L.A. Care Cal MediConnect Plan Agent Oversight Program

Agent Oversight Program

L.A. Care Health Plan (L.A. Care) requires all contracted General Agencies and its Agents and any other downstream entities representing L.A. Cares' Cal MediConnect (CMC) line of business to comply with our regulatory responsibilities including CMS regulations and guidance, specifically: the CMS Medicare Communication and Marketing Guidelines, the terms of our General Agency Contract Agreement and any applicable federal and state laws related to Medi-Cal and Medicare sales activities.

Ultimately, L.A. Care expects Agents will assist each Medi-Cal and Medicare beneficiary to obtain health care coverage that best meets the beneficiary's specific desires and needs.

L.A. Care has established this Agent Oversight Policy 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, L.A. Care will investigate, correct and monitor to ensure that appropriate corrective actions are taken and effective.

General Agencies and its Agents are responsible for cooperating with L.A. Care oversight and monitoring activities, including compliance with all corrective or disciplinary actions that are deemed appropriate by L.A. Care.

Contracting and Regulatory References:

- L.A. Care CMC General Agency Agreement, Section 3 (3.3.) Responsibilities of the Parties; Section 9 (9.1) Statutory and Regulatory Compliance.
- Medicare Managed Care Manual (MMCM) – Ch. 3 – Medicare Communication and Marketing Guidelines
- Medicare Managed Care Manual (MMCM) – Ch. 2 – Enrollment
- 42 CFR – Sections 422.2274 (Part C) and 423 (Part D)

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

Broker Contracting	PHI and Privacy Compliance
Lead Management	Enrollment Applications
Event Management	Sales Allegations
Secret Shopper Audits Marketing Materials	Rapid Disenrollment Corrective Action

Scope of Appointment	Broker Compensation
Personal Appointments	Compliance Integrity/Quality Review

Broker Contracting

Before an Agent may market the L.A. Care Cal MediConnect product, all L.A. Care's contracting requirements must be completed, including:

- Maintain an active California Department of Insurance license, Life and Health.
- Successful completion of annual AHIP Medicare Certification with Fraud, Waste and Abuse training
- Successful completion of annual L.A. Care CMC Product and Testing
- Review the L.A. Care Cal MediConnect Plan Agent Oversight Policy. Complete and sign Letter of Acknowledgement.

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 General Agency 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

L.A. Care 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 Communication and Marketing Guidelines which specify requirements related to sales and marketing activities, including event reporting, locations, materials, and gifts/promotional items.

Event Reporting.

L.A. Care requires the General Agency and its Agents to report all planned marketing/sales events 30 days in advance prior to any initial advertisement and no less than 14 days for last minute events. Reporting of sales events should be submitted via L.A. Care's event submission electronic form by the General Agency.

The event required information is as follows:

- Presentation Language
- Event Type
- Event Name
- Event Date
- Event Time
- Brokerage Firm/Agency
- Facility Type
- Representative / Agent National Producer Number
- Representative / Agent Name
- Venue Name
- Venue Phone
- Venue Address
- Venue City

- Venue State
- Venue Zip Code
- Event Contact Name (First, Last)
- Event Contact Phone

L.A. Care will report event information to CMS, as required and specified by the CMS Medicare Communication and 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 L.A. Care for Health Plan Management System (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 appointed General Agency 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 appointed General Agency must include a brief explanation of the cancellation reason.

Timely and accurate reporting of event submissions, changes and cancellations is monitored by L.A. Care. Deficiencies are investigated and corrective actions are implemented as appropriate.

Managing Events.

L.A. Care 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 L.A. Care approved sales presentation and L.A. Care prepared Medicare marketing materials only.

L.A. Care 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 $75 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 Communication and Marketing Guidelines specify sales and marketing event requirements and prohibited practices. L.A. Care 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 L.A. Care and substantiated by reviewing supporting statements and/or documentation provided by sources. When a deficiency is substantiated, L.A. Care will contact the Agent, and the appointed General Agency, who conducted the event to request a detailed response. The General Agency and its Agents must provide the response within five (5) calendar days of receiving L.A. Care's request.

L.A. Care will determine if corrective action is needed and ensures timely and effective implementation.

Marketing Materials

All advertising, sales presentations, marketing and enrollment materials, premium items including agent website, social media and third party websites, must have prior approval by L.A. Care 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 L.A. Cares created materials are expected to validate that only the most recently published versions are used for marketing purposes, such as: Event Flyers, Benefit Highlight Personalized Flyer, Business Reply Cards "BRC".

Scope of Appointment (SOA)

CMS' Medicare Communication and 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).

L.A. Care 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 (e.g. Cal MediConnect) 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 L.A. Care to ensure adherence with the CMS Medicare Communication and Marketing Guidelines. If deficiencies are found, then discipline will occur and we will follow corrective action plans (see Corrective Actions section).

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

PHI and Privacy Compliance

General Agency and its Agents intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to the Agreement.
Here are some important requirements:

- Mobile devices, including cell phones, iPads and laptops, must be securely stored or locked before you leave your workstation.
- Agent must secure Enrollee PHI to ensure paper documents are not exposed and available for unauthorized viewing.
- Oral conversations about Enrollee PHI or other sensitive information are not discussed in public areas (e.g., hallways, stairwells, break rooms, lunchrooms, and elevators).
- Documents containing Enrollee PHI are not found in public areas (e.g., break rooms, lunchrooms, and copy rooms).
- Trash cans and recycling containers do not contain PHI.

