direct links to provider directories, drug finders, plan & product info for each line of business in one convenient place

Important!

CLEARANCE TO MARKET (C2M)

- **Agents/Brokers MAY NOT receive material or conduct business until the plan completes all necessary steps and designates the agent/broker "Cleared to Market" (C2M). This includes completion of a background check, receipt of all requested documentation, verification of required trainings, and confirmation of State appointment.**

- **After completion of the above steps, the plan will update the status on the Agent's homepage to "Cleared to Market". This must be verified by both the agent/broker and the agent/brokers current Agency before representing products.**

- **Failure to verify the C2M status could result in termination for cause per CMS guidelines.**

- **If this status changes during Semi-Annual background checks, or DOI notification, the Plan will contact the Agent/Broker and Agency.**

Agent Homepage

1-877-877-0539
https://vipagentsupport.com

Home | Market Areas | Plans & Products | Agent Tools | Member Resources | Contact Us

Welcome : Q987654 !! You are Logged in as : Agent

Logout

Quick Links

- Home
- Agent
  - Join Agency
  - View/Edit Profile
  - Complete / Print producer agreement
  - Complete / Update payment options
  - Complete / Update W9
- Certification
  - Take Test
- VIP Answers Online
  - Create a Message
  - View Received Messages
  - View Sent Messages
- Announcements
  - View Announcements
- FAQ
  - View FAQ
- Marketing Materials
  - Order Materials Here
  - Online Enrollment Application
  - View Document
- Administration
  - Change Password
  - Compliance Documents
- Reports
  - Agent Statement

Welcome CSTest CSTest !

2015 Certification is now available !

Agent ID is: Q987654

2015-General Test Certification # : 201446240/Score 100.00 %

2015-Freedom Test Certification # : 201446242/Score 100.00 %

2015-Optimum Test Certification # : 201446314/Score 100.00 %

Your Contracted Agency is:

Name: Test Chrissy

Address:

Email: cstahl@sunlabusa.com

Clearance To Market

Company Name	Year Of Clearance	Market Clearance Date	Insert Datetime	Clear to Market
Freedom	2015	08/19/2014	8/19/2014 4:27:33 PM	Yes

Agent News

AnnouncementId	Title	Date	Company	Announcement Category
244	tufailannouncement	8/19/2014 6:14:53 PM	EasyChoice	Compliance
242	tufailannouncement	8/19/2014 6:14:53 PM	AFC S	Compliance
240	tufailannouncement	8/19/2014 6:14:53 PM	Optimum	Compliance
239	tufailannouncement	8/19/2014 6:14:53 PM	Freedom	Compliance
231	newAnnouncement	8/5/2014 9:59:30 AM	EasyChoice	Marketing

Your homepage contains:

-your test scores,
-clearance status,
-recent announcements,
-ability to print your producer agreement,
-update your payment options and W-9 (if direct pay),
-change your password.

You can also order materials, and if you are a direct pay agent you can view your commission statement and submit inquiries.

Visit our Concierge Offices

Healthcare is local – whether it's your doctor, your specialist, or your insurance provider. We're headquartered in Tampa, Florida, with local concierge centers throughout the State.

Member Services: **1-866-245-5360**
TTY: **711**

Our Local Concierge Centers Offer:

- Staff to help expedite general issues (replacement cards, PCP changes, etc.)
- Licensed agents
- 1-hour resolution time

Visit or Call Us at a Location Near You

Concierge Hours of Operation:
8am - 5pm, Monday - Friday

Orange/Osceola/Seminole
950 S. Winter Park Dr,
Ste. 340, Casselberry
Toll Free: **1-888-364-7905**

Manatee/Sarasota
3874 E SR 64, Bradenton
Toll Free: **1-888-850-5315**

Citrus/Hernando/Pasco
8373 Northcliffe Blvd, Spring Hill
Toll Free: **1-888-211-9921**

Hillsborough/Pinellas/Polk
5403 N. Church Ave, Tampa
Toll Free: **1-888-211-9918**

Lake/Marion/Sumter/Volusia
2102 SW 20th Place,
Building 200, Suite 201, Ocala
Toll Free: **1-888-420-2539**

You can also find us online at
www.youroptimumhealthcare.com

5 Concierge/Sales Office Statewide

$0 Cost Preventive Services

- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement
- Cardiovascular Screening
- Colorectal Cancer Screening
- Diabetes Screening
- Diabetes Self-Management Training
- EKG Screening
- Flu Shots
- Glaucoma Test
- HIV Screening
- Hepatitis B Shot
- Mammograms
- Medical Nutrition Therapy Service
- Pap Smears/Pelvic Exams
- Pneumococcal Shot
- Prostate Cancer Screening
- Annual Wellness Visit
- Smoking Cessation Counseling

FORMULARY TIER CHANGE

Formulary Information

Initial Coverage Stage Drug Costs

The plan has four (4) cost-sharing tiers. Every drug on the plan's Drug List is in one of four cost-sharing tiers. To find out which cost-sharing tier your drug is in, look it up in the plan's Formulary. Then refer to the benefits section for plan-specific cost-sharing.

How do you find your drugs in the Formulary?

There are two ways to find your drug within the formulary:

1) Alphabetical Listing
The Index of the Formulary provides an alphabetical list of all of the drugs along with the page number where you can find coverage information.

2) Medical Condition
Drugs in the formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular Agents".

In general Cost-Sharing Tier 1 Drugs are the lowest tier and includes only Generic Drugs, Tier 2 Drugs include Preferred Brand Drugs and some non-preferred Generic Drugs, Tier 3 Drugs include non-preferred Brand Drugs and non-preferred Generic Drugs and Tier 4 Drugs are the highest tier and include Specialty Tier Drugs.

In general, Cost-Sharing Tier 1 Drugs are the lowest tier and include **Only Generic Drugs**. Last year some brand were included.

Tier 2 Drugs include Preferred Brand Drugs and some Non- Preferred Generic Drugs, Tier 3 Drugs include Non-Preferred Brand Drugs and Non-Preferred Generic Drugs and Tier 4 Drugs are the highest tier and include Specialty Tier Drugs.

How Much Do You Pay for Prescription Drugs?

Stage 1
Initial Coverage Stage

The plan pays its share of the cost of your drugs and you pay your share of the cost.

You stay in this stage until your payments for the year plus the plan's payments total $3,310

Stage 2
Coverage Gap Stage/ Donut Hole

You pay 58% of the generic drug cost and the discounted cost for brand drugs until the yearly out-of-pocket drug cost reaches $4,850, unless you are already getting Medicare Extra Help.[1]

Stage 3
Catastrophic Coverage Stage

Once you have paid enough for your drugs to move onto this last payment stage, **the plan will pay most of the cost** of your drugs for the rest of the year.[2]

2016 Part D Standard Benefit Model changes for CY 2016

(2)You pay the greater of 5% or $2.95 for generic or preferred multi-source drugs and the greater of 5% or $7.40 for all other drugs.

Optimum HealthCare has a plan for you!

The Optimum HealthCare Medicare Advantage HMO are plans with prescription drug coverage that offer many valuable benefits.

Optimum HealthCare also offers two types of Special Needs Plans (SNPs). If you qualify to join a Medicare SNP, you get all of your Medicare hospital and medical health care services through the plan, including Medicare prescription drug coverage:

- **The Full & Partial Dual Eligible Special Needs Plans (HMO-SNP)** with drug coverage are plans available to anyone who has both Medical Assistance from the State and Medicare. Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive.

- **Chronic Condition Special Needs Plans (HMO-SNP)** with drug coverage are plans for those individuals who have been diagnosed with chronic or disabling conditions such as:

- Diabetes
- Cardiovascular Disease for:
  - Cardiac Arythmias
  - Coronary Artery Disease
  - Peripheral Vascular Disease
  - Chronic Venous Thromboembolic Disorder
- Chronic Congestive Heart Failure
- Chronic Lung Disorders:
  - COPD
  - Bronchitis
  - Asthma
  - Pulmonary Fibrosis

The plan will need to obtain verification of the chronic condition from your doctor. A response from your doctor's office is required within 30 days of enrollment. If you lose eligibility or there are changes to your eligibility or qualifying conditions, you will be disenrolled from the special needs plan. However, you will be eligible for a Special Election Period that will enable you to enroll in another plan.

Plans by County

2016

H5594

		Gold Rewards			Gold Plus	Platinum		Emerald		Diamond Rewards					
		HMO	HMO	HMO	HMO	HMO	HMO	Partial DSNP	Full DSNP	3 Cond CSNP	COPD CSNP	3 Cond CSNP	COPD CSNP	3 Cond CSNP	COPD CSNP
PBP#	County Code	001	026	022	032	002	019	016	017	028	029	030	031	34	35
Brevard	10040							X	X					X	
Broward	10050	X				X		X	X						
Charlotte	10070							X	X					X	X
Citrus	10080						X	X	X			X	X		
Collier	10100							X	X					X	X
Dade	10120	X				X		X	X						
Hernando	10260	X			X	X		X	X	X	X				
Hillsborough	10280	X				X		X	X	X	X				
Indian River	10300							X	X					X	X
Lake	10340		X					X	X			X	X		
Lee	10350							X	X					X	X
Manatee	10400							X	X			X			
Marion	10410		X					X	X			X	X		
Martin	10420							X	X					X	X
Orange	10470			X				X	X			X	X		
Osceola	10480			X				X	X			X	X		
Palm Beach	10490							X	X						
Pasco	10500	X				X		X	X	X	X				
Pinellas	10510	X				X		X	X	X	X				
Polk	10520						X	X	X			X	X		
Sarasota	10570						X	X	X			X			
Seminole	10580			X				X	X			X	X		
St Lucie	10550							X	X					X	X
Sumter	10590		X					X	X			X	X		
Volusia	10630			X				X	X			X			

Official Optimum HealthCare Plan Names

H5594	1	Optimum Gold Rewards Plan (HMO)
H5594	2	Optimum Platinum Plan (HMO)
H5594	16	Optimum Emerald Partial (HMO SNP)
H5594	17	Optimum Emerald Full (HMO SNP)
H5594	19	Optimum Platinum Plan (HMO)
H5594	22	Optimum Gold Rewards Plan (HMO)
H5594	26	Optimum Gold Rewards Plan (HMO)
H5594	28	Optimum Diamond Rewards (HMO SNP)
H5594	29	Optimum Diamond Rewards COPD (HMO SNP)
H5594	30	Optimum Diamond Rewards (HMO SNP)
H5594	31	Optimum Diamond Rewards COPD (HMO SNP)
H5594	32	Optimum Gold Plus Plan (HMO)
H5594	34	Optimum Diamond Rewards (HMO SNP)
H5594	35	Optimum Diamond Rewards COPD (HMO SNP)

Register & Do More Online with our Member Portal!

Here are some of the benefits you will receive:

Place & track orders for your over-the-counter medication and diabetic supplies.

Find a Plan Doctor, Pharmacy, Hospital and covered drug.

Print and order your ID CARD, provider directory, formulary and other Plan materials.

Gain access to health & wellness information.

View your claims activity and benefit information.

Access important Plan forms and documents from central location.

Track your out-of-pocket expenses. (MOOP)

Log onto **www.freedomhealth.com** and register **TODAY!**

Material Ordering

- Upon successful completion of certification, an agent will be able to access all the features of their homepage including material ordering.
- Please allow 24 hours from your "Clearance to Market" for your information to be relayed to the fulfillment center before you are able to order.
- From your homepage, you will see a material order quick link on the left side of the page. Once you click to order, you will be linked directly to the ordering site. Please review the kitting description on the next page. Kitting has been streamlined with simple kitting options.
- Your order is set to ship to the address you have listed on your VIP profile. However, you have an option to ship to an alternative address.

Material Ordering

Original Allocation Amount	Reallocation Criteria	Net Available
8	More than 1 apps	16
16	More than 2 apps	32
24	More than 3 apps	48
32	More than 4 apps	64
64	More than 5 apps	15%

VRA

Scope of Appointment Options

The Plan strongly recommends the Voice Recorded Appointment (VRA) as the preferred method of satisfying the scope of appointment prior to a presentation. Our VRA process is a brief, beneficiary driven call that mirrors the Scope of Appointment model document. A successful VRA call is one where the agent has educated the prospective member on what to expect when they call.

VRA

Voice Recorded Appointment Steps

1) Agent will refer the prospect to call the VRA line.

2) Operators at the VRA line will read the CMS required statements and gather the prospect's contact information. The beneficiary will be asked, but not required to provide their phone number and address. It is an optional element of the scope.

3) The prospect will record their agreement to discuss the plan's products.

4) The prospect will be asked the agent's name and tentative appointment time.

5) The prospect will be given a VRA confirmation number.

6) You will need the VRA confirmation number prior to visiting the prospect. You may arrange to have the prospect call you with the number, or you may call the prospect following the VRA call.

7) In addition, the VRA line will have a database of the Plan's certified agents, license numbers and will be able to provide you the VRA#.

8) You may also call Agent Services at 1-877-877-0539 to look up a completed VRA confirmation number.

OPTIMUM VRA

ENG: 1-800-428-2198

SPAN: 1-800-516-8076

PAPER SOA

Paper Scope of Appointment

The paper scope of appointment is another option to securing the required scope. Please review the required elements for completion.

Submission of a complete SOA is required.

For scanning purposes, please use black ink, print legibly following the box structure.

Original Paper scopes are not required if it was properly submitted by fax along with the enrollment applications. As part of CMS retention requirements, it is highly recommended you maintain a copy of all submissions.

Please Note: If doing an online enrollment, the SOA must still be faxed in using a coversheet identifying the member it is associated with. Indicate on the coversheet the submission is an SOA for online enrollment only.

Paper Scope of Appointment

Important! All items must be completed!

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug ... prescription drug coverage to ... some Medicare Private-Fee- ... Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO)— A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare Preferred Provider Organization (PPO) Plan— A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the ... mbers. You will usually ...

... tage Plan that has a ... e needs. Examples of ... edicare and Medicaid, ... ertain chronic medical conditions.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: ______

(Plan Use Only) Application # ______

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss ... y do not ... id based ... enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature: ______

Signature Date: (MM-DD-YYYY) ______

If you are the authorized representative, please sign above and print below:

Representative First Name ______ I. ___ Last Name ______

Your Relationship to Beneficiary: ______

To Be Completed By Agent:

Agent First Name ______ I. ___ Agent Last Name ______

Agent Phone Number ______

Beneficiary First Name ______ I. ___ Beneficiary Last Name ______

Beneficiary Phone Number (Optional) ______

Beneficiary Address (Optional) ______

Beneficiary City ______ State ___ Beneficiary Zip Code ______

Initial Method of Contact: (Indicate here if beneficiary was a walk-in) ______

Agent's Signature: ______

Plan(s) the agent represented during this meeting: ______

Date Appointment Completed: (MM-DD-YYYY) ______

Member must Initial in the box next to plans they want discussed

Agent must provide an explanation if SOA completed at time of the appointment

Fill in the application form number associated with the SOA found in lower right of application

Fill in as required.

- Beneficiary or Rep Signature and date

Please note: It is optional for the beneficiary to provide a phone number or address

- Fill in initial method of contact with prospect
- Your Signature
- Fill in PBP# of plans discussed
- Date you held appointment

Enrollment Application PG 1 &2

H55942015E1

Please contact Optimum HealthCare, Inc. if you need information in another language or format.

