At SilverScript, we know that Medicare-eligible beneficiaries will look to you for information regarding Medicare Part D prescription drug plans.

CMS requires that marketing agents and brokers be tested annually on rules, regulations, and details about the products they sell.

To help you properly represent our products, we have developed a training & certification program:

- The program consists of several easy-to-follow online training modules.
- Each module presents information on a different subject, testing your knowledge along the way with questions on what you have learned.
- Answering 90% or more of the questions correctly in the certification test allows you to proceed to the next module.

Once you pass all modules:

- You will be permitted to view plan offerings and sell SilverScript prescription drug plans.

Welcome to SilverScript University.
Welcome to SilverScript University

- As you move forward, please take your time and pay close attention to the information presented in the training modules. If you have any questions, please contact the SilverScript Producer Support team.
- We have placed copies of the training modules on the SilverScript Agent Portal under the Reference Material tab.
- Feel free to print the training materials and reference them as you take the certification test.
- You must pass each module within three attempts to sell SilverScript Medicare Part D plans.
- We want you to be well informed as you sell our PDPs.
- In addition to the training requirements, in order to sell Medicare products an agent or broker must be appointed in accordance with the appropriate State’s appointment law for each state the agent or broker is licensed.
Objective

SilverScript markets our Prescription Drug Plans (PDPs) through a select group of insurance carriers and national marketing organizations. As a marketing representative with one of our marketing partners, your contract obligates you to:

- Abide by the rules, regulations and guidance issued by CMS
- Abide by HIPAA and state privacy laws
- Abide by the policies, procedures and guidelines issued by SilverScript

At the completion of this training module, you should be familiar with the following:

- CMS Medicare Marketing Guidelines
- HIPAA guidelines
- SilverScript policies and procedures for agents/brokers
- Your reporting obligations
SilverScript & Medicare Part D

- SilverScript contracts with CMS as plan sponsors to administer the Medicare Part D prescription drug benefit
- One aspect of our oversight program is to provide marketing representatives with proper training on how to comply with the Medicare Part D rules and regulations
- It is important that you understand and comply with guidelines as defined by CMS, HIPAA regulations, SilverScript because:
  - You are in a position to affect the decision of potential beneficiaries regarding their plan choice
  - You are held accountable for your marketing activities in the Medicare Part D marketplace
  - SilverScript is ultimately responsible for your activities when marketing our PDPs
  - You are held accountable to comply with all Federal and State privacy and security laws.
Protected Health Information (PHI)

- The HIPAA Privacy Rule standards address the use and disclosure of an individual’s health information, called Protected Health Information (PHI). PHI is any information that can be used to identify an individual and that is obtained by or on behalf of a health plan or health care provider.

- The Privacy Rule protects all PHI held or transmitted in any form or media, whether electronic, paper or oral, by a covered entity (such as SSIC) or its business associate (such as you).

- PHI includes information that relates to:
  - The individual's past, present or future physical or mental health or condition, or
    - The provision of health care to the individual, or
  - The past, present, or future payment for the provision of health care to the individual.
    - Information that identifies the individual or for which there is a reasonable basis to believe that it can be used to identify the individual.

- Examples of PHI include demographic information with any health diagnoses, medications, Medicare or SSN numbers, names of doctors, dates of treatment, etc.
Health Insurance Portability Accountability Act (HIPAA)

- HIPAA protects the privacy and security of personal health information and provides assurance to individuals that their personal health information will not be misused
- HIPAA establishes standards for certain electronic transactions and minimum privacy and security requirements
- Your obligations under HIPAA were defined in the Business Associates Agreement you signed at the time of contracting. In particular:
  - Use and disclose PHI only for purposes for which it was provided (i.e. marketing and enrollment in a SilverScript plan)
  - Use and disclose only the minimum necessary PHI for a particular task
  - Always keep PHI secure (e.g. don't leave documents containing PHI on your desk when you go out, stand by the fax machine when expecting a fax with PHI if the fax machine is not in a secure area, don't send PHI unencrypted over public networks)
  - Always encrypt PHI when sending over public networks
Anti-Kickback Statute

- One important law that governs the behavior of marketing agents is the Anti-Kickback Statute.
- This law prohibits anyone from offering inducements to purchase or use health products or services if these products or services are reimbursable in whole or in part by the federal government.
- Importantly, a violation of this statute can result in exclusion from participation in the Medicare Part D program and other federal healthcare programs. In addition, this statute carries both civil and criminal penalties for violation.
CMS Regulations

- One of the primary regulations that govern your activities as a Medicare Part D marketing agent is the Part D rule found at Code of Federal Regulations (CFR) Title 42, Part 423


- The following slides describe the do’s and don’ts for your marketing activities as described in Chapter 3 of the Prescription Drug Benefit Manual
Marketing and Sales Oversight

- Marketing includes any activity of an employee of a plan sponsor, an independent agent, or an independent broker or any other person that acts on a plan sponsor’s behalf to affect a beneficiary’s choice among Medicare plans.

