Agent Medicare Sales
ATRIO Health Plans Oversight

Agent Oversight Policy
ATRIO Health Plans requires all Sales Producers, Sales Agents, Sales Entities and any other downstream entities representing ATRIO Health Plans' Medicare line of business to comply with our regulatory responsibilities including CMS regulations and guidance, specifically: the CMS Medicare Marketing Guidelines, the terms of our Agent Independent Contractor Agreement and any applicable federal and state laws related to Medicare sales activities.

Ultimately, ATRIO Health Plans expects Agents will assist each Medicare beneficiary to obtain Medicare coverage that best meets the beneficiary's specific desires and needs.

ATRIO Health Plans has established this oversight program and performs such activities in order to help prevent, detect and correct non-compliant sales activities, including any activities that mislead or confuse beneficiaries or misrepresent the health plan. When potential noncompliance is detected or reported, ATRIO Health Plans will investigate, correct and monitor to ensure that appropriate corrective actions are taken and effective.

Sales entities, Agents and producers are responsible for cooperating with ATRIO Health Plans' oversight and monitoring activities, including compliance with all corrective or disciplinary actions that are deemed appropriate by ATRIO.

Contracting and Regulatory References:
- ATRIO Health Plans Agent Independent Contractor Agreement
- Medicare Managed Care Manual (MMCM) – Ch. 3 – Medicare Marketing Guidelines
- Medicare Managed Care Manual (MMCM) – Ch. 2 – Enrollment
- 42 CFR – Sections 422 (Part C) and 423 (Part D)

The Agent/Broker Oversight Program provides oversight and monitoring of the following areas:

- Broker Contracting
- Lead Management
- Event Management
- Secret Shopper Audits
- Scope of Appointment
- Personal Appointments
- PHI and Privacy Compliance
- Enrollment Applications
- Sales Allegations
- Rapid Disenrollment
- Corrective Action
- Broker Compensation
- Marketing Materials
- Website Audits

Broker Contracting
Before an agent may market or sell any of ATRIO Health Plans' Medicare products, all ATRIO Health Plans Medicare contracting requirements must be completed, including:

- Maintain an active Oregon health insurance producer license
- Successful completion of annual AHIP/Gorman National Medicare Certification with Fraud, Waste and Abuse training
- Successful completion of annual ATRIO Health Plans' Medicare Product and Compliance Training
- Complete ATRIO contracting attestations and documentation.

Producers affiliated with a Sales Entity which contracts with ATRIO Health Plans to sell Medicare products must meet all of the above requirements and also be listed by the Sales Entity on "Exhibit C," of the entity's ATRIO Independent Contractor Agreement.

Lead Management
Agents must obtain permission from a beneficiary prior to contacting them to schedule a sales or marketing appointment. Permission given by a beneficiary may be obtained via a "Permission to Call" Card, also commonly referred to as a Lead Card or Business Reply Card (BRC). When permission to call is given by a beneficiary, such permission applies:

- Only to the sales agent or sales entity from which the individual requested contact
- For the duration of that transaction
- For the scope of products previously discussed or specified

Permission to contact may not be treated as open-ended permission for future contact. Unsolicited, direct contact of beneficiaries is strictly prohibited, including, but not limited to:

- Door-to-door solicitation
- Telephonic or Email solicitation
- Distribution of information at a residence or car
- Approaching beneficiaries in common areas
- Contacting an individual who comments, likes or follows a Plan or Agent on social media

Prohibited telephonic activities include:

- Calls to beneficiaries based on leads obtained from other sources
- Bait-and-Switch strategies - making unsolicited calls about other business as a means of generating leads for Medicare plans

- Calls to a sales event attendee, unless the attendee gave express written permission at the event for a follow-up call
- Calls based on referrals
- Calls to former beneficiaries who have dis-enrolled, or to current beneficiaries who are in the process of voluntarily dis-enrolling, to market plans or products
- Calls to beneficiaries to confirm receipt of mailed information

ATRIO Health Plans will investigate any reported instances of unsolicited or inappropriate beneficiary contact to determine if corrective action is necessary.

Event Management
Marketing and Sales Events must be conducted in accordance with CMS' Medicare Marketing Guidelines which specify requirements related to sales and marketing activities, including event reporting, locations, materials, and gifts/promotional items.

Event Reporting. ATRIO requires Agents to notify their regional Sales Manager at least 14 days prior to any marketing/sales event or 7 days prior to the initial advertisement, whichever is earlier. Reporting of sales events should be submitted via ATRIO's event submission template, which can be obtained from the Sales Manager.