General Agency and its Agents shall comply with the privacy and confidentiality requirements of applicable federal and state laws to safeguard the privacy of any information that identifies a particular Enrollee, and to have procedures in place that specify the purpose for which the information will be used within General Agency's organization and to whom and for what purposes General Agency may disclose the information outside of the General Agency. General Agency shall maintain records in accurate and timely manner, and ensure timely access to the records and information that pertains to them.

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 L.A. Care Health Plans is able to meet CMS requirements. L.A. Care Health Plan requires Agents to submit enrollment applications and SOAs to your respective General Agency no later than one (1) calendar business day after the Agent receives the enrollment application from the beneficiary. Failure to follow L.A. Care requirements for submitting applications may result in processing delays, which may impact enrollees' requested coverage date and/or commission payments.

Authorized agent affiliated with an L.A. Care contracted General Agency may submit applications to their respective General Agency. In such cases, the Agent and General Agency are responsible for

timely submission, ensuring L.A. Care Health Plan receives the application no later than one (1) calendar business day after receipt from the beneficiary/Agent.

Note: Sharing beneficiary or application information with an individual or General Agency outside of an L.A. Care contracting agreement is a violation of HIPAA privacy guidelines.

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 L.A. Care 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 L.A. Cares' electronic enrollment tool (Ascend); beneficiaries are required to execute the signature portion of on-line enrollments.

L.A. Care prohibits telephonic enrollments by agents who are not L.A. Care employed telesales agents.

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 General Agency (via mail or in person)
- Use the correct enrollment application for the CMC plan.
- 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 ask to see or obtain the beneficiary's Medi-Cal and Medicare ID card to verify CMC eligibility from appropriate resources.
- Provide enrollment materials as needed – Enrollment kits and forms will be available in the Medi-Cal threshold languages (English, Spanish, Chinese, Armenian, Arabic, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese).

- Make sure that the beneficiary's permanent residence is within L.A. County where the L.A. Care CMC plan is offered.
- Confirm Enrollee's provider/specialists/medical groups are within the L.A. Care's CMC network and document the provider name and site ID in the application.
- Confirm Enrollee's medications are within the L.A. Care's CMC formulary.
- Complete the appropriate "Office Use Only" section with legible information, including your California Life, Accident and Health License and the Contract/Plan code in which the applicant is enrolling in L.A. Care CMC Plan, whether there is creditable coverage and the effective date. Incorrect or illegible information may result in delays regarding accurate agent or record assignment and payment of commissions.

Outbound Enrollment Verification

The enrollment request will be sent to the CA Department of Health Care Services. The Department will confirm the enrollment eligibility and process the enrollment. The Enrollee will receive a phone call from the state (Health Care Options) to acknowledge the enrollment into the Cal MediConnect Health Plan. The Enrollee will also receive an enrollment confirmation letter with the effective date of coverage. If the Enrollee does not receive a phone call or letter, the Enrollee can reach Health Care Options directly with questions at 1-844-580-7272.

Enrollment Related Oversight Activities

- The General Agency is responsible for reviewing and investigating:
  - Enrollment applications submitted by unqualified and/or unlicensed agents
  - Late enrollment applications submitted by an Agent (i.e. an application submitted to General Agency more than 24 hours after Agent completes the enrollment, and more than 48 hours submitted to L.A. Care.)

If the results of the investigation confirm Agent non-compliance, or patterns of failing to meet L.A. Cares business requirements, then the General Agency will coordinate to determine appropriate 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.

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 L.A. Cares as a Grievance, as a complaint filed with CMS through the Complaint Tracking Module (CTM), or via other regulatory agencies.

All complaints involving L.A. Care's Cal MediConnect contracted 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 L.A. Care Sales & Marketing Operations Team 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, L.A. Care Sales & Marketing Operations Team 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 the General Agency and L.A. Care 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 General Agency will coordinate with L.A. Care 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 General Agency 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 the General Agency and L.A. Care Sales Management. High severity allegations will be presented to the L.A. Care Compliance Officer for review and approval.

Results are provided to the General Agency and L.A. Care Sales Management 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 L.A. Cares' rapid disenrollment reporting, as specified by CMS in the Medicare Communication and Marketing Guidelines.

L.A. Cares 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. L.A. Care will monitor rapid disenrollment rates for the General Agents and its Agents. Agents whose book of business exhibits a pattern of rapid disenrollment are subject to corrective action. Additionally, L.A. Cares 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. L.A. Cares 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 L.A. Cares 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.

Corrective Actions:

Corrective action plans are developed to address Agent/Producer specific noncompliance issues and are tracked to completion. L.A. Care retains sole discretion to determine the appropriate corrective action to be taken for any infraction identified, which may include: actions as described in the following discipline may occur:

- 1st offense: Counseling and retraining (e.g. submit SOA)
- 2nd offense: Written reprimand
- 3rd offense: Suspension of authorization to market products
- 4th offense: Contract Termination (which may include reporting to the state, CMS and other federal regulatory agencies).

Compliance Integrity/Quality Review

L.A. Care's Quality Review Team will conduct the CMC enrollment quality review for the General Agency and its Agents. The process will be conducted by using the electronic enrollment tool (Ascend) and will select random calls, 3-5 calls per General Agency quarterly. Monitoring reports will be provided to the General Agency displaying number of evaluated calls, monitoring evaluation results and recommendations. In addition, we will provide a report with recording opting rate per Agent.