To Enroll in Optimum HealthCare, Inc. Please Provide the Following Information:

Please check which plan you want to enroll in:

- ❑ Optimum Gold Rewards Plan (HMO-POS): **$0** per month
- ❑ Optimum Emerald Partial (HMO SNP): **$25.80** per month
- ❑ Optimum Emerald Full (HMO SNP)*: **$25.80** per month
  *(For QMB full-benefit dual eligible only)
- ❑ Optimum Platinum Plan (HMO-POS): **$0** per month
- ❑ Optimum Diamond Rewards (HMO-POS SNP): **$0** per month
- ❑ Optimum Diamond Rewards COPD (HMO-POS SNP): **$0** per month
- ❑ Optimum Gold Plus Plan (HMO-POS)**: **$0** per month
  **(Hernando County Only)

LAST Name: (use boxes below) ❑ Mr. ❑ Mrs. ❑ Ms. FIRST Name: MI:

Birth Date: M M D D Y Y Y Y Sex: ❑ M ❑ F Home Phone Number:

Permanent Residence Street Address 1: (PO Box is not allowed) Alternate Phone Number: (optional)

Street Number Street Name Lot/Apartment

City: State: Zip Code:

E-mail Address: (optional)

Mailing Address (only if different from your Permanent Residence Address):

Street Number Street Name Lot/Apartment

City: State: Zip Code:

Emergency contact: (optional)

FIRST Name: MI: LAST Name:

Phone Number: Relationship to You:

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

Name: SAMPLE ONLY

Medicare Claim Number: Sex: ❑ M ❑ F

Is Entitled To — Effective Date: M M D D Y Y Y Y

HOSPITAL (Part A)

MEDICAL (Part B)

Paying Your Plan Premium (If Applicable)

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Optimum HealthCare the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionaly, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 711. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

- ❑ Get a bill.
- ❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums).

H55942015E2

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ❑ YES ❑ NO

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to Optimum HealthCare? ❑ YES ❑ NO

   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage:

   ID # for this coverage: Group # for this coverage:

3. Are you a resident in a long-term care facility, such as a nursing home? ❑ YES ❑ NO

   If "yes" please provide the following information:

   Name of Institution: Phone Number: Address: (Number and Street)

4. Are you enrolled in your State Medicaid program? ❑ YES ❑ NO

   If yes, please provide your Medicaid number:

5. Do you or your spouse work? ❑ YES ❑ NO

Special Needs Plans Criteria: If you are applying for any one of the following plans then please fill out 'Chronic Special Needs Plan (SNP) Pre-Qualification Form' attached at the end of this Application Form.

- Optimum Diamond Rewards (HMO-POS SNP)
- Optimum Diamond Rewards COPD (HMO-POS SNP)

Please choose the NAME of a Primary Care Physician (PCP), Clinic or Health Center: **PCP ID Number:**

FIRST Name: (use boxes below) MI: LAST Name:

Are you an existing member of this PCP? ❑ Yes ❑ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ❑ Spanish ❑ Large Print

Please contact Optimum HealthCare at 1-866-245-5360 if you need information in another format or language than what is listed above. Our office hours are from October 1, 2014 to February 14, 2015 from 8 a.m. to 8 p.m. 7 days a week, from February 15, 2015 to September 30, 2015 from 8 a.m. to 8 p.m. Monday through Friday and from October 1, 2015 to December 31, 2015 from 8 a.m. to 8 p.m. 7 days a week. TTY users should call 711.

STOP Please Read This Important Information for MA-PD Plans STOP

If you currently have health coverage from an employer or union, joining Optimum HealthCare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Optimum HealthCare. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Optimum HealthCare, Inc. is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

(Continued on next page)

Enrollment Application PG 3 & 4

H55942015E3

Please Read and Sign Below

Optimum HealthCare serves a specific service area. If I move out of the area that Optimum HealthCare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Optimum HealthCare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Optimum HealthCare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Optimum HealthCare coverage begins, I must get all of my health care from Optimum HealthCare, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Optimum HealthCare and other services contained in my Optimum HealthCare Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR OPTIMUM HEALTHCARE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Optimum HealthCare, he/she may be paid based on my enrollment in Optimum HealthCare.

Release of Information: By joining this Medicare health plan, I acknowledge that Optimum HealthCare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Optimum HealthCare will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: **Today's Date:** M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name: Phone Number:

Address:

Relationship to Enrollee:

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment):

Effective Date: (MM/DD/YYYY) Agent Received Date Signature:

Election Type: ❑ ICEP/IEP ❑ AEP ❑ SEP(type) ❑ Not Eligible

COUNTY: Plan ID#

Agency of Agent: Current Insurance:

Agent Name: (First) (Last) Agent ID#:

TR K-1 ❑ Referral by Provider ❑ Referral by MCR ❑ Company Website ❑ Direct Mail ❑ Local Community Event ❑ Media (TV, News Ad, Mag) ❑ DNR save ❑ Referred by Member

TR K-2 ❑ Personal Appt; Benefit Reply Card (SOA/BRC) ❑ Walk-in; Other site (SOA) ❑ Seminar, Sales Event (Submit) ❑ Application Mailed by Beneficiary ❑ Routine Marketing Site (Submit) ❑ Voice Recorded Appt (VRA)

Online/Telephonic Application Confirmation #

Date Received: Member ID # - 0 1

Information to Include with Enrollment Mechanism

ATTESTATION OF ELIGIBILITY
FOR AN ENROLLMENT PERIOD

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ❑ I am new to Medicare.
- ❑ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (MM-DD-YYYY)
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (MM-DD-YYYY)
- ❑ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ❑ I get extra help paying for Medicare prescription drug coverage.
- ❑ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (MM-DD-YYYY)
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (MM-DD-YYYY)
- ❑ I recently left a PACE program on (MM-DD-YYYY)
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (MM-DD-YYYY)
- ❑ I am leaving employer or union coverage on (MM-DD-YYYY)
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (MM-DD-YYYY)
- ❑ Other:

If none of these statements applies to you or you're not sure, please contact Optimum HealthCare at 1-866-245-5360 (TTY users should call 711) to see if you are eligible to enroll. We are open from October 1, 2014 to February 14, 2015 from 8 a.m. to 8 p.m. 7 days a week, from February 15, 2015 to September 30, 2015 from 8 a.m. to 8 p.m. Monday through Friday and from October 1, 2015 to December 31, 2015 from 8 a.m. to 8 p.m. 7 days a week.

OFFICE USE ONLY

Enrollee's LAST Name: (use boxes below) FIRST Name: MI:

Medicare Claim # Effective Date: (M M D D Y Y Y Y)

Chronic Special Needs Plan (SNP) Pre-Qualification Form

Special Needs Plan (SNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. Optimum HealthCare offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions.

You may be eligible to join one of our chronic-care SNPs If you can answer YES to any of the questions below. Optimum HealthCare will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. We are required to disenroll you from the special needs plan if we are unable to verify your chronic condition. It is very important, therefore, that you let your doctor know that we will require their verification and that you provide us with accurate contact information for your doctor at the bottom of this form.

CHF/CVD/Diabetes:

Has your doctor or other licensed health care professional diagnosed you with any of the following medical conditions?
(Check all that apply):
Congestive Heart Failure (CHF) ❑ YES ❑ NO Cardiovascular Disease (CVD) ❑ YES ❑ NO Diabetes ❑ YES ❑ NO

CHF:

Do you have fluid in your lungs?	❑ YES	❑ NO
Do you have swelling in your feet and legs almost every day because of too much fluid in your body?	❑ YES	❑ NO
Do you take medicine for the fluid in your lungs or to help your heart beat stronger?	❑ YES	❑ NO

CVD:

Have you had a heart attack or been told by your doctor you are at risk to have one?	❑ YES	❑ NO
Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?	❑ YES	❑ NO
Do you take medicine for your heart or circulation?	❑ YES	❑ NO

Diabetes:

Do you check your blood sugar at home?	❑ YES	❑ NO
Do you have high blood sugar?	❑ YES	❑ NO
Do you take medicine to control your blood sugar?	❑ YES	❑ NO

Chronic Obstructive Pulmonary Disease:

Has your doctor or other licensed health care professional diagnosed you with the following medical condition?

(Check if this applies): Chronic Obstructive Pulmonary Disease (COPD)	❑ YES	❑ NO
Do you have difficulty breathing every day or almost every day even with normal activity?	❑ YES	❑ NO
Do you take medicine to help you breathe better?	❑ YES	❑ NO

Doctor/Health Care Provider Contact Information:

Name of your Doctor or Health Care Provider:

LAST Name: FIRST Name:

Telephone #: Fax #:

Beneficiary Information:

Beneficiary Signature:____________________ **Date:** M M D D Y Y Y Y

LAST Name: FIRST Name:

Optimum HealthCare, Inc. is an HMO plan with a Medicare contract and a contract with the Florida Medicaid program. Enrollment in Optimum HealthCare, Inc. depends on contract renewal.

Enrollment Application PG 5

Application Timeliness

- ✓ **The paper enrollment application <u>MUST</u> be received at the operations center within <u>48 hours</u> of the writing date by either the Agent or the Agency. Weekends & Holidays included.**
- ✓ **The Plan is scored by CMS on its ability to submit timely applications to CMS.**
- ✓ **The Plan must submit all enrollment applications to CMS within 7 calendar days so that members can receive plan materials by 10 days.**
- ✓ **Please verify with your TMO/GA their submission routing policy. Some allow direct submission to the plan, while others will handle the submission for you in a timely manner. The submission timeliness standard applies either way.**
- ✓ **Failure to submit applications in a timely manner could result in corrective actions.**

Submission of Paper Applications

- ✓ **When submitting by fax, you will use the fax coversheet found on the next page. PDF's of the coversheet are available on our agent portal and a handout in Face to Face training.**
- ✓ **Fill the coversheet out completely. This includes all required fields.**
- ✓ **Please make sure your fax confirmation page count matches the coversheet count you sent. Also make sure the confirmation is not just a count of what is saved in the fax memory but was actually submitted.**
- ✓ **It is no longer necessary to mail in the original application or SOA as long as we have received it by fax.**
- ✓ **If using a paper scope of appointment with a paper application, fax both together.**
- ✓ **If using a paper scope of appointment with an electronic application, please fax it separately and within 4 days.**

FAX INSTRUCTION COVERSHEET FREEDOM & OPTIMUM

1. Fax Coversheet must be filled out completely for receipt to be confirmed.
2. Fill out Enrollee Last Name, First Name & Unique App ID for each app.
3. Only include 5 enrollments per fax
4. If paper scope is used, please fax with application. If paper scope is used with Online enrollment, please fax within 4 days of appointment. It is not necessary to submit original applications or scopes by mail. Call 1-877-877-0539 for questions.

Fax To: 800-864-1529 to: Attention AST TEAM

FROM: NAME OF AGENCY/TMO ____________________

FAXED BY (Name): ____________ SENT BY FAX # ____________

CONTACT PH # ____________

Total PAGES including cover ____________ DATE FAXED: ____________

ENROLLEE LAST	ENROLLEE FIRST	UNIQUE APPLICATION ID See bottom right form number on application

The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). The message is intended for the sole use of the individual or entity to which it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the message is strictly prohibited. If you received this transmission in error, please contact the sender immediately by replying to this email and delete the material from any computer Revised: 06/03/13

Freedom /Optimum Fax Coversheet Instructions

- ✓ Remember to submit applications by fax or mail within 48 hours!
- ✓ If faxed, it is not necessary to mail originals.
- ✓ If sending applications by mail without faxing, Overnight applications to:

ATTENTION: AST TEAM
5403 N. CHURCH AVENUE
TAMPA, FL 33614

CSNP Verification

- ✓ A Pre-qualification form, which is part of the application, MUST be completed if the prospect is applying for a CSNP plan.
- ✓ In addition, the Provider Verification of the condition must be received by the Plan within 30 days or the member will be disenrolled by 60 days.
- ✓ Members are sent reminders to secure the provider verification at the time of enrollment, at 30 days and at 45 days.

- ✓ In addition, the SNP department continually outreaches to Providers for the forms
- ✓ Agents should follow up with CSNP enrollments to ensure the forms have been submitted. Due to PHI, forms may not be sent by the Agent. Contact Agent Services for more information.
- ✓ Per CMS, the Plan will also conduct an Annual Verification of the member's condition using Plan data or with the Provider.

Post Enrollment Verification - 3 Condition / COPD

P.O. Box 151108, Tampa, FL 33684

Chronic Care SNP Post Enrollment Qualification Verification

<Date>

URGENT

<Member Name>
<Member Address>
<City>, <State> <Zip>

<Member ID#>

Dear Member,

In order to confirm that you have the qualifying conditions, please have your doctor complete the verification form below. Visit your doctor and return this signed verification form in the return envelope provided by <Date>.

You can Fax At: 1-888-314-0795

Post Enrollment Verification

MUST BE SIGNED BY THE DOCTOR'S OFFICE

The above applicant has applied to enroll in the Chronic Special Needs Plan (CSNP) offered by Optimum HealthCare. To qualify to enroll in this Chronic Special Needs Plan, the applicant must have one of the following conditions. By signing our enrollment application, the Applicant has permitted us the use of individually identifiable health information. Optimum HealthCare complies with all HIPAA and Federal law requirements concerning the Privacy of such information. If you have any questions, please call Member Services at 1-866-245-5360, TTY/TDD: 1-800-955-8771 7 days a week 8AM – 8PM, October 1 – February 14, Monday – Friday 8AM – 8PM February 15 – September 30 and ask for any SNP Verification Team Member. We request you to confirm that the applicant has one of the qualifying conditions by placing a check mark in the appropriate box(s).

- [] **Chronic Heart Failure (CHF)**
- [] **Cardio Vascular Disease (CVD)**
- [] **Diabetes Mellitus**
- [] **Cardiac Arrhythmias**
- [] **Coronary Artery Disease**
- [] **Peripheral Vascular Disease**
- [] **Chronic Venous Thromboembolic Disorder**

Please provide the following:

Doctor's First Name: M.I. Doctor's Last Name:

Authorized Signature: ____________________ Date: __/__/____

MUST BE SIGNED BY THE DOCTOR'S OFFICE

P.O. Box 151108, Tampa, FL 33684

Chronic Care SNP Post Enrollment Qualification Verification

<Date>

URGENT

<Member Name>
<Member Address>
<City>, <State> <Zip>

<Member ID#>

Dear Member,

In order to confirm that you have the qualifying conditions, please have your doctor complete the verification form below. Visit your doctor and return this signed verification form in the return envelope provided by <Date>.

You can Fax At: 1-888-314-0795

Post Enrollment Verification

MUST BE SIGNED BY THE DOCTOR'S OFFICE

The above applicant has applied to enroll in the Chronic Special Needs Plan (CSNP) offered by Optimum HealthCare. To qualify to enroll in this Chronic Special Needs Plan, the applicant must have one of the following conditions. By signing our enrollment application, the Applicant has permitted us the use of individually identifiable health information. Optimum HealthCare complies with all HIPAA and Federal law requirements concerning the Privacy of such information. If you have any questions, please call Member Services at 1-866-245-5360, TTY/TDD: 1-800-955-8771 7 days a week 8AM – 8PM, October 1 – February 14, Monday – Friday 8AM – 8PM February 15 – September 30 and ask for any SNP Verification Team Member. We request you to confirm that the applicant has one of the qualifying conditions by placing a check mark in the appropriate box(s).

- [] **Chronic Obstructive Pulmonary Disease (COPD)**
- [] **Pulmonary Hypertension**
- [] **Asthma**
- [] **Chronic Bronchitis**
- [] **Emphysema**
- [] **Pulmonary Fibrosis**

Please provide the following:

Doctor's First Name: M.I. Doctor's Last Name:

Authorized Signature: ____________________ Date: __/__/____

MUST BE SIGNED BY THE DOCTOR'S OFFICE

MAKE THE SWITCH AND GO PAPERLESS!

The Online Enrollment Advantage...

- ✓ Saves Valuable Agent time especially during AEP
- ✓ No Faxing – Less Paperwork
- ✓ Immediate Application Processing
- ✓ Eliminates Application Errors & Timeliness issues
- ✓ Get Immediate Confirmation
- ✓ Keeps Record of Submitted Applications
- ✓ Easy to Learn!
- ✓ Call Agent Support for the Flowfinity Instructions or download from your homepage!