ATRIO will report event information to CMS, as required and specified by the CMS Medicare Marketing Guidelines. CMS uses the sales event data reported by plans to determine events to be audited via their "Secret Shopper" program. Cancellations and changes to sales events must be submitted to ATRIO Health Plans for HPMS submission at least 48 hours prior to the event's scheduled date. Agents are responsible for notifying beneficiaries of cancellations or changes by the same means used to advertise or promote the event. In the event that 48 hours advance notice cannot be provided, coordinate with your Sales Manager to have a representative present at the event location at least 15 minutes prior to, through 15 minutes after the scheduled start time to inform beneficiaries of the cancellation or change. If the event was cancelled due to inclement weather, a representative is not required to be present at the site. However, notification to the Sales Manager must include a brief explanation of the cancellation reason.

Timely and accurate reporting of event submissions, changes and cancellations is monitored by ATRIO Health Plans. Deficiencies are investigated and corrective actions are implemented as appropriate.

Managing Events. ATRIO requires that Agents implement the following event management practices:

- Arrive at least 15 minutes early
- Use signage to direct attendees to the correct event location

- If the event location has a lobby or general reception area, inform the desk attendant about the specific event location so that attendees can be directed accordingly
- Announce your name, the company you represent and all plans to be discussed during your presentation
- Use ATRIO Health Plans' approved sales presentation and ATRIO prepared Medicare marketing materials only.

ATRIO Health Plans allows use of event Sign-in Sheets with a column for Permission to Call indication as a mechanism for a beneficiary to voluntarily provide contact information so that an Agent may follow-up with the beneficiary after the sales event. When distributing the Sign-in Sheet, the Agent must clearly inform attendees/beneficiaries that providing contact information is strictly optional. Agents must not pressure or coerce a beneficiary to provide contact information.

Gifts and Promotional Items. Gifts and promotional items may be offered during the course of sales and marketing activities provided that they do not exceed the allowed maximum of $15 per person or a maximum of $50 per person, per year based on fair market value. Gifts and promotional items must be offered to all attendees, regardless of enrollment and without discrimination.

Gifts and Promotional items may not consist of:

- Cash, or other monetary rebates (including gift cards and gift certificates that can easily be converted to cash)
- Items that could be considered a health benefit (e.g. a free checkup)
- Meals (refreshments or light snacks are acceptable)

Secret Shopper / Event Surveillance. CMS' Medicare Marketing Guidelines specify sales and marketing event requirements and prohibited practices. ATRIO Health Plans and CMS regularly conduct event surveillance in order to:

- Monitor compliance with applicable Laws, Regulations and Policies
- Better understand marketing, beneficiary education, and enrollment practices
- Rapidly respond to emerging problems/issues
- Strengthen knowledge for program administration and oversight

All potential deficiencies identified during surveillance will be reviewed by ATRIO and substantiated by reviewing supporting statements and/or documentation provided by sources. When a deficiency is substantiated, ATRIO will contact the Agent who conducted the event to request a detailed response. Agents must provide the response within five (5) calendar days of receiving ATRIO's request.

ATRIO will determine if corrective action is needed and ensures timely and effective implementation.

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Scope of Appointment (SOA)
CMS' Medicare Marketing Guidelines require that a documented Scope of Appointment (SOA) be completed, when practicable, 48 hours prior to any personal/individual marketing appointment. SOAs are required for all marketing appointments regardless of whether or not the appointment results in an enrollment and regardless of venue (e.g. in-home, library, conference call or walk-ins to an agent office). Note: ATRIO does not permit telephonically recorded SOAs.

ATRIO requires a signed and completed SOA form to be submitted with all Agent assisted enrollments. Additionally, all SOA forms must be retained for at least 10 years regardless of the enrollment outcome.

SOA forms must contain the following:

- The product type(s) (e.g. MA, PDP) that the beneficiary has agreed to discuss during the appointment.
- Must be initialed by the beneficiary or his/her authorized representative.
- Date of appointment
- Beneficiary contact information (e.g. name, address, telephone number)
- Signature (e.g. beneficiary or authorized representative)
- Method of contact (e.g. in home, walk-in, etc.)
- 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 48 hours prior to the appointment, include an explanation why it was not completed

Each beneficiary (or his/her appointed representative) must initial the plan types to be discussed during the appointment and must sign and date a SOA form. Lines of business not agreed to in advance by the beneficiary may not be discussed. During an appointment, if an Agent would like to discuss additional plan products which the beneficiary did not agree to discuss in advance, he/she must:

- Document a second SOA
- Wait 48 hours before meeting to discuss the additional products.