- Marketing by a person who is directly employed by an organization with which a plan sponsor contracts to perform marketing or a downstream marketing contractor is considered marketing by the plan sponsor.

- The only amount that the beneficiary is required to pay is the plan’s approved premium (which is to be paid directly to the plan). Agents are not permitted to collect premiums from beneficiaries.
Licensure

- Agents must be actively licensed in the beneficiary’s state of residence at the time of the marketing activity and enrollment
- The use of state-licensed marketing representatives helps ensure that:
  - A minimum standard of integrity and professionalism is displayed when marketing to Medicare-eligible beneficiaries; and
  - Medicare beneficiaries are not the victims of substandard or inappropriate marketing activities
- In order to market SilverScript plan offerings, you must:
  - Be licensed in the state in which you conduct marketing activities;
  - Meet the necessary state educational requirements;
  - Be appointed by the plan in accordance with state appointment regulations; and
  - Obtain your training certification by passing the training modules at the required level (as described in the beginning of this module)
Compliance with State Appointment Laws

In order to sell Medicare products, plan sponsors must comply with applicable State licensure and/or appointment laws.
Plan Reporting of Terminated Agents

- Plan sponsors must report the termination of any brokers or agents and the reasons for the termination to the State in which the broker or agent has been appointed in accordance with the State appointment law.
- When plan sponsors discover incidents of unlicensed agents or brokers submitting applications, they must terminate the agent/broker and report them to the authority in the State where the application was submitted. Additionally, plan sponsors must notify any beneficiaries that were enrolled in their plans by unqualified agents or brokers and advise those beneficiaries of the agents’ and brokers’ status. Beneficiaries may request to make a plan change.
Background Check

- SilverScript is required to screen all marketing representatives against the Department of Health and Human Services (DHHS) and Office of the Inspector General (OIG) Lists of Excluded Individuals & Entities. This is done to ensure that the marketing representatives are not excluded from participation in any Federal health care programs.

- Marketing representatives found to be on these lists are immediately barred from marketing SilverScript PDPs and sanctions will be imposed for failure to disclose this information. However, if after being barred, a marketing representative is reinstated, a monitoring plan will be established to ensure that future business submitted by the marketing representative will be scrutinized in order to mitigate the risk of future non-compliance.
Agent/Broker Training for Employer/Union Group Plans

- Plan sponsors must ensure annually that all brokers and agents, including those employed by MA and Part D plans, selling Medicare products are trained annually on Medicare rules and regulations and on details specific to the plan products that they sell.

- Plan sponsors must ensure that their training programs are designed and implemented in a way that the integrity of the training is maintained. Plan sponsors should document that each agent/broker has been trained and must have the ability to provide this information to CMS upon request.
Required Materials in Pre-Enrollment Package

- When a beneficiary is provided marketing materials that include an enrollment form, the following information should also be included:
  - Enrollment instructions and forms
  - Plan ratings information must be a standalone document
  - Summary of Benefits (SB)
  - Multi-language insert
- Plan sponsors have the option of including the following materials in their enrollment kits but must make them available upon request. However, if a beneficiary enrolls with the plan sponsor, the materials below must be distributed to him/her no later than ten calendar days from receipt of CMS confirmation of enrollment or by the last day of the first month of enrollment, whichever occurs first:
  - Pharmacy directory
  - Formularies
  - A cover letter including the plan’s toll-free customer service telephone number, a TTY telephone number, customer service hours of operation, and a physical or post office address is optional since the contact information is included in the SB.
Required Materials for New/Renewing Members

- Plan sponsors must ensure their current members receive the ANOC and EOC no later than September 30th of each year. New Enrollees with an effective date of November 1st or December 1st should receive both an EOC for the current contract year and an ANOC/EOC for the upcoming contract year.

- Regardless of the effective date, the EOC document must be provided to all new enrollees no later than ten calendar days from receipt of CMS confirmation of enrollment or by the last day of the first month of enrollment, whichever occurs first.

- Materials all members are required to receive:
  - Combined ANOC/Evidence of Coverage
  - Comprehensive Formulary or Abridged Formulary including information on how the beneficiary can obtain a complete formulary
  - Pharmacy Directory
  - Membership ID Card (required only at time of enrollment and as needed or required by plan sponsor post-enrollment)

- We automatically mail these items to members.