Using a Tablet:

Those that want to participate using a tablet may use any of the popular selling tablets. However, an iPad will allow you to use our free Flowfinity app from the App store. This application has additional features not offered on the VIP Online Enrollment Center. It is preferable that a stylus be purchased to ensure the member signature will be as close to a penned signature as possible.

Outbound Enrollment Verification (OEV)

- Per new CMS guidance, the Plan will be sending outbound enrollment verification (OEV) letters rather than calls to ensure individuals requesting enrollment understand the plan rules.
- The plan will supply a copy of the letter when available for the agent to show the new member.
- It is important that the agent educate the member to expect the letter and briefly describe the process:
- Members are informed the plan has received their enrollment request.
- Members are educated about receiving the new member packet.
- Members are asked if the agent covered fees and co-pays.
- Members are reminded about network requirements, if applicable.
- Confirmation of their desire to enroll is made.

Star Rating

- You will find a Medicare Plan Ratings sheet in the Plan enrollment kit which must be provided to the member.
- The Plan rating is given by Medicare and shows how well a plan is performing in different categories.
- Medicare evaluates Plans based on a 5 star rating system.
- Star Ratings are calculated each year and may change from one year to the next.
- For more information on Plan Star Ratings go to www.Medicare.gov.

Late Enrollment Penalty - LEP

The Late Enrollment Penalty (LEP) is an amount that Medicare adds to your Part “D” Premium. You may owe the LEP if at any time after your initial enrollment period is over, there is a period of more than 63 days in a row when you don’t have Part “D” or other creditable prescription drug coverage. There are exceptions: If you get Extra Help then you will not owe a LEP. Beneficiaries can find out at enrollment the amount of their LEP, if any. If you are found to be the subject of an LEP but disagree, you may request a “Reconsideration Request Form” from the Plan.

Formulary

Show every enrollee how to use the formulary even if they are not currently using medications. There are two ways to find a drug within the Formulary:

- ✓ By Alpha Index: The index of the Formulary also provides an alphabetical listing of all the drugs along with the page number where you can find coverage
- ✓ By Medical Condition: You can look it up depending on the type of medical conditions it is used to treat. For example… drugs used to treat a heart condition can be found under the category "Cardiovascular Agents".

Formulary Drug Restrictions

Show the member how to determine if their medication has any restrictions.

- **LA:** Limited Availability. This prescription may be available only at certain pharmacies.
- **QL:** Quantity Limit. For certain drugs, the Plan limits the amount of the drug that will be covered..
- **PA:** Prior Authorization. The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from the Plan before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **ST:** Step Therapy. In some cases, the Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.
- **B/D:** Prior Authorization. The Plan requires authorization to determine whether certain drugs are covered by Medicare Part B or Medicare Part D.
- **MO:** Mail Order. These are drugs that can be obtained for an extended number of days supply, up to a maximum of 90 days

Formulary Transition and Exceptions

If the member is newly eligible, switching Plans or has a change in the level of healthcare, they can receive a one-time 31 day supply of their current medications within the first 90 days of membership. This is called the **Formulary Transition Process**.

A member can also ask the Plan to make an exception to the coverage rules by asking for a **Formulary Exception.**

How the Medicare AEP, MADP, ICEP & SEP Enrollment Periods Work...

Annual Enrollment Period (AEP)	Medicare Advantage Disenrollment Period (MADP)	Initial Coverage Enrollment Period (ICEP)	Special Enrollment Period (SEP)
October 15th – December 7th	January 1st – February 14th	7 months of eligibility: begins 3 months before first entitlement to Part A & B; ends the later of either the last day of the month preceding entitlement to Part A & B or last day of Part B initial enrollment	Varies: refer to the "Attestation of Eligibility" on the enrollment application for qualifying reason
All Medicare beneficiaries may enroll or disenroll. Coverage begins 1/1/16	May switch back to Original Medicare and elect a Part D plan	Newly eligible may enroll in a Medicare Advantage plan	May enroll or disenroll in a plan due to a qualifying reason

ENROLLMENT

- A Medicare beneficiary is generally the only individual who may execute a valid enrollment or disenrollment request from an MA plan.
- However, another individual could be the legal representative or appropriate party to execute an enrollment request as the law of the State in which the beneficiary resides may allow.
- CMS will recognize State laws that authorize persons to make an enrollment request for Medicare beneficiaries. For example, persons authorized under State law may be court-appointed legal guardians, persons having durable power of attorney for health care decisions or individuals authorized to make health care decisions under State surrogate consent laws, provided they have authority to act for the beneficiary in this capacity.
- If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request or complete an enrollment mechanism due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the enrollment request on behalf of the beneficiary.
- Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, MA organizations should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

ENROLLMENT

Plans 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 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. A Plan 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-eligible, institutionalized individuals, or individuals with severe or disabling chronic conditions and/or may target items and services to corresponding categories of beneficiaries.

ENROLLMENT EFFECTIVE DATES

- With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their enrollment effective date.

- Furthermore, except for EGHP enrollment requests, the effective date is generally not prior to the receipt of an enrollment request by the MA organization.

- An enrollment cannot be effective prior to the date the beneficiary or his/her legal representative signed the enrollment form or submitted the enrollment request.

- Enrollment Guidance includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined.

ENROLLMENT EFFECTIVE DATES

- The effective date also may not be earlier than the first day of the individual's entitlement to both Medicare Part A and Part B.

- To determine the proper effective date, the MA organization must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the enrollment request is received by the MA organization.

- Once the election period is identified by the MA organization, the MA organization must determine the effective date.

ENROLLMENT EFFECTIVE DATES

Effective dates are as follows:

Election Period	**Effective Date of Coverage**	**Do MA organizations have to accept enrollment requests in this election period?**
Initial Coverage Election Period and Initial Enrollment Period for Part D	First day of the month of entitlement to Medicare Part A and Part B – or- The first of the month following the month the enrollment request was made if after entitlement has occurred.	Yes – unless capacity limit applies (see §30.9 for capacity limit information). IEP for Part D is applicable only to MA-PD enrollment requests.
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MA organization receives an enrollment request	No - the MA organization can choose to be "open" or "closed" for enrollments during this period.
Annual Election Period	January 1 of the following year	Yes – unless capacity limit applies
Special Election Period	Varies, as outlined in §30.4	Yes – unless capacity limit applies

VOLUNTARY DISENROLLMENT

Except as stated below, an MA organization may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. While an MA organization may contact members to determine the reason for disenrollment, the MA organization must not discourage members from disenrolling after they indicate their desire to do so. The MA organization must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

A member may request disenrollment from an MA plan only during one of the election periods. The member may disenroll by:

1. Enrolling in another plan (during a valid enrollment period);
2. Giving or faxing a signed written notice to the MA organization, or through his/her employer or union, where applicable;
3. Submitting a request via the Internet to the MA organization (if the MA organization offers such an option); or
4. Calling 1-800-MEDICARE.

VOLUNTARY DISENROLLMENT

If a member verbally requests disenrollment from the MA plan, the MA organization must instruct the member to make the request in one of the ways described above. The MA organization may send a disenrollment form to the member upon request.

The disenrollment request must be dated when it is initially received by the MA organization. When someone other than the Medicare beneficiary completes a disenrollment request, he or she must:

1. Attest that he or she has the authority under State law to make the disenrollment request on behalf of the individual;
2. Attest that proof of this authorization (if any), as required by State law that empowers the individual to effect a disenrollment request on behalf of the applicant is available upon request by the MA organization or CMS; and
3. Provide contact information.

VOLUNTARY DISENROLLMENT

- When providing a written request, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request. If a legal representative signs the request for the individual, then he or she must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect a disenrollment request on behalf of the applicant is available and can be presented upon request to the MA organization or CMS.

- The individual and/or legal representative should write the date he/she signed the disenrollment request; however, if he/she inadvertently fails to include the date, then the date of receipt that the MA organization places on the request form will serve as the signature date.

- If a written disenrollment request is received and the signature is not included, the MA organization may verify with the individual or legal representative with a phone call and document the contact, rather than return the written request as incomplete.

CANCELLATION

- An individual's enrollment request can be cancelled only if the cancellation request is received by the organization prior to the effective date of the enrollment via phone, in writing or in person, unless otherwise directed by CMS.
- To ensure the cancellation is honored, the MA organization should not transmit the enrollment to CMS. If, however, the organization had already transmitted the enrollment by the time it receives the valid request for cancellation, it must submit a cancellation transaction to CMS to cancel the now-void enrollment transaction. In the event the cancellation transaction fails or the MA organization has other difficulty, the MA organization must submit the request to cancel the action to the CMS Retroactive Processing Contractor in order to cancel the enrollment.
- When canceling an enrollment transaction, the MA organization must send a letter to the individual that states that the cancellation is being processed. This notice should be sent within ten calendar days of receipt of the cancellation request. This notice must inform the member that the cancellation should result in the individual remaining enrolled in the health plan in which he/she was originally enrolled, so long as the individual remains eligible to be enrolled in that health plan.
- An MA organization may submit a transaction to cancel only those enrollment transactions it submitted. To cancel an enrollment, the MA organization must submit an enrollment cancellation transaction with an effective date equal to the effective date of the enrollment being cancelled.

CANCELLATION

- If the member's request for cancellation occurs after the effective date of the enrollment, the cancellation generally cannot be processed. (An exception to this is a cancellation requested during the Outbound Education and Verification (OEV) process.)
- The organization must inform the beneficiary that he/she is a member of its MA plan. If he/she wants to return to the other MA plan he/she will have to submit an enrollment request during a valid election period for a prospective enrollment effective date.
- If the member wants to return to Original Medicare instead of returning to his/her previous plan, the member must be instructed to disenroll from the previous plan as described in Ch 2 MMCM. The member must be informed that the disenrollment must be made during an election period and will have a current effective date and must be instructed to continue to use plan services until the disenrollment goes into effect.
- Regardless of the plan personnel receiving the request, the plan must document all contact with the beneficiary associated with the cancellation request.
- When an organization receives notification of an individual's reinstatement, the organization has ten (10) calendar days to send the individual a notice of reinstatement.

Important Disclaimers

Optimum HealthCare is an HMO plan with a Medicare contract and a contract with the Florida Medicaid program. Enrollment in Optimum HealthCare depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information.

Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium. Limitations, co-payments and restrictions may apply. Benefit amounts may vary based on plan and county.

The Part B premium is covered for full dual members of Special Needs Plans.

Our dual eligible Special Needs plans are available to anyone who has both Medical Assistance from the State and Medicare. Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help that you receive.

Our chronic condition Special Needs plan is available to anyone with Medicare who has been diagnosed with Diabetes, Cardiovascular Disease, Chronic Heart Failure, or Chronic Obstructive Pulmonary Disease (COPD).

Optimum HealthCare is accredited by the National Committee for Quality Assurance and received a "Commendable" rating and awarded a 3 year accreditation through December 26, 2015. NCQA Health Plan Accreditation evaluates how well a health plan manages all parts of its delivery system -- physicians, hospitals, other providers and administrative services -- in order to continuously improve the quality of care and services provided to its members.

Optimum HealthCare has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) until December 2018 based on a review of Optimum HealthCare's Model of Care.

HMO eligible beneficiaries may enroll in the plan only during specific times of the year.
HMO-SNP eligible beneficiaries can enroll at any time.

A sales person will be present with information and applications. For accommodation of persons with special needs at sales meetings call 1-888-796-0946,

Contact the Plan for more information at the number listed on the back page.

REGULATORY MARKETING ACTIVITIES GUIDANCE

For Sales Agents & Brokers 2016

TRAINING GOALS

- Increase awareness and understanding of Federal, State and Plan Sponsor marketing rules and guidelines
- Discuss CMS requirements for Educational and Sales Marketing events
- Provide marketing Best Practices for Personal or In-Home presentations, and allowable contacts with Beneficiaries
- Provide guidance for Scope of Appointments and Beneficiary Applications

PROMOTIONAL ACTIVITIES

Appendix & 70

Promotional Activities are activities performed by a plan sponsor or an individual or organization on a plan sponsor's behalf, to inform current and potential enrollees of the products available.

Generally, promotional activities are designed to retain current members and attract the attention of potential members.

For example: An ice cream social, a speaker or a concert

Sales and marketing activities are considered promotional activities

ANY PROMOTIONAL ACTIVITIES OR ITEMS OFFERED BY PLAN SPONSORS MUST: 70.1

- Be worth $15 or less based on the fair market value, with a maximum aggregate of $50 per person, per year
- Be offered to all people regardless of enrollment and without discrimination
- Be tracked and documented during the contract year (current members only)
- Be in compliance with guidance for Nominal Gifts
- **Not** be items that are considered a health benefit (free blood pressure checks)
- **Not** consist of lowering or waiving co-pays
- **Not** be used or included with the SB or ANOC/EOC
- **Not** inappropriately influence the beneficiary’s selection of a provider, practitioner, or supplier of any item or service
- **Not** be tied directly or indirectly to the provision of any other covered item or service

EDUCATIONAL EVENTS

Educational Events – Designed to inform Medicare beneficiaries about MA, MAPD, PD or other Medicare programs, but do not steer or attempt to steer potential enrollees toward a specific plan or limited number of plans.

For example, you may discuss the general advantages of enrollment in Medicare Advantage plans without discussing a specific plan.

The plan's policy is not to participate in educational events.

EDUCATIONAL EVENTS 70.8

- ✓ **May** be hosted by the Plan or an outside entity.
- ✓ **Must** be held in a public venue and do not extend to in-home or one-to-one settings.
- ✓ **Must** be explicitly advertised as "Educational" otherwise CMS will view them as Sales/Marketing events.
- ✓ **May Not** include any sales activities such as distribution of marketing materials or the distribution or collection of enrollment forms.

AT AN EDUCATIONAL EVENT YOU MAY 70.8:

- Provide printed materials free of plan specific information or benefit information.
- Display Banners with the plan name or logo.
- Provide promotional items with a fair market value less than $15.
- Provide meals that do not exceed $15 retail value *Special note: The retail cost of a meal and any promotional items combined may not exceed $15.*
- Respond to questions asked by attendees provided your response does not go beyond the specific question asked.
- Provide a Business Card **only** upon request by the beneficiary.

AT AN EDUCATIONAL EVENT YOU MAY NOT:

- Discuss any plan specific premiums and/or benefits.
- Distribute any plan specific materials. Materials may not show premiums, copayments or contact information.
- Distribute or display Business Reply Cards, Scope of Appointment forms, Enrollment forms or Sign-in sheets.
- Set up sales appointments or get permission to call the beneficiary.
- Attach Business Cards or your contact information to educational materials unless requested by the beneficiary.

MARKETING 70.9

CMS' definition of **Marketing** extends beyond the general public's concept. It includes materials and activities conducted by the plan or any individual on behalf of the plan, that steer or attempt to steer a potential enrollee toward a plan or limited number of plans.

Marketing extends to the activities of a plan sponsor's employees, independent agents or brokers, subcontracted ***Third Party Organizations*** (TMO) or other similar type organizations that contribute to the steering of a potential enrollee toward a specific plan or limited number of plans and may receive compensation directly or indirectly from a plan sponsor for marketing activities.

MARKETING / SALES EVENTS

- ***"Marketing / Sales Events*** are events designed to steer, or attempt to steer, potential enrollees toward a plan or limited set of plans. Plan Representatives may discuss plan specific information like premium, cost sharing or benefits." Applications may also be distributed, or accepted.
- All one-on-one appointments, with beneficiaries, regardless Of venue, are considered by CMS to be Sales/Marketing Events.