If it is not practicable to wait 48 hours, or if the beneficiary initiates the request to discuss additional products, the Agent must document a second SOA form prior to continuing the appointment and note the reason for the exception on the second form.

If an Agent conducts a personal appointment with more than one Medicare eligible beneficiary, then the Agent must obtain a signed and completed SOA for each individual.

Periodic reviews of SOAs are performed by ATRIO to ensure adherence with the CMS Medicare Marketing Guidelines. If deficiencies are found, then in addition to corrective actions the following discipline may occur:

- 1st Offense: Counseling
- second Offense: Written reprimand
- 3rd offense: Suspension of authorization to market products
- 4th offense: Contract Termination

Personal/Individual Appointments

When conducting personal/individual marketing appointments, Agents may only discuss plan options that were agreed to in advance by the beneficiary and are prohibited from marketing non-healthcare products (such as annuities or life insurance). Agents should:

- Provide a business card at the beginning of every appointment
- Announce their name, the company they represent, and all plan types that will be discussed, as indicated on the SOA
- If the beneficiary has a legal representative who assists with healthcare decisions (e.g. Power of Attorney, Conservator, or other state- appointed guardian), make sure the legal representative attends the appointment
- Ask about current health insurance coverage
- Clearly explain the benefits and cost shares of plans being considered
- Clearly explain the provider network
- Clearly explain prescription drug coverage
- Clearly communicate to the beneficiary what to expect when changing from his/her current coverage to a new plan
- Ensure that the beneficiary receives a copy of the Pre-Enrollment Kit and all other necessary and required materials
- Remind the beneficiary that he/she will receive a welcome packet in the mail and an Outbound Enrollment Verification (OEV) letter that confirms their plan selection
- At the end of the appointment, encourage the beneficiary to contact you with any additional questions or concerns

Marketing in Healthcare Settings

CMS regulations prohibit sales activities in any healthcare settings where patients primarily receive, or are waiting to receive, health care services. Providing plan information to beneficiaries on a frequently scheduled basis at provider offices are not considered walk-in appointments. These marketing activities are informal events and are subject to CMS event reporting requirements. Agents/Brokers may not

conduct any Sales/Marketing activities in healthcare settings except in common areas. Common areas are locations only accessible to the public. Rooms that serve dual purpose as a treatment or waiting area and a 'common' area should be considered a prohibited area and not used for sales or marketing purposes. Examples of acceptable and prohibited healthcare settings include:

Healthcare Setting Area	Acceptable	Prohibited
• Conference rooms	✓	
• Cafeterias	✓	
• Recreation rooms	✓	
• Community rooms	✓	
• Exam rooms / Treatment areas		✓
• Doctors' private offices		✓
• Waiting rooms		✓
• Patient rooms		✓
• Pharmacy counter areas		✓

Enrollment Applications and Outbound Enrollment Verification (OEV)
Timely and accurate submission of enrollment applications is critical to ensuring that beneficiaries receive the benefits they expect and that ATRIO Health Plans is able to meet CMS requirements. ATRIO Health Plans requires Agents to submit enrollment applications and SOAs to ATRIO Health Plans' Membership Services department no later than one (1) calendar day after the Agent receives the enrollment application from the beneficiary. Failure to follow ATRIO Health Plans requirements for submitting applications may result in processing delays, which may impact enrollees' requested coverage date and/or commission payments.

Authorized Producers affiliated with an ATRIO Health Plans contracted Sales Entity may submit applications to their respective Sales Entities. In such cases, the Agent and Sales Entity are responsible for timely submission, ensuring ATRIO Health Plans receives the application no later than one (1) calendar day after receipt from the beneficiary. **Note: Sharing beneficiary or application information with an individual or sales entity outside of an ATRIO Health Plans contracting agreement is a violation of HIPAA privacy guidelines.** The preferred submission method is by fax utilizing the appropriate fax number provided by ATRIO Health Plans.

Mailed applications must be sent by overnight mail on the same day as received from the beneficiary. Hand delivered applications must be received by an ATRIO Health Plans the same day as received from the beneficiary. Agents may assist beneficiaries with completing paper applications; however, only the beneficiary or his/her legal representative (as recognized by state law) may sign an enrollment request. Agents may also assist beneficiaries with entering information to submit online applications, but only when in-person and through ATRIO Health Plans'

website; beneficiaries are required to execute the signature portion of on-line enrollments.