- Plan sponsors offering the Part D benefit must provide their enrollees an Explanation of Benefits (EOB) on at least a monthly basis for those months in which the enrollees use their Part D benefit.
Plan Ratings Information

- The Medicare program rates how well plan sponsors perform in different categories
- Plan performance summary star ratings are assessed each year and may change from one year to the next
- Plan performance summary ratings are issued in October of the previous plan contract year
- Plan sponsors must provide information about their plans’ ratings information to current and prospective enrollees by
  - Referring prospective and active members to www.medicare.gov
  - Including plan ratings information in the pre-enrollment packets
  - Making plan rating information available on plan websites
  - Making plan rating information available upon request
Rules for Telephonic Contact

• Agents may contact their own clients and plan sponsors may contact current members at anytime to discuss plan business. Prohibited telephonic activities include, but are not limited to, the following:
  
  • Bait-and-switch strategies - making unsolicited calls about other business as a means of generating leads for Medicare plans.
  
  • Calls based on referrals. 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 individual needs to contact the plan or agent/broker directly.
  
  • Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling (except as permitted below), to market plans or products. 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.
  
  • Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call (including documentation of permission to be contacted)
  
  • Calls to beneficiaries to confirm receipt of mailed information, except as permitted below.
Rules for Telephonic Contact

- Plan sponsors may do the following:
  - Contact beneficiaries who submit enrollment applications to conduct quality control and agent/broker oversight activities.
  - Contact their members or use third-parties to contact their current members. Examples of allowed contacts include, but are not limited to, calls to members aging-in to Medicare from commercial products offered by the same sponsoring organization and calls to an organization’s existing Medicaid plan members to talk about its Medicare products.
  - Contact members to promote other plan types, (e.g., sponsors may contact their PDP members to promote their MA-PD offerings), and discuss plan benefits.
  - Contact their members to discuss educational events.
  - Contact their members to conduct normal business related to enrollment in the plan, including calls to members who have been involuntarily disenrolled to resolve eligibility issues.
  - Call former members after the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes. Disenrollment surveys may be done by phone or sent by mail, but neither calls, nor mailings, may include sales or marketing information.

continued
Rules for Telephonic Contact

- Plan sponsors may do the following:
  - Under limited circumstances and subject to advance approval from the appropriate CMS Regional Office, call LIS-eligible members that a plan is prospectively losing due to reassignment to encourage them to remain enrolled in their current plan.
  - Call individuals who have expressly given permission for a plan or sales agent to contact them, for example, by filling out a BRC or asking a customer service representative (CSR) to have an agent contact them. This permission applies only to the entity from which the individual requested contact, for the duration of that transaction, for the scope of product, (e.g., MA-PD plan or PDP), previously discussed or indicated in the reply card.
  - Return phone calls or messages, as these are not unsolicited.
  - Contact their members via an automated telephone notification to inform them about general information such as the AEP dates, availability of flu shots, upcoming plan changes, and other important information.
Specific Guidance on Telephone Contact

- Agents may not accept an MA plan or PDP appointment that resulted from an unsolicited contact with a beneficiary (including if the call started based on a non-MA or non-PDP product). We reiterate that any agent/broker representing a Medicare health plan is subject to the CMS marketing requirements at any point in which a discussion with a beneficiary turns to Medicare health plans, even if during the sale of an unrelated product, such as long-term care insurance. (See scope of appointment guidance):

- Finally, for those outbound calls that are allowable under these Medicare Marketing Guidelines, agents must comply to the extent applicable with the following:
  - Federal Trade Commission’s Requirements for Sellers and Telemarketers
  - Federal Communications Commission rules and applicable State law
  - National-Do-Not-Call Registry
  - Honor “Do not call again” requests, and
  - Abide by Federal and State calling hours

- All outbound scripts utilized by agents must be submitted to the plan for review and approval prior to being used in the marketplace.
Outbound Enrollment and Verification Calls

- All plan sponsors are required to conduct outbound enrollment and verification (OEV) calls for enrollments effectuated by both independent and employed agents/brokers to ensure individuals requesting enrollment understand the plan rules. It is important for the plan sponsor’s sales staff to obtain from the applicant the best phone number to be used for verification and to provide a description of the enrollment verification process to the applicant during the application process.

- OEV calls must be made to the applicant after the sale has occurred; they cannot be made at the point of sale. The plan sponsor must ensure that the verification calls are not conducted by sales agents and those sales agents are not physically present with the applicant at the time of the verification call. Plan sponsors may not use automated calling technologies to conduct these outbound calls; CMS expects OEV calls to be interactive.