TYPES OF MARKETING / SALES EVENTS

There are 2 main types of Marketing/Sales Events:

1. ***Formal Events*** are typically structured in an audience/presenter style with a sales person formally providing specific plan sponsor information via a presentation on the products being offered.
   i.e. ***Seminars***

2. ***Informal Events*** are conducted with a less structured presentation or in a less formal environment. i.e. ***Pharmacy and Flea Market sites***

MARKETING/SALES EVENTS 70.9.2

- **All Formal and Informal Marketing/Sales Events must be uploaded in HPMS prior to advertising the event or 7 calendar days prior to the event's scheduled date, whichever is earlier.**
- **Changes to marketing/sales events, including cancellations, presenter or room changes should be updated in HPMS at least 48 hours prior to the scheduled event.**
- **Cancellations have special notification rules:**

Less Than 48 Hours Notice:	More Than 48 Hours Notice:
Immediately notify your Manager	Immediately notify your Manager
Ensure that a representative of the plan is present at the site, at the time the event was scheduled, for at least 15 minutes after the scheduled start to inform attendees.	The plan must notify beneficiaries of the cancellation by the same means used to advertise the event. A representative is not required at the site.

INFORMAL MARKETING EVENTS

- All **Informal Marketing Events** must be uploaded to HPMS according to the same rules regarding timing for uploads, cancellations and changes that apply to formal events.
- **Informal Events** include marketing activities from a kiosk, table, recreational vehicle or booth and may be located within or outside of:
  - Doctor Offices
  - Drug Stores
  - Senior or Recreational Centers
  - Flea Markets or Trade Shows
  - Festivals or Health Fairs
  - Community Centers
  - Shopping Malls or other store locations
  - Nursing Home Cafeterias or Conference Rooms

AT A SALES/MARKETING EVENT, YOU MAY: 70.9.2

- Discuss plan specific information
- Distribute brochures and enrollment forms
- Complete and accept enrollment forms
- Formally present benefit information using an approved script, slides or handouts
- Provide educational content
- Provide a Scope of Appointment form for a subsequent meeting; if a beneficiary requests a one-on-one meeting then the beneficiary must complete a SOA
- Provide a Nominal Gift to attendees with no obligation - $15.00 fair market value or less
- Provide light snacks

AT A SALES/MARKETING EVENT, YOU MAY NOT:

- Conduct Health screenings or other activities that may give the impression of "cherry picking."
- Compare one plan sponsor to another by name unless both sponsors have concurred.
- Require beneficiaries to provide any contact information as a condition to RSVP or as a prerequisite for attending.
- Use a plan name that does not include the plan type – HMO, PFFS.
- Require beneficiaries to provide any contact information for a raffle or drawing.
- Solicit enrollment applications prior to the start of the AEP.
- Provide meals to attendees.
- Market any non-health care related products such as Life insurance or Annuities during any MA or MAPD sales activity or presentation. Cross-selling is prohibited.
- Use prohibited statements.

MARKETING IN A HEALTH CARE SETTING 70.11

- **Generally, sales activities are not permitted in health care settings where people receive services or treatment, interact with doctors and their staff, clinicians, technicians or pharmacists and their staff or where patients/customers are waiting to receive such services.**
- **Prohibited Sales activities in a health care setting generally include:**
  - Conducting Sales Presentations
  - Distributing or accepting enrollment applications
  - Soliciting Medicare beneficiaries
- **Sales activities may only be conducted in health care *Common Areas*. Common areas where sales activities are allowed include:**
  - Hospital or nursing home cafeterias, community or recreational rooms and conference rooms.
  - Pharmacy space outside of where patients wait for services or interact with pharmacists and technicians.

MARKETING IN A HEALTH CARE SETTING

- **Health care settings where Sales Activities are not permitted generally include, but are not limited to:**
  - Waiting areas
  - Dialysis center treatment areas (where patients interact with their clinical team and receive treatment.)
  - Pharmacy counter areas (where patients interact with pharmacy providers and obtain medications.)
  - Doctors’ office waiting rooms and treatment areas.
  - Hospital treatment areas or waiting areas.
- The prohibition against conducting Sales Activities in health care settings extends to activities planned in health care settings outside of normal business hours.
- Remember, these are Informal Events and must be uploaded to HPMS.

RULES REGARDING NOMINAL GIFTS 70.1.1

- Generally, **Nominal Gifts** are used to attract the attention of potential enrollees.
- Gifts may be offered to potential enrollees:
  - ✓ **As long as they are of *Nominal Value* - $15 fair market value or less**
  - ✓ **Provided regardless of enrollment – offered to everyone without discrimination, do not have to enroll to receive**
- If a **Nominal Gift** is one large gift enjoyed by all in attendance, the total fair market value must be $15 or less per person, when it is divided by the estimated attendance. Use advertising circulation, venue size and/or response rate to estimate attendance.
- **Nominal Gifts** may not be in the form of a cash gift or other monetary rebates. Cash gifts include charitable contributions made on behalf of the attendee, and gift cards or certificates that can be readily converted to cash regardless of dollar amount.

70.1.1

FORMS, FLYERS, LOGOS & OTHER MATERIALS

- Only **CMS Approved** materials issued by the Plan with an **Approval ID Code** may be used.
- You **may not** create your own forms, other marketing materials or websites without prior Plan approval.
- Marketing Materials & Forms allowed by CMS are:

Checklists or Needs Assessments	Advertisements or Flyers
Statements of Understanding	Business Reply Forms
Websites	Plan Overviews
Newspaper Ads	Summaries of Benefits

The plan will assist in the creation of ads, flyers, and use of logos upon request. Please contact Agent/Broker Services at (877) 877-0539 for questions and assistance.

70.5

CMS STATES THAT PERMISSION TO CONTACT A BENEFICIARY MUST BE CONSIDERED "SHORT TERM, & EVENT SPECIFIC" PERMISSION AND "NOT OPEN ENDED PERMISSION FOR FUTURE CONTACT."

Contacts With Beneficiaries

MARKETING THROUGH UNSOLICITED CONTACTS 70.5

There is a **general prohibition** on marketing through unsolicited direct contacts. For example:

- Door-to-Door solicitation including leaving information such as a leaflet, flyer or door hanger at a residence or on someone's car in a parking lot or on the street.
- Approaching beneficiaries in common areas such as parking lots, hallways, lobbies or sidewalks.
- Telephonic or electronic solicitation including leaving electronic voicemail messages, text messaging or sending unsolicited e-mail messages.

MARKETING THROUGH UNSOLICITED CONTACTS 70.5

- **The prohibition on marketing through unsolicited contacts does not extend to mail and other print media, provided the materials are constructed and mailed in accordance with CMS marketing guidelines. The prohibition does pertain to web-sites and e-mail.**
- ***Leads may be generated through mailings, websites, advertising and public sales events.*** **Information should be supplied on how beneficiaries may contact you.**
  - You **may not require** any beneficiary web page registration or contact information.
  - Instructions for supplying contact information should clearly state that by supplying contact information, a licensed sales agent will contact the beneficiary.

MARKETING THROUGH UNSOLICITED CONTACTS 70.3

Unsolicited E-Mail Policy

E-Mails may not be sent to a beneficiary, unless the beneficiary agrees to receive e-mails and the beneficiary has provided his/her e-mail address to you.

Sales Agents/Brokers may not:

- **Rent or purchase e-mail lists to distribute information about MA, PDP or section 1876 cost plans.**
- **E-Mail beneficiaries at e-mail addresses obtained through friends or other referral methods.**

An opt-out process must be provided to beneficiaries who no longer wish to receive e-mail communications.

TELEPHONIC CONTACTS WITH BENEFICIARIES
70.6

Agents/Brokers and Plan Sponsors may contact their own clients and plan members at anytime to discuss plan business without consent.

- **You may** return a phone call from a member or a prospective member.
- **You may** Initiate a phone call to confirm an appointment that has already been agreed to by a beneficiary via a VRA or paper Scope of Appointment.

CONTACT US

TELEPHONIC CONTACTS WITH BENEFICIARIES 70.6

- **You may** call beneficiaries who have expressly given you permission to call them by completing a **Business Reply Form** or asking a service representative to have an agent contact them.
- This permission only applies:
  - **To the entity from which the beneficiary requested contact,**
  - **For the duration of that transaction,**
  - **For the scope of the product, (e.g.MA-PD, PFFS or PDP) previously discussed or indicated in the reply form.**

PROHIBITED TELEPHONIC CONTACTS

- ***Bait and Switch Strategies*** – **You may not make unsolicited outbound calls to beneficiaries about other business as a means of generating leads for Medicare plans.**
- **You may not** make calls to beneficiaries based on referrals gained through an unsolicited contact. If an individual would like to refer a friend or relative to an agent or plan sponsor, the agent or plan sponsor may provide contact information such as a business card that the individual may give to the friend or family member. In all cases, a referred beneficiary needs to contact the plan or agent/broker directly.

PROHIBITED TELEPHONIC CONTACTS

- **You may not** call beneficiaries who attended a sales event unless, the beneficiary gave specific permission at the event for a follow-up call.
- **You may not** call to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling to market plans or products.
- **You may not** make calls to beneficiaries to confirm receipt of mailed information.

Members who are voluntarily disenrolling from a plan should not be contacted for sales purposes or be asked to consent in any format to further sales contacts.

SCOPE OF APPOINTMENT GUIDANCE

70.9.3

SCOPE OF APPOINTMENT
70.9.3

When conducting marketing activities, a Plan/Part D Sponsor may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed before the meeting with that individual. The Plan/Part D Sponsor must document the scope of the agreement **48 hours prior to the appointment, when practicable**.

Distinct lines of plan business include MA, PDP and Cost Plan products. If a Plan/Part D Sponsor would like to discuss **additiona**l products during the appointment in which the beneficiary indicated interest, but did not agree to discuss in advance, the Plan/Part D Sponsor must document a second scope of appointment (SOA) for the **additional product** type to continue the marketing appointment

SCOPE OF APPOINTMENT (SOA) 70.9.3

- A **Scope of Appointment** (SOA) defines the products that are to be discussed or presented during a marketing appointment.
- An SOA may be in writing through the use of a form, or a voice recorded system (VRA).
- ***We have developed a VRA system and our own form based upon the CMS model format which meets CMS VRA requirements. Our form and directions for use can be found on the agent portal. Instructions for use of the VRA can also be found on the agent portal. (https://vipagentsupport.com)***

SCOPE OF APPOINTMENT (SOA)

- The sales person is bound to only discuss during that appointment those products that have been agreed upon by the beneficiary during that appointment.
- A beneficiary may set a SOA at a marketing/sales event for a future appointment.
- An SOA **may not** be displayed or distributed at any **Educational Event**.
- Documentation may be a paper scope or a recorded oral agreement. Any technology, (conference calls, fax machines, designated recording line, prepaid envelopes and email) can be used to document the scope of appointment. (Recordings are subject to certain requirements)

SCOPE OF APPOINTMENT

- You may not market any ***health care related products*** during a marketing appointment beyond the scope agreed upon by the beneficiary and documented by the plan prior to the appointment. (48-hours in advance when practicable)
- If it is not feasible, for the form to be signed 48 hrs. prior to the appointment, the form **must be fully documented as to why it was not feasible to obtain the SOA prior to the appointment.**
- Use the "***Notes Section***" of our SOA form for this documentation.

YOU ARE EXPECTED TO INCLUDE THE FOLLOWING WHEN DOCUMENTING THE SOA:

- Product type (e.g. MA, PDP) that has been agreed
- Date of appointment
- Beneficiary contact information
- Signature of beneficiary
- Method of contact (e.g. walk-in)
- Agent information (e.g. name and contact information and signature
- A statement that beneficiaries are not obligated to enroll in a plan; their current or future Medicare enrollment status will not be impacted and clearly explain that the beneficiary is not automatically enrolled in the plan(s) discussed.
- If the SOA was not signed prior to the appointment, include an explanation why it was not completed.

SOA EXAMPLES . . .

- A SOA is written for an MAPD plan, if the beneficiary asks questions about or asks for more information on just a stand alone Prescription Drug Plan (PDP), a second SOA may be written for the PDP and the conversation may continue.
- A meeting is scheduled to discuss an enrollee's current Medi-Gap coverage. During the meeting, you are asked to present a Medicare Advantage Prescription Drug Plan (MAPD). You must complete a SOA and wait 48 hours to meet with him again.
- A beneficiary attends a marketing presentation, and, after the presentation, requests an individual appointment, the sales person can arrange for that appointment to take place immediately following the sales presentation provided the beneficiary has completed a scope of appointment form.

SCOPE OF APPOINTMENT

- If a VRA has been completed for a beneficiary, a paper SOA may be completed for their spouse at the time of the appointment. **Remember to document the reason on the form and include the VRA tracking number.**

- In instances where a beneficiary visits a plan or an agent's office on their own accord, a SOA may be completed on the spot and the 48-hour waiting period does not apply. **Remember to document that it was a walk-in on the form.**

Always document your SOA's !

VOICE RECORDED APPOINTMENTS (VRA)

- It is the preference of the Health Plan that the VRA be used in most instances.
- When a beneficiary initiates contact requesting a personal appointment , they may be referred to the plan to perform the VRA.
- The agent may not participate in the call.
- Please contact the plan for specifics on the **VRA** program.

  (https://vipagentsupport.com)

Personal
Or
In-Home
Appointments

Preparation

Presentation

Enrollment Guidance

MARKETING APPOINTMENTS
70.9.2

- *Marketing Appointments* are ***individual*** appointments designed to steer or attempt to steer, potential enrollees toward a plan or limited number of plans.
- ***All one-on-one appointments between an agent and a beneficiary, regardless of venue are considered marketing/sales appointments and must follow the SOA guidance.***

MARKETING APPOINTMENTS

Plan Sponsor Representatives May Not:

- Discuss plan options that were not agreed to by the Medicare beneficiary.
- Market any non-health care related products, such as annuities or life insurance.
- Ask a beneficiary for referrals.
- Solicit or accept an enrollment application for a January 1 effective date prior to the start of the **Annual Enrollment Period** (AEP 10/15 through 12/7) unless the beneficiary is entitled to a special enrollment period.

PERSONAL OR IN-HOME PRESENTATIONS

Although a personal appointment may feel less formal than a sales event or seminar, you must still follow the presentation requirements, which includes using the following introduction at the beginning of each in-home presentation:

- ✓ **Begin by greeting the beneficiary and introducing yourself.**
- ✓ **State that you are an employee of the Plan (use the plan name) or a contracted agent of _____ agency representing the Plan.**
- ✓ **Always announce the Plan types and specific Plans to be discussed by their Official Plan Name.**

For Example: Optimum Diamond Rewards (HMO-SNP)

Once you have spoken the Plan Name, you may refer to the plan by its number.

PERSONAL OR IN-HOME PRESENTATIONS

- Use our CMS approved Video Presentation at all personal or in-home presentations. It contains all CMS required disclaimers and information.
- If you absolutely cannot use the video, you **must** read the entire CMS approved script. In most cases, this is the Plan Overview. This assures that all CMS required language is covered.
- Do not ad-lib additional information or deviate from the approved presentation in any way.
- Review the CMS **In-Home Secret Shopping Checklist** to make sure you perform all the elements required in your presentation.
- If your scheduled appointment becomes a "**NO-Show**" you may leave information at their residence.

PERSONAL OR IN-HOME PRESENTATIONS

It is very important that each beneficiary fully understands the type of plan they are joining:

- ✓ Our HMO plans require members to always see network providers except in an emergency or urgent care situation. Other plans such as PFFS or PPO plans are not as restrictive.
- ✓ Prescription Drug coverage may sometimes be confusing. Always check to make sure how a drug is covered. (Part B or Part D)
- ✓ A Medicare Advantage Plan is not a Supplement, or Medi-Gap or Prescription Drug type plan.
- ✓ Most of our plans have Prescription Drug coverage, some do not. Know the tier names and what is included in each tier.