ATRIO Health Plans prohibits telephonic enrollments by agents who are not ATRIO Health Plans employed telesales agents or within a delegated telesales entity; however, Agents are permitted to provide telephonic assistance to beneficiaries who are completing paper or on-line enrollments and require agent assistance.

Beneficiaries not already enrolled in an ATRIO Health Plans Medicare Advantage plan must complete the Plan Election Form, also known as the Application. An existing ATRIO Health Plans member who wishes to change from one ATRIO Health Plans Medicare Advantage plan to another within the same H contract (H7006, H5995, H6743, etc.) may complete the Plan Change Form.

Agents must:

- Sign, date, and submit all applications upon receipt from the beneficiary (in the "Office Use Only" section)
- "Receipt Date" must accurately reflect the date on which the application was received by the Agent or Sales Entity (via mail, by fax, or in person)
- Use the correct enrollment application for the specific plan year in which enrollment is desired
- Not solicit or accept enrollment applications for a January 1st effective date prior to the start of the Annual Enrollment Period (AEP) on October 15th of each year (unless the beneficiary is new to Medicare on the basis of age or disability, or they qualify for a special election period)
- Include a completed Scope of Appointment form when submitting an enrollment application

Note: All corrections and amendments made on an application must be initialed and dated by the individual making the changes. This includes corrections made in the "Office Use Only" section.

Best practices when obtaining enrollment applications include:

- Confirm contact information is current (address and phone number)
- Always verify basic eligibility by asking to see the beneficiary's red, white and blue Medicare card
- Verify D-SNP Eligibility by asking to see the beneficiary's Medicaid card, if available, or verify eligibility from an appropriate resource
- Provide native language materials when available – Enrollment kits and forms in other languages (e.g. Spanish and Chinese) are readily available in certain geographic areas
- Make sure that the beneficiary's permanent residence is within the county where the plan is offered
- Complete the appropriate "Office Use Only" section with legible information,

including your Health Plans assigned producer ID, the Contract/Plan code in which the applicant is enrolling, the type of enrollment (e.g., AEP, IEP, etc.), whether there is creditable coverage and the desired effective date. Incorrect or illegible information may result in delays regarding accurate agent or record assignment and payment of commissions.

Outbound Enrollment Verification

- ATRIO Health Plans conducts Outbound Enrollment Verification (OEV) calls for all agent effectuated enrollments, including plan changes. Agents/Brokers are expected to:
    - Obtain the best contact information to be used for verification from the beneficiary
    - Explain the verification process that will be performed by ATRIO Health Plans
    - ATRIO Health Plans will call beneficiaries within 15 calendar days from receipt of the enrollment request.

Enrollment Related Oversight Activities

- The Regional Sales Manager is responsible for reviewing and investigating:
    - Agent assisted AEP enrollment applications received prior to the start of AEP (October 15th)
    - Enrollment applications submitted by unqualified and/or unlicensed agents
    - Late enrollment applications submitted by an Agent (i.e. an application submitted to ATRIO Health Plans more than one (1) calendar day after Agent receives from the beneficiary

Enrollment will identify any Agent assisted AEP enrollment applications received prior to the start of AEP (10/15) and route those applications to the Regional Sales Manager. Agents or Sales Entities that collect, offer to hold, or submit AEP enrollment applications prior to the start of AEP will be subject to disciplinary action since this type of activity is expressly prohibited by CMS.

If the results of the investigation confirm Agent or Sales Entity non-compliance, or patterns of failing to meet ATRIO Health Plans business requirements, then the Regional Sales Manager will coordinate with Sales Management to determine appropriate corrective action. The Agent/Broker Oversight Committee discusses and approves corrective action.

Monitoring of applications submitted by unqualified agents and untimely submission of applications is tracked by the Medicare Sales Operations team. Results are provided to the Program Medicare Review (PMR) and Regional Sales Managers on a monthly basis.

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Sales Allegations

A “sales allegation” is a type of complaint which involves potential misconduct or misrepresentation by a Sales Agent. Sales Allegations are typically filed by a beneficiary (or an authorized representative) and may be received by ATRIO Health Plans as a Grievance, as a complaint filed with CMS through the Complaint Tracking Module (CTM), or via other regulatory agencies.