- The following agent/broker-effectuated enrollments are excluded from the OEV requirement:
  - Enrollments into employer or union sponsored plans
  - Plan-to-plan switches within a parent organization involving the same plan type or product type (e.g., PFFS to PFFS, D-SNP to D-SNP, PDP to PDP).
Outbound Enrollment and Verification Calls

- Plan sponsors must make a minimum of three documented attempts to contact the applicant by telephone within fifteen (15) calendar days of receipt of the application; the first two attempts must be made within the first 10 days. If the enrollment application is incomplete, plan sponsors should concurrently conduct the OEV process while obtaining the missing information needed to complete the application.

- Plan sponsors must not delay processing the enrollment request (including, but not limited to, activation of benefits and submission of enrollment request data to CMS) while completing the OEV process. If the sponsor does not have all the information required to complete the enrollment process at the time of the OEV call, the sponsor should obtain that information during the call. If the sponsor makes a determination to deny an enrollment request prior to completing the OEV process, the sponsor must discontinue the OEV process. If the sponsor receives a TRR from CMS rejecting the enrollment prior to completing the OEV process, the sponsor must suspend the OEV process but must resume if the sponsor determines the rejection to be erroneous, such that the enrollment will be resubmitted to CMS.

- Plan sponsors that do not successfully reach the beneficiary on the first or second attempt must send the applicant an enrollment verification letter in addition to making the third documented outbound verification call attempt within the 15 day timeframe.
Legal Representation

- If a potential beneficiary is unable to enroll him or herself into one of SilverScript's plan products, a family member can authorize the enrollment of the potential beneficiary only with written, legal documentation showing that the family member has the authority to act on the beneficiary's behalf.

- This legal representative must attest on the appropriate form that they have the authority to make healthcare decisions under the pertinent State law to effect the enrollment request on behalf of the beneficiary and that a copy of the documentation (e.g. a durable power of attorney or court-appointed guardianship) required by State law that evidences the representative's authority is available upon request.

- It is important to understand that you are not expected to be an expert on legal documentation. However, it is expected that you will use good professional judgment when working with a potential beneficiary and a family member or other party who is indicating that they have authority to act on the potential beneficiary's behalf.
CMS Auditing and Monitoring

- In addition to SilverScript audits, CMS conducts audits throughout the year using several mechanisms to ensure marketing agent compliance, including:
  - Prospective and retrospective review of marketing materials to ensure that they were approved by CMS
  - Marketplace surveillance of agent activities
  - Partnership with States’ Department of Insurance and beneficiary advocates, such as the National Association of Insurance Commissioners (NAIC)
  - Secret Shopping by CMS representatives
  - Monitoring marketing activity complaints and issues using the CMS Compliant Tracking Module (CTM)
  - Attendance of marketing/sales events
Disciplinary Action

- Current SilverScript policy provides for the immediate termination of an agent’s contract to market SilverScript upon evidence of a violation of any law, regulation, or CMS guidance regarding the marketing or distribution of Medicare products

- CMS has the authority to levy a financial penalty for each beneficiary affected, or likely to be affected, by each violation.
Your Disclosure Requirement

- You MUST disclose all relevant aspects of SilverScript's products that you are marketing
  - However, never disclose more than you know
  - If you are unsure of an answer to a question, it is important not to provide a response that could be incorrect. In doing so, you could give the potential beneficiary the impression that you are misrepresenting the facts. Instead, tell the beneficiary that you will get back to him or her as soon as possible with answers to the requested information
Your Reporting Obligations

- You are required to report any suspected non-compliance and/or fraud, waste or abuse with any of CMS’s and/or SilverScript’s rules and regulations as soon as you become aware of it. You have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible.

- You have an obligation to disclose any action or situation that is, or may appear to be, a conflict of interest that would make it difficult for you to perform your work objectively or effectively.

- If you suspect issues of non-compliance or potential fraud, waste and abuse, you must report the issue to any resources available to you as outlined in the next slide.
Compliance Resources

- Feel free to contact the SilverScript Medicare Part D Compliance department if you are unsure of the answer to a question, want verification on a process, or need some direction on a compliance topic.

- The CVS Caremark Ethics Line:
  - (877) CVS-2040 or Ethics.BusinessConduct@cvs.com
- Todd Meek, Medicare Part D Compliance Officer
  - 480-614-7202 or Todd.Meek@caremark.com
- Patrick Jeswald, Director, Compliance / Fraud, Waste & Abuse
  - 480-661-2030 or Patrick.Jeswald@caremark.com
Summary

CMS provided PDP sponsors with guidelines to use in developing their curricula for training and testing agents and brokers for calendar year 2013. The goal of CMS is to ensure that all agents and brokers selling Medicare products have a comprehensive and consistent understanding of Medicare rules.

This section was designed to provide you with an overview of Marketing Guidance. Other modules address Medicare Basics and Beneficiary Protections, Enrollment, and Product-Specific details.