PERSONAL OR IN-HOME PRESENTATIONS

- During your meeting or any time prior to enrollment, you may not ask any Direct Medical Questions of the beneficiary. For Example, **do not ask**:

  Do you have COPD or other chronic breathing problems?

- Instead, state the following:

  If you have a Cardiovascular Disorder, Chronic Heart Failure, Diabetes Mellitus or a Chronic Lung Disorder you may qualify for one of our Special Needs plans.

- The only exception to this rule is "Do you have ESRD?"
- When assisting in filling out the application, you can ask the specific health questions listed on the application.

IMPORTANT REMINDERS FOR ENROLLMENT APPLICATIONS

1. Make sure you are using the correct Enrollment Application with the correct Plan Sponsor name and specific Plan Benefit Package (PBP) the enrollee has chosen.
2. Recap the following information with the beneficiary:
   - ✓ **The enrollee has both Medicare Part A and B.**
   - ✓ **The enrollee understands that they are enrolling in a Medicare Advantage plan, not a Medi-Gap or a stand alone PDP.**
   - ✓ **The Plan PBP selected by the enrollee is correct.**
   - ✓ **The PCP selected is in the directory, the Provider ID is correct on the enrollment form and the PCP is accepting new patients. (HMO plans)**
   - ✓ **The Dates are correct on the form.**
   - ✓ **The beneficiary's personal information is correct.**
   - ✓ **The VRA Tracking Number is in the correct box.**
3. Review the completed application to make sure all mandatory boxes are filled in and you have secured the appropriate signature.

ENROLLMENT APPLICATIONS

- If a beneficiary calls you to cancel or dis-enroll, please communicate this information to the Plan immediately. Also instruct the member to call **Member Services** at:
  - **Freedom** 800-401-2740
  - **Optimum** 866-245-5360
- A Disenrollment request MUST be received in writing. It cannot be processed until the written request is received.
- A Cancellation (usually prior to an effective date) may be received verbally. The plan will reach out to the beneficiary to request the cancellation in writing, but will not delay the processing while waiting on the written request.
- A letter may be hand delivered, faxed, or sent regular mail to a Concierge Office. Mailing addresses may also be found on the Plans' website: http://www.freedomhealth.com http://www.youroptimumhealthcare.com

TOP MEMBER COMPLAINTS AND ISSUES

Let's look at some of the most common issues surfaced during complaint investigations:

TOP COMPLAINTS

Provider Network Issues:

Closed PCP panel

Specialist or PCP not in network

Formulary Issues:

Tier level cost issues

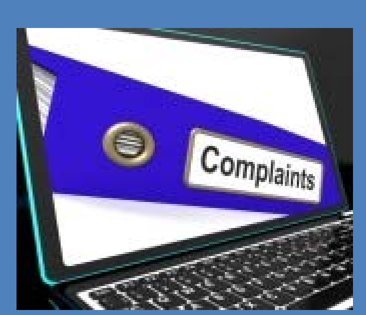
Coverage for medications

Other Issues:

Video presentations

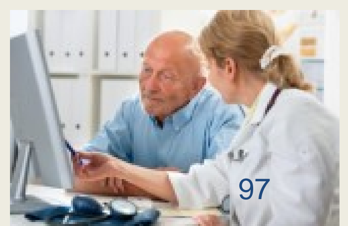
Plan benefit confusion

Chronic SNP enrollment



PCP/ NETWORK ISSUES

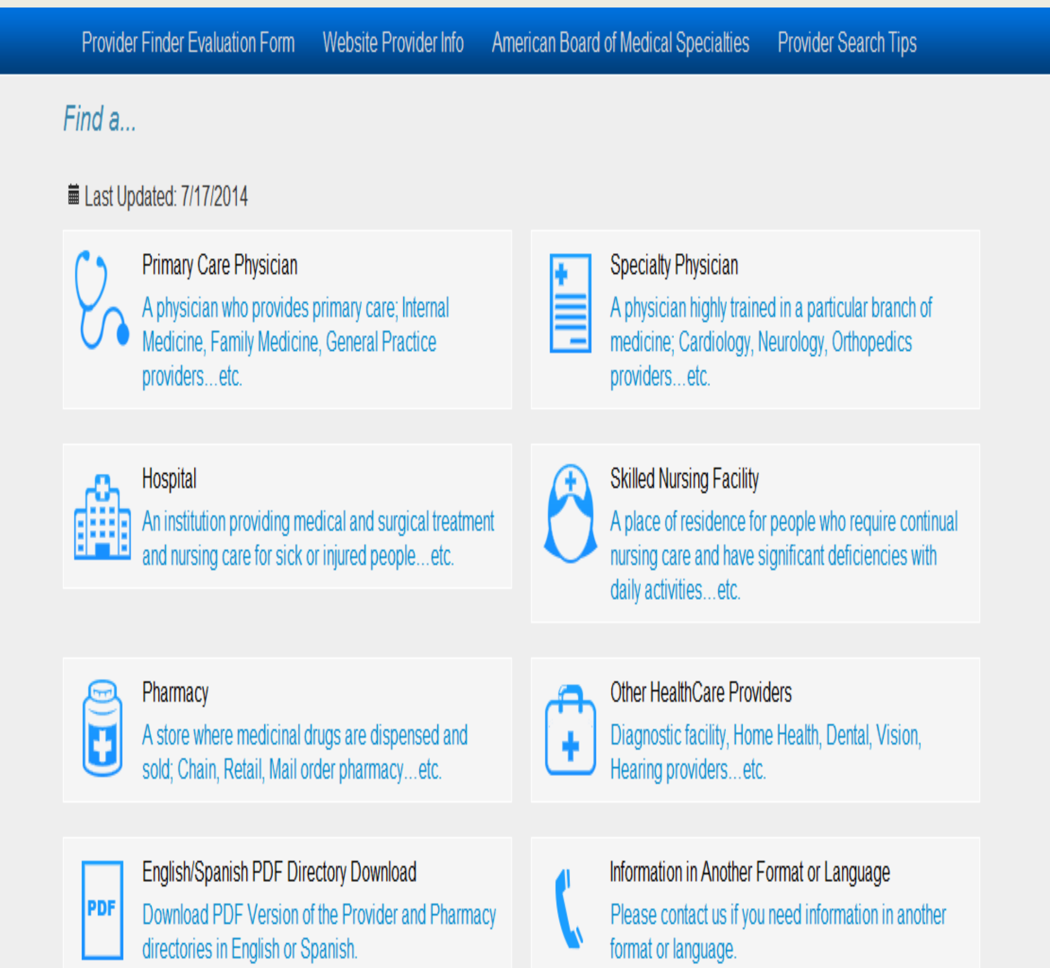
- HMO Members must select a PCP from our network. Use the most recent Provider Directory available.
  - Agents should use the On-Line Directory available with electronic enrollments.
  - If using paper directory, please use along with the periodic supplemental directories or check online. You may also call Agent/Broker Services at (877) 877-0539
- Only Providers listed in the Provider Directory as receiving new patients may be selected by the member.
- Special Note: The *printed* Provider Directory is only printed once each year at the beginning of AEP. Supplemental Directories are sent out periodically by Agent/Broker services.



PCP/NETWORK ISSUES

Members may also use the search engine located on each of our Internet sites.

Members may continue their search by providing certain key information such as county, distance from their zip code, physician name or specialty.



PCP/ NETWORK ISSUES

- Providers in our directories are designated as:
  - ***Closed Panel*** – The provider is not accepting any **new** patients. New or existing members may not choose this provider as their PCP. **No exceptions.**
  - ***Current Patients Only*** – The provider is not accepting **new** patients but may be named as a new enrollee's PCP if that enrollee is an existing patient of the provider and has been treated during the last 12 months.
- IKA will show a designation for PR to close the panel, allow current patients only or accept new patients.
- **If the provider is closed panel or current patients only, the on-line application will not allow that provider to be named as PCP for existing patients. A paper app must be done.**

PCP/ NETWORK ISSUES

Process to follow if new enrollee is an existing patient of a current patient only Provider and wants to select that provider as their PCP: (on-line will not allow that provider to be selected)

1. A Paper application must be used instead of an on-line application with a "YES" to the question are you an existing patient.

2. Enrollment will review application for PCP selection and verify that new enrollee is an existing patient or not.

3. Phone calls will be made to the member if the PCP selected does not accept the new enrollee's selection.

PCP/NETWORK ISSUES

- Certain services require a Referral from the PCP or in some instances Authorization from the Plan. (Excluding PFFS plans)
- In most situations, the PCP must give a Referral before the member may use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies.
- A Referral from a PCP is not required for emergency care or urgently needed care.
- If there is a particular plan specialist or hospital the member wants to use, advise the member to check first to be sure their PCP makes Referrals to that specialist, or uses that hospital. (Also advisable in the case of a PCP change)

NETWORK PROVIDERS MUST BE USED FOR THE FOLLOWING SERVICES (HMO PLANS):

- Chiropractic Services
- Dermatology Services
- Ophthalmology/Vision Services/Routine Vision Exams/Glasses/Contacts
- Behavioral Health Services
- Podiatry Services
- Dental Services
- Hearing Services/Hearing Aids
- Laboratory Services
- Prescription Drugs
- Hospitals
- All Specialist Physicians
- Primary Care Services
- PT/OT/ST Services
- Health Club/Fitness Membership
- Over-the-Counter Medicine
- Smoking Cessation Counseling
- Transportation Services
- Other Ancillary Services such as Home Health

FORMULARY & DRUG COST ISSUES

- All our Prescription Drug coverage is subject to our formularies. Drugs not found on our Formulary are not covered.
- Each PBP is assigned to a specific Formulary.
- Our covered drugs are usually classified into 4 tiers. Tier level determines the member's copay amount.
- The information contained in the Formulary's Requirements column tells the member if there are any special requirements for coverage.
- Not all prescription drugs are covered under Part D coverage. Some Prescription drugs may be covered under Part B. When the Formulary displays "B/D" in the Requirements column, it means that the Plan must make a determination as to whether the drug is covered by Part B or Part D.
- Generic drugs are covered in Tiers 1, 2, 3 and 4.
- Don't assume you know how a drug is covered. Refer any prescription drug coverage questions to Member Services for response. The proper response can be complicated.

CHRONIC SNP ISSUES

- The plan has only till the end of the first month of enrollment to confirm that the enrollee has the qualifying condition necessary for enrollment into the chronic condition SNP.

- If the plan cannot confirm that the enrollee has the qualifying condition within that time, the plan has the first seven calendar days of the following month (i.e., the second month of enrollment) in which to send the beneficiary notice of his/her disenrollment at the end of that month for not having the qualifying condition.

CHRONIC SNP ISSUES

- Disenrollment is effective at the end of the second month of enrollment; however, the organization must retain the member if confirmation of the qualifying condition is obtained at any point during the second month of enrollment. In the event the organization submits a disenrollment request to CMS prior to confirming the qualifying condition, a reinstatement request must be submitted to CMS (or its designee).

- The beneficiary has an SEP that begins with the month of notification and continues through the two following months to enroll in another MA organization for a prospective effective date. This SEP allows a beneficiary time to find a new plan while reducing the potential for incurring a late enrollment penalty.

OTHER ISSUES

- Our Plans are not Supplement Plans or Medigap plans.
- If enrolled, our Plans replace original Medicare coverage. We are not secondary payers to Medicare.
- Our Plans provide members with all Medicare covered Part A and B services and some plans also provide Part D benefits.
- Members must understand the PBP they have selected. Review copays and coverage, specifically restrictions and seek confirmation prior to enrollment.

Special Note: It is required that all presentations, whether in-home or in a group setting begin with the **video presentation**. This is not optional.

ADDITIONAL INFORMATION FOR AGENTS/BROKERS

Financial Assistance

Dual Eligibility

Creditable Coverage

Fraud Awareness

FINANCIAL ASSISTANCE

Beneficiaries may be eligible to save money on medical and drug costs. They may not be aware of these Federal and State programs. Information can be found on the **http://Medicare.gov** website.

- ✓ **Medicaid**
- ✓ **Medicare Savings Plans - Dual Eligible, Medically Needy**
- ✓ **Extra Help Program – Low Income Subsidy**
- ✓ **State Pharmaceutical Assistance Programs – If available in the state**
- ✓ **Other Pharmacy Assistance Programs**

DUAL ELIGIBLES

- Dual Eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.
- There are separate eligibility requirements for each program.
- Medicaid may pay Medicare Deductibles and the Medicare Premium.
- Beneficiaries are qualified by Medicaid as to the level of cost sharing that is made available to them. Each qualified beneficiary is assigned an ID number.

CREDITABLE COVERAGE

- Beneficiaries should check with the benefits administrator of their Employer Group Health Plan (EGHP) before changing plans to keep from possibly losing coverage or to determine if it is the type of plan that can be used along with the plan (s)he is joining.
- Individuals with other drug coverage(s), including private stand alone PDP's, TRICARE, Federal employee health benefits coverage, VA (Dept. of Veterans Affairs) benefits, or State pharmaceutical assistance programs may be affected by joining a new plan.
- Please take necessary precautions and advise beneficiaries to discuss their coverage with the benefits administrators of these plans so they are fully aware of the circumstances before joining any new plan.

EGHP/VA OR OTHER CREDITABLE COVERAGE

"WHO PAYS FIRST" Guidance Table

IF YOU	SITUATION	PAYS FIRST	PAYS SECOND
Are 65 or older and covered by a group health plan because you or your spouse is working	Entitled to Medicare	Group Health Plan	MA or MAPD Plan
	The employer has 20 or more employees		
	The employer has less than 20 employees	MA or MAPD Plan	Group Health Plan
Are a Veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	The Plan pays for Medicare covered services.	Usually doesn't apply
		Veterans' Affairs pays for VA-Authorized services.	
		Note: Generally, The Plan and VA can't pay for the same service.	
Are covered under TRICARE	Entitled to Medicare and TRICARE	The Plan pays for Medicare covered services.	TRICARE may pay second.
		TRICARE pays for services from a military hospital or any other federal provider.	

STOP Medicare Fraud

U.S. Department of Health & Human Services and U.S. Department of Justice

About Fraud | Prevent Fraud | Report Fraud | For Providers

Medicare Fraud Strike Force Charges 90 Individuals for Approximately $260 million in False Billing

27 Medical Professionals, Including 16 Doctors, Charged with Health Care Fraud

- Read the Press Release
- Learn more about the HEAT Task Force

Report Medicare Fraud Now

Office of Inspector General
Call: 800-447-8477
TTY: 800-377-4950
Online: Report Fraud

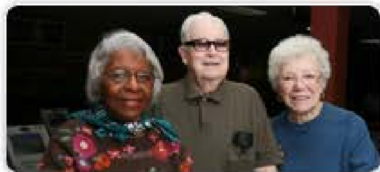
Centers for Medicare and Medicaid
Call: 800-633-4227 / TTY 877-486-2048

More >

Identify Common Scams

- Learn to recognize fraud and protect yourself against identity theft.

Senior Medicare Patrols



- Seniors learn and teach each other to battle fraud.

Partnership to Fight Fraud

- A new partnership unites public and private organizations to fight fraud.

Anti-Fraud News

- War on fraud goes high-tech
- More fraud news

Fraud Waste and Abuse costs the Medicare system approximately $60 billion per year. Encourage seniors to be informed, consult federal and state resources and report any suspected issues.

REPORT FRAUD, WASTE & ABUSE

Our Plan has partnered with EthicsPoint to provide a phone and web based reporting system. Sales Agents/Brokers, members, providers and our plan employees may file a confidential and anonymous report 24 hours a day, seven days a week.