All complaints involving ATRIO Health Plans Medicare Sales Agents are logged and tracked by the Appeals and Grievance (A&G) department. A&G will attempt to contact the complainant to verify the complaint issues and request additional detail to ensure a clear understanding -- prior to routing the Sales Allegation to ATRIO Health Plans’ Regional Sales Manager for full investigation. Sales Allegation details are data entered by A&G and are tracked to ensure timely resolution and response (within 30 calendar days of receipt).

Upon receipt from A&G, ATRIO Health Plans’ Regional Sales Manager is responsible for:

- Working with Sales Management to obtain Agent responses to the allegation determining whether the complaint has been substantiated
- Developing corrective actions (in collaboration with Sales Management) that adequately address the specific issues identified in the complaint ensuring that the corrective actions are carried out in a timely manner

The Regional Sales Manager will coordinate with Sales Management to notify an Agent about a specific Sales Allegation. Upon notification, the Agent must submit a written response within five (5) calendar days. The Agent response should contain detailed, case specific information which addresses all Agent related issues expressed in the beneficiary’s complaint. Additionally, the following information should be included in the Agent response to provide context:

- Date and time of the appointment (or event)
- Source of the lead
- Information about others present at the appointment and relationship to the beneficiary (if known)
- Any concerns expressed by the beneficiary during the appointment
- Description of any follow-up contact with the beneficiary

The Regional Sales Manager and Sales Management will review each case on its own merits – including the beneficiary’s complaint statement, the Agent’s response, and all other pertinent documents– in order to recommend a determination with a severity level and identify corrective actions, if necessary. Findings and proposed corrective actions of low severity allegations will be adopted with concurrence by Regional Sales Manager and Sales Management. High severity allegations will be presented to the ATRIO Compliance Officer for review and approval.

Results are provided to the Program Medicare Review (PMR) team on a monthly basis.

Rapid Disenrollment

A “rapid dis-enrollment” is defined as disenrollment from the plan during the first 3 months of a beneficiary’s effective date. Rapid disenrollment also applies when a beneficiary moves from one Parent Organization to another Parent Organization (e.g. Contract Number), or when a beneficiary moves from one plan to another plan within the same Parent Organization. Certain dis-enrollments that occur within the first three months of enrollment are excluded from ATRIO Health Plans’ rapid disenrollment reporting, as specified by CMS in the Medicare Marketing Guidelines.

ATRIO Health Plans encourages all agents to prevent rapid dis-enrollments by striving to enroll each beneficiary into a plan that best meets his/her particular needs and ensuring that all plan features, benefits, provider network restrictions, etc. are clearly explained. ATRIO Health Plans’ Regional Sales Manager monitors rapid disenrollment rates for Agents and Sales Entities. Rapid disenrollment rates that trend over 7% calculated as a percentage of Sales in a rolling 12 month lookback period are flagged for investigation to determine why members have left. Agents whose book of business exhibits a pattern of rapid disenrollment are subject to corrective action. Additionally, ATRIO Health Plans follows CMS rules related to compensation recovery and will chargeback any compensation paid to an Agent for an enrollment which results in a rapid disenrollment.

Broker Compensation

In order to receive initial and renewal sales commissions, Agents must continue to be fully licensed and appointed, as required by CMS and state law. ATRIO Health Plans will investigate sales activity by unlicensed agents and report instances to CMS or other state and federal regulatory agencies. Additionally, both initial and renewal sales commissions are dependent on Agents completing annual Medicare training and certification, as well as all required ATRIO Health Plans product and compliance trainings.

Producer compensation may not be issued to agents prior to the member’s enrollment effective date as accepted by CMS.

Compensation is recovered for dis-enrollments that are not effective at the end of the plan year, as required by CMS. Chargebacks occur on a pro-rated basis, equal to the number of months that the beneficiary was not enrolled, unless recovery in full is required due to a rapid disenrollment.

Marketing Materials

All advertising, sales presentations, marketing and enrollment materials, including agent website, social media and third party websites, must have prior approval by ATRIO Health Plans and CMS prior to use by agents.

Marketing material content and/or required disclaimers may change based on changing regulatory requirements or plan design changes. Agents using ATRIO Health Plans created materials are expected to validate that only the most recently published versions (as available on the ATRIO website) are used for marketing purposes.

Corrective Actions:

Corrective action plans are developed to address Agent/Producer specific non-compliance issues and are tracked to completion. ATRIO retains sole discretion to determine the appropriate corrective action to be taken for any infraction identified, which may include:

- Counseling
- Retraining
- Warnings
- Suspension
- Contract termination, which may include reporting to the state, CMS and other federal regulatory agencies.