- **On the Internet: http://americas1stchoice.ethicspoint.com**
- **Send an E-Mail to: compliancereporting@americas1stchoice.com**
- **By Phone: Florida – (888) 548-0094**

Medicare Parts C & D Fraud, Waste, and Abuse Training and General Compliance Training

Developed by the Centers for Medicare & Medicaid Services

Important Notice

This training module consists of two parts:

(1) Medicare Parts C & D Fraud, Waste, and Abuse (FWA) Training and

(2) Medicare Parts C & D General

Compliance Training. All persons who provide health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. This module *may* be used to satisfy both requirements.

Table of Contents

1) Fraud, Waste, and Abuse and HIPAA Training

2) General Compliance Training

3) Best Practices for You

Part 1: Medicare Parts C and D Fraud, Waste, and Abuse Training

Developed by the Centers for Medicare & Medicaid Services

FWA Training Exception - Notice

There is one exception to the FWA training and education requirement. Regulations effective June 7, 2010 implemented a “deeming” exception which exempts FDRs who are enrolled in Medicare Parts A or B from annual FWA training and education.

Therefore, if an entity or an individual is enrolled in Medicare Parts A or B, the FWA training and education requirement has already been satisfied. If you are unsure if this “deeming” exception applies to you please contact your sponsor for more information.

Why Do I Need Training?

Every year *millions* of dollars are improperly spent because of fraud, waste, and abuse. It affects everyone.

Including <u>YOU</u>.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

<u>YOU</u> are part of the solution.

Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse
- Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
- Provide information on how to report fraud, waste, and abuse
- Provide information on laws pertaining to fraud, waste, and abuse

Requirements

The Social Security Act and CMS regulations and guidance govern the Medicare program, including parts C and D.

- Part C and Part D sponsors must have an effective compliance program which includes measures to prevent, detect and correct Medicare non-compliance as well as measures to prevent, detect and correct fraud, waste, and abuse.
- Sponsors must have an effective training for employees, managers and directors, as well as their first tier, downstream, and related entities. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Where Do I Fit In?

As a person who provides health or administrative services to a Part C or Part D enrollee you are either:

- **Part C or D Sponsor Employee**
- **First Tier Entity**
  - Examples: PBM, a Claims Processing Company, contracted Sales Agent
- **Downstream Entity**
  - Example: Pharmacy
- **Related Entity**
  - Example: Entity that has a common ownership or control of a Part C/D Sponsor

What are my responsibilities?

You are a vital part of the effort to prevent, detect, and report Medicare non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Part C or Part D requirements, including adopting and implementing an effective compliance program.
- **SECOND** you have a duty to the Medicare Program to report any violations of laws that you may be aware of.
- **THIRD** you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

An Effective Compliance Program

- Is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste and abuse.

- Must, at a minimum, include the 7 core compliance program requirements. (42 C.F.R. §422.503 and 42 C.F.R. §423.504)

Prevention

How Do I Prevent Fraud, Waste, and Abuse?

- Make sure you are up to date with laws, regulations, policies.
- Ensure you coordinate with other payers.
- Ensure data/billing is both accurate and timely.
- Verify information provided to you.
- Be on the lookout for suspicious activity.

Policies and Procedures

Every sponsor, first tier, downstream, and related entity must have policies and procedures in place to address fraud, waste, and abuse. These procedures should assist you in detecting, correcting, and preventing fraud, waste, and abuse.

Make sure you are familiar with your entity's policies and procedures.

Detection

Understanding Fraud, Waste and Abuse

In order to detect fraud, waste, and abuse

you need to know the **Law**

Criminal FRAUD

Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

18 United States Code §1347

What Does That Mean?

Intentionally submitting false information to the government or a government contractor

in order to get money or a benefit.

Waste and Abuse

Waste: overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse: includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.

Differences Between Fraud, Waste, and Abuse

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

Report Fraud, Waste, and Abuse

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your compliance department or your sponsor's compliance department . Your sponsor's compliance department area will investigate and make the proper determination.

Indicators of Potential Fraud, Waste, and Abuse

Now that you know what fraud, waste, and abuse are, you need to be able to recognize the signs of someone committing fraud, waste, or abuse.

Indicators of Potential Fraud, Waste, and Abuse

The following slides present issues that may be potential fraud, waste, or abuse. Each slide provides areas to keep an eye on, depending on your role as a sponsor, pharmacy, or other entity involved in the Part C and/or Part D programs.

FAKE HOAX FRAUD SCAM PHONY RIP-OFF BOGUS

Key Indicators: Potential Beneficiary Issues

- Does the prescription look altered or possibly forged?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the service/picking up the prescription the actual beneficiary(identity theft)?
- Is the prescription appropriate based on beneficiary's other prescriptions?
- Does the beneficiary's medical history support the services being requested?

Key Indicators: Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Is the provider performing unnecessary services for the member?

Key Indicators: Potential Provider Issues

- Is the provider's diagnosis for the member supported in the medical record?
- Does the provider bill the sponsor for services not provided?

Key Indicators: Potential Pharmacy Issues

- Are the dispensed drugs expired, fake, diluted, or illegal?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?
- Are proper provisions made if the entire prescription cannot be filled (no additional dispensing fees for split prescriptions)?
- Are generics provided when the prescription requires that brand be dispensed?

Key Indicators: Potential Pharmacy Issues

- Are PBMs being billed for prescriptions that are not filled or picked up?
- Are drugs being diverted (drugs meant for nursing homes, hospice, etc. being sent elsewhere)?

Key Indicators: Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?

- Is the wholesaler diverting drugs meant for nursing homes, hospices, and AIDS clinics and then marking up the prices and sending to other smaller wholesalers or to pharmacies?

Key Indicators:
Potential Manufacturer Issues

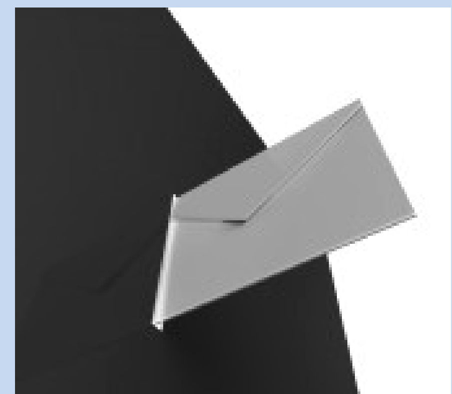
- Does the manufacturer promote off label drug usage?

- Does the manufacturer provide samples, knowing that the samples will be billed to a federal health care program?

Key Indicators: Potential Sponsor Issues

- Does the sponsor offer cash inducements for beneficiaries to join the plan?
- Does the sponsor lead the beneficiary to believe that the cost of benefits are one price, only for the beneficiary to find out that the actual costs are higher?
- Does the sponsor use unlicensed agents?
- Does the sponsor encourage/support inappropriate risk adjustment submissions?

How Do I Report Fraud, Waste, or Abuse?



Reporting Fraud, Waste, and Abuse

Everyone is required to report suspected instances of fraud, waste, and Abuse. Your sponsor's Code of Conduct and Ethics should clearly state this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.

Reporting Fraud, Waste, and Abuse

Every MA-PD and PDP sponsor is required to have a mechanism in place in which potential fraud, waste, or abuse may be reported by employees, first tier, downstream, and related entities. Each sponsor must be able to accept anonymous reports and cannot retaliate against you for reporting. Review your sponsor's materials for the ways to report fraud, waste, and abuse.

When in doubt, call the MA-PD or PDP fraud, waste, and abuse Hotline or the Compliance Department.

To Report Suspected Compliance, FWA & HIPAA Issues

- Compliance Officer: Pawan Shah
- Secured Compliance Hot Lines:

FL: (888) 548-0094	NC & SC: (888) 548-0095

- Secured web site for FL, SC, & NC :
  www. Americas1stchoice.ethicspoint.com

For Issues in FL, NC, SC:
E-Mail: compliance reporting @americas1stchoice.com
Fax: (888) 548 – 0092
P.O. Box: Compliance Department P.O. Box 152137 Tampa, FL 33684

Correction

Correction

Once fraud, waste, or abuse has been detected it must be promptly corrected.

Correcting the problem saves the government money and ensures you are in compliance with CMS' requirements.

How Do I Correct Issues?

Once issues have been identified, a plan to correct the issue needs to be developed. Consult your compliance officer or your sponsor's compliance officer to find out the process for the corrective action plan development.

The actual plan is going to vary, depending on the specific circumstances.

Laws You Need to Know About

Laws

The following slides provide very high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

Civil Fraud
Civil False Claims Act

Prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it’s true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733

Civil False Claims Act Damages and Penalties

The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

Criminal Fraud Penalties

If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code §1347

Anti-Kickback Statute

Prohibits:

Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

42 United States Code §1320a-7b(b)

Anti-Kickback Statute Penalties

Fine of up to $25,000, imprisonment up to five (5) years, or both fine and imprisonment.

Stark Statute (Physician Self-Referral Law)

Prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn

Stark Statute Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with Stark are not payable.

Up to a **$15,000** fine for each service provided.

Up to **a $100,000** fine for entering into an arrangement or scheme.

Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

HIPAA

Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

Basic HIPAA Privacy Rule

The **HIPAA Privacy Rule** (Standards for Privacy of Individually Identifiable Health Information) provides the first national standards for protecting the privacy of health information.

The **Privacy Rule** regulates how certain entities, called covered entities, use and disclose certain individually identifiable health information, called **Protected Health Information (PHI)**.

PHI is individually identifiable health information that is transmitted or maintained in any form or medium (e.g., electronic, paper, or oral), but excludes certain educational records and employment records.

HIPAA Communication Methods

- HIPAA applies to PHI in **ALL** forms of communication, whether electronic, written or oral.

- This means that HIPAA applies to:
  - Face to face interactions
  - Telephone conversations
  - Faxed or scanned documents
  - Printed materials and documents
  - E-mail and other internet based communications such as Face-Book

What Is Considered PHI?

- Names, Addresses
- All elements of dates directly related to an individual, including birth date, admission date discharge date, date of death
- Telephone or Fax number
- E-Mail Address
- Medical Record Number
- Health Plan Beneficiary Number
- Account Numbers

- Certificate/License Number
- Vehicle Identifier and Serial Numbers (License plates)
- Device Identifiers & Serial Numbers
- URL, IP Addresses
- Biometric Identifiers (finger and voice prints)
- Full-Face Photos and Comparable Images
- Any other unique identifying number, characteristic or code

PHI Use & Disclosure

Use = Information shared within our organization.

Disclosure = Information provided to individuals or entities outside our organization.

HIPAA prohibits use or disclosure of PHI unless:

- It is used to provide treatment, payment or health care operations; or
- It's use is authorized by or provided to our member; or
- It's used for any one of 12 national priority purposes, such as if required by law, public health activities and safety, law enforcement, judicial or administrative proceedings, victims of abuse or domestic violence, or research, to name a few. Disclosure rules may apply.

Minimum Necessary

We must make reasonable efforts to use, disclose or request only the ***minimum amount*** of PHI required to accomplish the task at hand.

Do not ask for any information you do not need to investigate or resolve an issue.

- We must keep track of disclosures of PHI.
- We must document privacy policies and procedures.
- We must notify members of our privacy practices and uses of their PHI as well as any breach of information.

Consequences

Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation.

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care programs

Scenario #1

A person comes to your pharmacy to drop off a prescription for a beneficiary who is a "regular" customer. The prescription is for a controlled substance with a quantity of 160. This beneficiary normally receives a quantity of 60, not 160. You review the prescription and have concerns about possible forgery.

What is your next step?

Scenario #1

A. Fill the prescription for 160
B. Fill the prescription for 60
C. Call the prescriber to verify quantity
D. Call the sponsor’s compliance department
E. Call law enforcement

Scenario #1 Answer

Answer: C

Call the prescriber to verify

If the subscriber verifies that the quantity should be 60 and not 160 your next step should be to immediately call the sponsor’s compliance hotline. The sponsor will provide next steps.

Scenario #2

Your job is to submit risk diagnosis to CMS for purposes of payment. As part of this job you are to verify, through a certain process, that the data is accurate. Your immediate supervisor tells you to ignore the sponsor's process and to adjust/add risk diagnosis codes for certain individuals.

What do you do?

Scenario #2

A. Do what is asked of your immediate supervisor

B. Report the incident to the compliance department (via compliance hotline or other mechanism)

C. Discuss concerns with immediate supervisor

D. Contact law enforcement

Scenario #2 Answer

Answer: B

Report the incident to the compliance department (via compliance hotline or other mechanism)

The compliance department is responsible for investigating and taking appropriate action. Your sponsor/supervisor may NOT intimidate or take retaliatory action against you for good faith reporting concerning a potential compliance, fraud, waste, or abuse issue.

Scenario #3

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider ("Doe Diagnostics") has requested a substantial payment for a large number of members.

Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics' claims far exceed any other provider that you reviewed.

What do you do?

Scenario #3

A. Call Doe Diagnostics and request additional information for the claims

B. Consult with your immediate supervisor for next steps

C. Contact the compliance department

D. Reject the claims

E. Pay the claims

Scenario # 3 Answer

Answers B or C

Consult with your immediate supervisor for next steps

or

Contact the compliance department

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance department have occurred, including whether additional documentation is necessary.

Scenario #4

You are performing a regular inventory of the controlled substances in the pharmacy. You discover a minor inventory discrepancy.

What should you do?

Scenario #4

A. Call the local law enforcement
B. Perform another review
C. Contact your compliance department
D. Discuss your concerns with your supervisor
E. Follow your pharmacies procedures

Scenario #4 Answer

Answer E

Follow your pharmacies procedures

Since this is a minor discrepancy in the inventory you are not required to notify the DEA. You should follow your pharmacies procedures to determine the next steps.

Part 2: Medicare Parts C & D Compliance Training

Developed by the Centers for Medicare & Medicaid Services

IMPORTANT NOTICE

This training module will assist Medicare Parts C and D plan Sponsors in satisfying the Compliance training requirements of the Compliance Program regulations at 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi) and in Section 50.3 of the Compliance Program Guidelines found in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

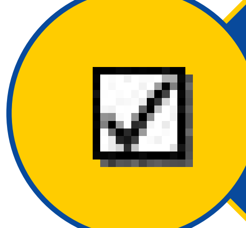
While Sponsors may choose to use this module to satisfy compliance training requirements, completion of this training in and of itself does not ensure that a Sponsor has an "effective Compliance Program." Sponsors are responsible for ensuring the establishment and implementation of an effective Compliance Program in accordance with CMS regulations and program guidelines.

Why Do I Need Training?

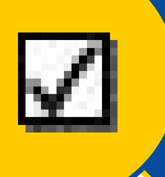
Compliance is <u>EVERYONE'S</u> responsibility!

As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare program, or the Medicare trust fund.

Training Objectives



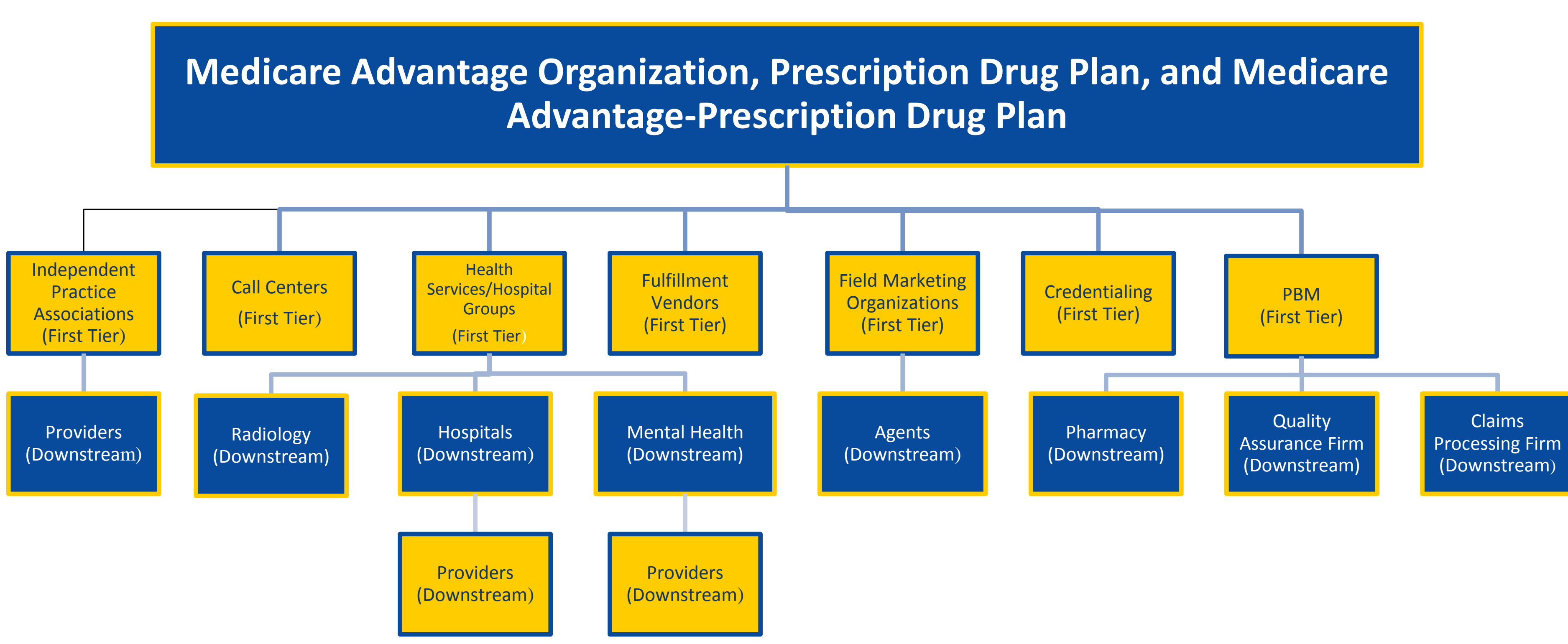
To understand the organization's commitment to ethical business behavior



To understand how a compliance program operates

To gain awareness of how compliance violations should be reported

Where Do I Fit in the Medicare Program?



Background

- CMS requires Medicare Advantage, Medicare Advantage-Prescription Drug, and Prescription Drug Plan Sponsors (“Sponsors”) to implement an effective compliance program.

- An effective compliance program should:

Compliance

A culture of compliance within an organization:

- Prevents Noncompliance
- Detects Noncompliance
- Corrects Noncompliance

Compliance Program Requirements

At a minimum, a compliance program must include the 7 core requirements:

1. Written Policies, Procedures and Standards of Conduct;
2. Compliance Officer, Compliance Committee and High Level Oversight;
3. Effective Training and Education;
4. Effective Lines of Communication;
5. Well Publicized Disciplinary Standards;
6. Effective System for Routine Monitoring and Identification of Compliance Risks; and
7. Procedures and System for Prompt Response to Compliance Issues

42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi); Internet-Only Manual ("IOM"), Pub. 100-16, Medicare Managed Care Manual Chapter 21; IOM, Pub. 100-18, Medicare Prescription Drug Benefit Manual Chapter 9

Compliance Training

- CMS expects that all Sponsors will apply their training requirements and “effective lines of communication” to the entities with which they partner.

- Having “effective lines of communication” means that employees of the organization and the partnering entities have several avenues through which to report compliance concerns.

Ethics – Do the Right Thing!

Act Fairly and Honestly

Comply with the letter and spirit of the law

As a part of the Medicare program, it is important that you conduct yourself in an ethical and legal manner.

It's about doing the right thing!

Adhere to high ethical standards in all that you do

Report suspected violations

How Do I Know What is Expected of Me?

Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which an organization operates.

Contents will vary as Standards of Conduct should be tailored to each individual organization's culture and business operations.

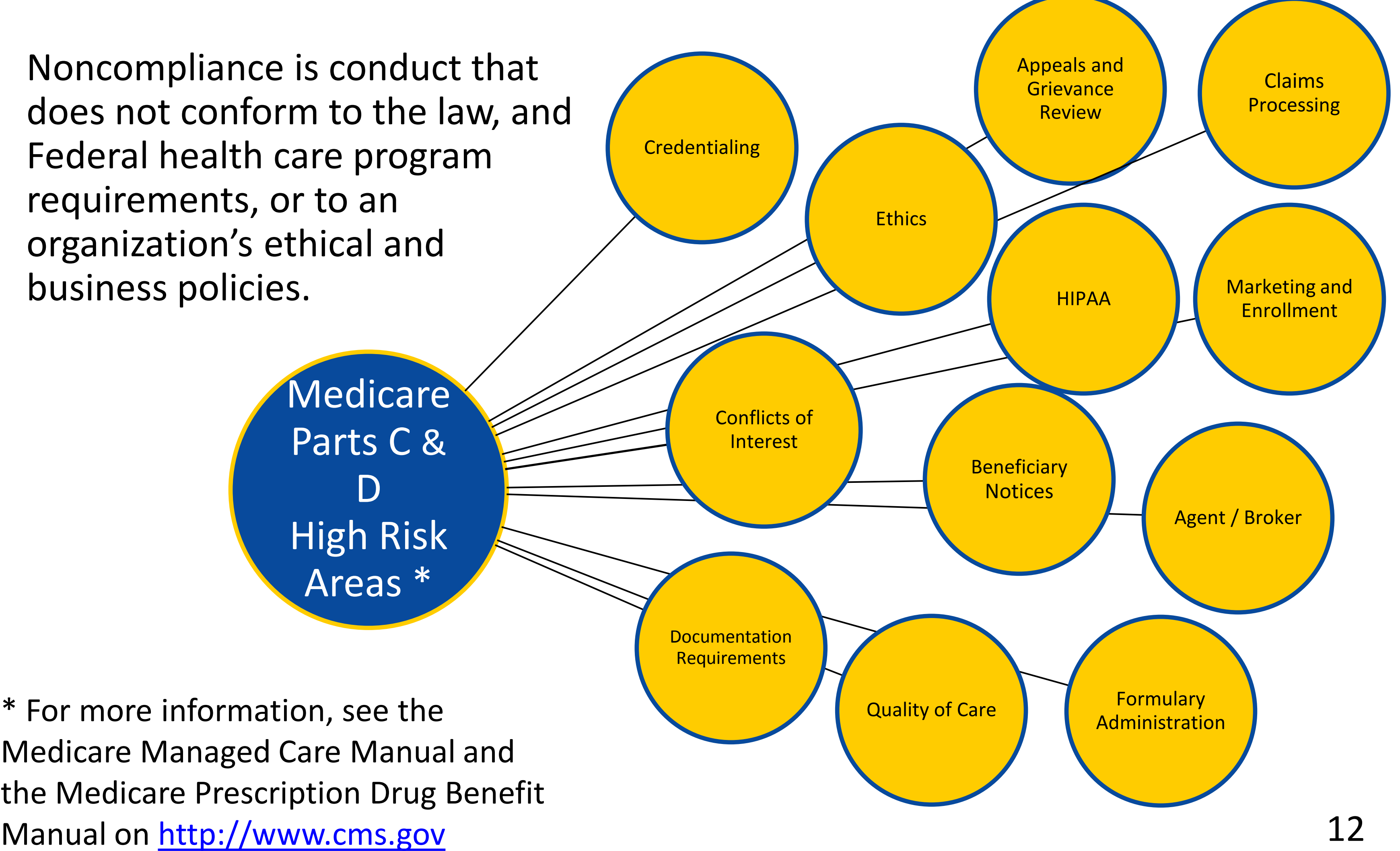
How Do I Know What is Expected of Me (cont.)?

Everyone is required to report violations of Standards of Conduct and suspected noncompliance.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report.

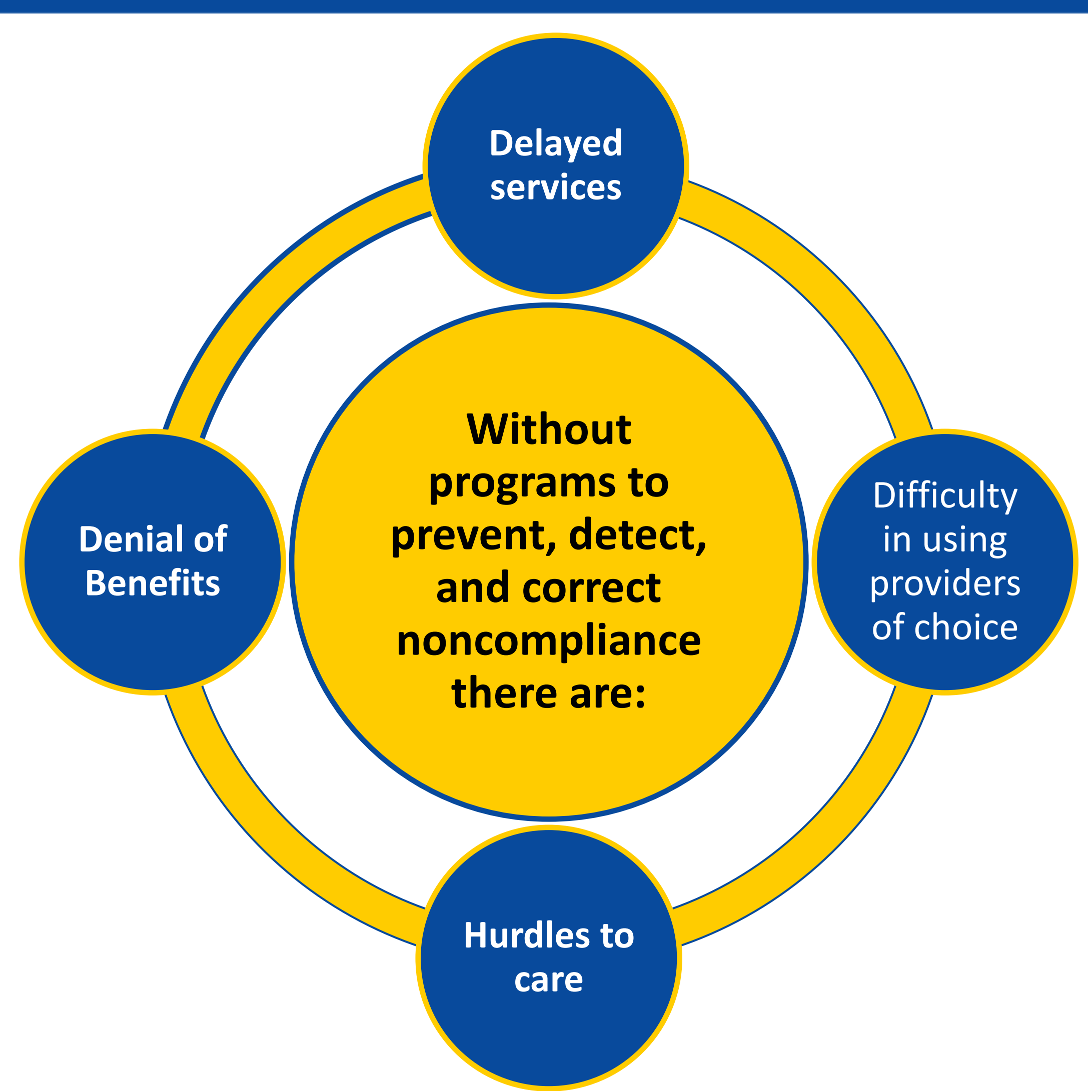
What Is Noncompliance?

Noncompliance is conduct that does not conform to the law, and Federal health care program requirements, or to an organization's ethical and business policies.



* For more information, see the Medicare Managed Care Manual and the Medicare Prescription Drug Benefit Manual on http://www.cms.gov

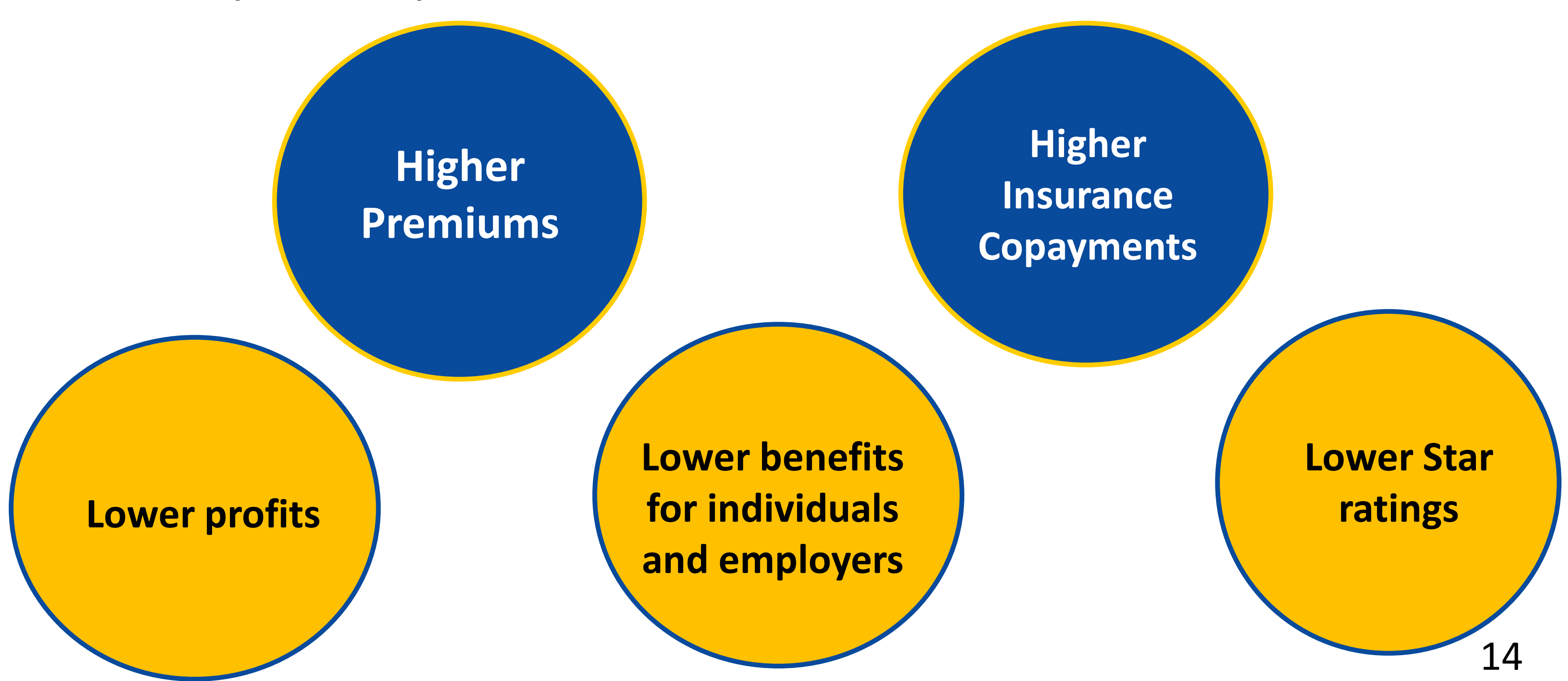
Noncompliance Harms Enrollees



Noncompliance Costs Money

Non Compliance affects EVERYBODY!

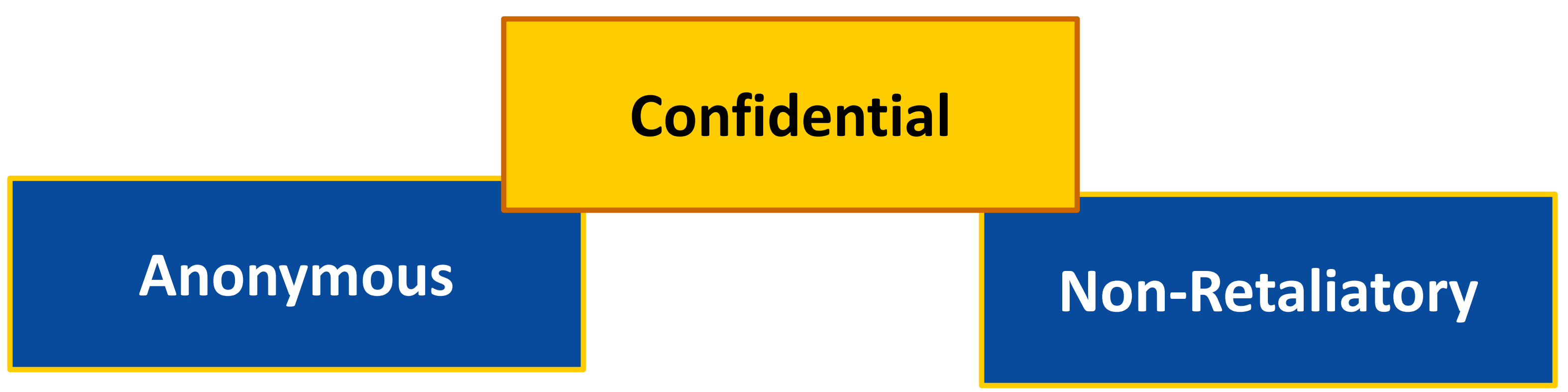
Without programs to prevent, detect, and correct noncompliance you risk:



I'm Afraid to Report Noncompliance

There can be **NO** retaliation against you for reporting suspected noncompliance in good faith.

Each Sponsor must offer reporting methods that are:



How Can I Report Potential Noncompliance?

Employees of an MA, MA-PD, or PDP Sponsor

- Call the Medicare Compliance Officer
- Make a report through the Website
- Call the Compliance Hotline

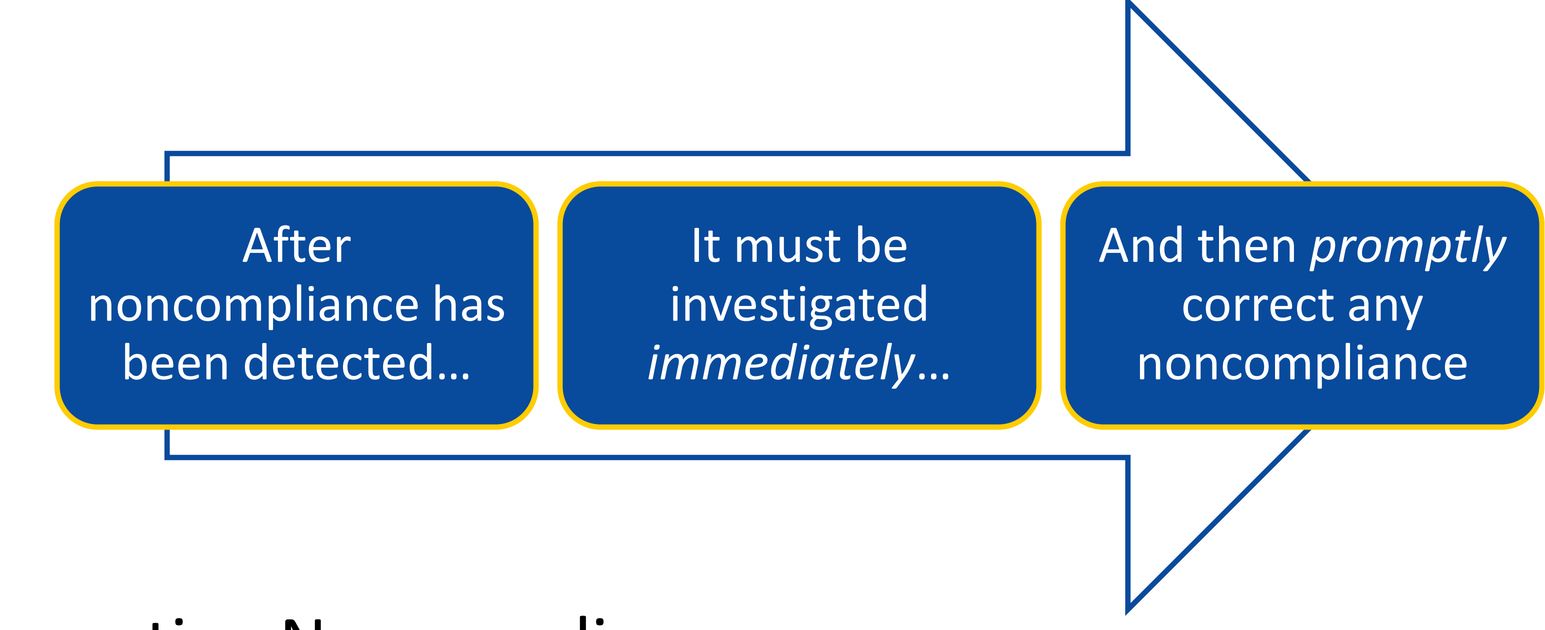
FDR Employees

- Talk to a Manager or Supervisor
- Call Your Ethics/Compliance Help Line
- Report through the Sponsor

Beneficiaries

- Call the Sponsor’s compliance hotline
- Make a report through Sponsor’s website
- Call 1-800-Medicare

What Happens Next?

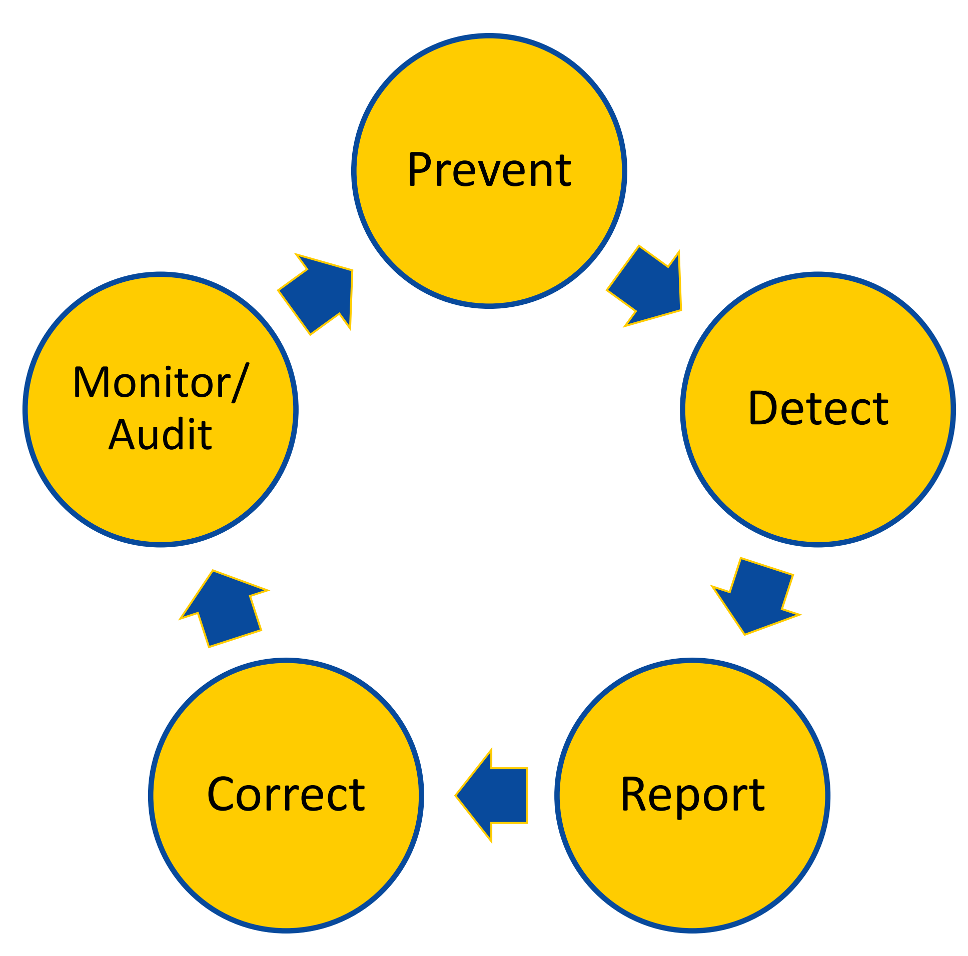


Correcting Noncompliance

- Avoids the recurrence of the same noncompliance
  - Promotes efficiency and effective internal controls
    - Protects enrollees
      - Ensures ongoing compliance with CMS requirements

How Do I Know the Noncompliance Won't Happen Again?

- Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.
- Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.
- Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures



Know the Consequences of Noncompliance

Your organization is required to have disciplinary standards in place for non-compliant behavior. Those who engage in non-Compliant behavior may be subject to any of the following:

Mandatory Training or Re-Training → **Disciplinary Action** → **Termination**

Compliance is EVERYONE'S Responsibility!!

Prevent

- Operate within your organization's ethical expectations to PREVENT noncompliance!

Detect & Report

- If you DETECT potential noncompliance, REPORT it!

Correct

- CORRECT noncompliance to protect beneficiaries and to save money!

Scenario 1

You have discovered an unattended email address or fax machine in your office which receives beneficiary appeals requests.

You suspect that no one is processing the appeals.

What should you do?

Scenario 1

A. Contact Law Enforcement

B. Nothing

C. Contact your Compliance Department

D. Wait to confirm someone is processing the appeals before taking further action

E. Contact your supervisor

Scenario 1

The correct answer is: C

Contact your Compliance Department.

Suspected or actual noncompliance should be reported immediately upon discovery. It is best to report anything that is suspected rather than wait and let the situation play out.

Your Sponsor’s compliance department will have properly trained individuals who can investigate the situation and then, as needed, take steps to correct the situation according to the Sponsor’s Standards of Conduct and Policies and Procedures.

Scenario 2

A sales agent, employed by the Sponsor's first-tier or downstream entity, has submitted an application for processing and has requested two things:

- the enrollment date be back-dated by one month
- all monthly premiums for the beneficiary be waived

What should you do?

Scenario 2

A. Refuse to change the date or waive the premiums, but decide not to mention the request to a supervisor or the compliance department.

B. Make the requested changes because the sales agent is responsible for determining the beneficiary's start date and monthly premiums.

C. Tell the sales agent you will take care of it, but then process the application properly (without the requested revisions). You will not file a report because you don't want the sales agent to retaliate against you.

D. Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.

E. Contact law enforcement and CMS to report the sales agent's behavior.

Scenario 2

The correct answer is: D

Process the application properly (without the requested revisions). Inform your supervisor and the compliance officer about the sales agent's request.

The enrollment application should be processed in compliance with CMS regulations and guidance. If you are unclear about the appropriate procedure, then you can ask your supervisor or the compliance department for additional, job-specific training.

Your supervisor and the compliance department should be made aware of the sales agent's request so that proper retraining and any necessary disciplinary action can be taken to ensure that this behavior does not continue. *No one*, including the sales agent, your supervisor, or the Compliance Department, can retaliate against you for a report of noncompliance made in good faith.

Scenario 3

You work for an MA-PD Sponsor. Last month, while reviewing a monthly report from CMS, you identified multiple enrollees for which the Sponsor is being paid, who are not enrolled in the plan.

You spoke to your supervisor, Tom, who said not to worry about it. This month, you have identified the same enrollees on the report again.

What do you do?

Scenario 3

A. Decide not to worry about it as your supervisor, Tom, had instructed. You notified him last month and now it's his responsibility.

B. Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting. To be safe, you submit a report through your Compliance Department's anonymous tip line so that you cannot be identified.

C. Wait until next month to see if the same enrollees are on the report again, figuring it may take a few months for CMS to reconcile its records. If they are, then you will say something to Tom again.

D. Contact law enforcement and CMS to report the discrepancy.

E. Ask Tom about the discrepancies again.

Scenario 3

The correct answer is: B

Although you have seen notices about the Sponsor's non-retaliation policy, you are still nervous about reporting. To be safe, you submit a report through your Compliance Department's anonymous tip line so that you cannot be identified.

There can be no retaliation for reports of noncompliance made in good faith. To help promote reporting, Sponsors should have easy-to-use, confidential reporting mechanisms available to its employees 24 hours a day, 7 days a week.

It is best to report any suspected noncompliance to the Compliance Department promptly to ensure that the Sponsor remains in compliance with CMS requirements. Do the right thing! Compliance is everyone's responsibility.

Where Can I Find Documents?

What Governs Compliance?

- **Social Security Act:**
  - Title 18
- **Code of Federal Regulations*:**
  - 42 CFR Parts 422 (Part C) and 423 (Part D)
- **CMS Guidance:**
  - Manuals
  - HPMS Memos
- **CMS Contracts:**
  - Private entities apply and contracts are renewed/non-renewed each year
- **Other Sources:**
  - OIG/DOJ (fraud, waste and abuse (FWA))
  - HHS (HIPAA privacy)
- **State Laws:**
  - Licensure
  - Financial Solvency
  - Sales Agents

** 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)*

Best Practices For You . . .

- Use passwords, encryption and other security measures on computers.
- Use the Print/Lock feature for copier/printers.
- Verify the identity of any person requesting PHI.
- Remember to only ask for the minimum amount of information you need for the task at hand.
- Discuss member information privately, and only when required. Never discuss a member in break rooms, elevators, lobbies or corridors.
- Always lock your computers while away from your desk. Log Off at the end of the day.

Best Practices For You . . .

- Any documents in your possession that contain member PHI should be face down on your desk, in a closed file folder, or faced toward the wall in the case of a wall box.
- Remove documents that contain PHI from copiers, printers and fax machines immediately.
- Dispose of unnecessary documents by shredding.
- Challenge any individual who accesses areas that contain PHI. Question and verify their need to have access.
- **All plan documents must be retained by all departments, including patient medical records for a minimum of 10 years.**

Additional Resources

- For more information on laws governing the Medicare program and Medicare noncompliance, or for additional healthcare compliance resources please see:
  - Title XVIII of the Social Security Act
  - Medicare Regulations governing Parts C and D (42 C.F.R. §§ 422 and 423)
  - Civil False Claims Act (31 U.S.C. §§ 3729-3733)
  - Criminal False Claims Statute (18 U.S.C. §§ 287,1001)
  - Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
  - Stark Statute (Physician Self-Referral Law) (42 U.S.C. § 1395nn)
  - Exclusion entities instruction (42 U.S.C. § 1395w-27(g)(1)(G))
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) (45 CFR Part 160 and Part 164, Subparts A and E)
  - OIG Compliance Program Guidance for the Healthcare Industry: http://oig.hhs.gov/compliance/compliance-guidance/index.asp

Any Questions?

Important Plan Numbers

Optimum VRA - English	1-800-428-2198	**Argus Dental/Vision**	1-866-853-4063
Optimum VRA - Spanish	1- 800-516-8076	**Assured RX**	1-888-987-9977
AST Fax # (Apps & SOA's)	1-800-864-1529	**HearRX**	1-800-333-3389
Agent Licensing Fax # (Background Check Documentation, Any Attestations)	1-800-609-2701	**Quest Diagnostics**	1-866-697-8378
		SilverSneakers®	1-888-423-4632
		Transportation	1-888-994-1545
		OTC Ordering	1-866-900-2688

IMPORTANT COMPLIANCE REMINDER!

You have completed the Plan Specific section for Optimum HealthCare. Please remember to verify your Clearance to Market status found on your homepage prior to marketing.

STEPS TO COMPLETE

- Background check (The Plan)
- Online Certification (You)
- Face to Face Benefit Training (You)
- State appointment (The Plan)
- Verify Clearance to Market (C2M) designation in Portal (You)