Helpful Tips for Conducting a Successful Sales Enrollment: TeleDigital

When conducting a sales appointment to sell Medicare Advantage plans, be sure to cover the following topics. Use only scripts that have been approved by Wellcare and accepted by the Centers for Medicare & Medicaid Services (CMS). Agents are expected to present all information to consumers in an understandable format.

This is a guide for agent reference only and is not approved for public distribution or for use as a presentation script. Do not submit with enrollment applications.

Introduction

- Provide your name, the company you represent, and contact information.
- Inquire about legal/authorized representatives.

Disclosure Information

- Plans are offered under contracts with CMS that are renewed annually.
- Plan benefits are subject to change annually.
- Presenter is a state-licensed insurance agent.
- Presenter does not represent Medicare, the Social Security Administration, or any branch of the federal or state government.

Medicare Overview

- Explain how a Medicare Advantage plan differs from Original Medicare and Medicare Supplements.
- The plan will be responsible for covered medical services and prescription drugs (if applicable).
- Medicare Advantage (MA) plan changes result in automatic disenrollment from other MA/Part D plans.

Eligibility Requirements

- MA/MAPD Plans – Medicare Parts A and B
- PDP Plans – Medicare Parts A and/or B
- Must continue to pay Medicare Part B
- Must maintain residency within the plan service area (at least 6 months per year).
- Additional Special Needs Plan (SNP) eligibility qualifications (For D-SNP/C-SNP)
  Note: Eligibility, including MBI/SSN or other personally identifiable information, is never required to provide a beneficiary with plan benefit details.

When Selling D-SNP

- Explain dual eligibility requirements.
- Verify eligibility for a D-SNP plan through the Ascend platform, the SPOP call center, (866) 211-0544, or other verification tools as applicable.
- Verify if the member is currently covered by a Centene Medicaid plan and if so, explain that Wellcare is also a wholly owned subsidiary of Centene.
- Explain that changes in Medicaid eligibility may affect enrollment and/or cost-sharing.
- Members should use their plan and Medicaid cards to obtain healthcare and Rx coverage.

When Selling C-SNP

- Explain chronic condition/conditions eligibility requirements.
- Healthcare provider contact information must be provided at the time of enrollment for eligibility verification purposes.
- Provider or staff must verify qualified medical condition(s) within 30 days to prevent an automatic disenrollment.

Enrollment Periods

- Provide an overview of election periods and timeframes beneficiaries may enroll in or disenroll from Medicare Advantage plans (e.g., ICEP, AEP, SEP, and MA OEP).
  Note: Dual Eligible/LIS SEP may now only be used once during each of the first three calendar quarters annually. Disaster, FEMA, and state of emergency SEP enrollment requires the beneficiary to have been eligible for another valid election period AND have missed making an election due to the stated emergency.

Benefits/Plan Information

- Following your approved script, cover all required elements of a plan and benefit review including, but not limited to:
  - Star Ratings
  - Covered services/cost-sharing
- Optional Supplemental Benefits (dental, vision, hearing, etc.) and costs
- Appeals and Grievances, prior authorizations, and referral processes
- Ensure that, prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussed.

Health Plan Costs

- Explain the requirement for payment of Medicare Part B and Plan premiums.
- Review the plan deductible, copayments, coinsurance, and Maximum Out-of-Pocket Limits (MOOP).
- Explain the Late Enrollment Penalty that is imposed by CMS if creditable coverage is not maintained.
- Explain the Low-Income Subsidy (LIS).
- Explain PPO and POS in-network and out-of-network costs.

Network Information

HMO (Health Maintenance Organization):

- Explain that only plan-contracted physicians may be seen.
- Verify that all the beneficiary's current PCP, specialists, hospitals, facilities, etc. participate in the plan and are in-network.

PFFS (Private Fee-for-Service):

- Explain that the member can go to any doctor, hospital, or healthcare provider as long as they accept the plan's payment terms.

PPO (Preferred Provider Organization):

- Explain that out-of-network care may result in higher healthcare costs.
- Explain that out-of-network healthcare providers are not obligated to accept a PPO plan.
- PCP selection is not required but encouraged.
- Explain the referral process.

POS (Point of Service):

- Share that a PCP is required under this plan.
- Verify that the beneficiary's current PCP as well as all the beneficiary's specialists, hospitals, facilities, etc. participate in the plan and are in-network.
- Explain that out-of-network care may result in higher healthcare costs.
- Explain the referral process.

Prescription Drug Coverage (if covered under plan)

- Explain prescription coverage (Prior Authorizations, Tiers, Quantity Limits, Transition Fills, Step Therapy).
- Explain stages of drug coverage (e.g., coverage gap).
- Explain any applicable LIS cost reductions for copays and premiums.
- Review Part D deductible, copays, and coinsurance.
- Explain how to look up drugs and drug pricing.
- Explain annual out-of-pocket limits.

Enrollment Process

- Ensure enrollment is completed in its entirety using your preferred enrollment platform.
- Verify that the PCP is in-network for the plan. If an out-of-network PCP is selected, or no designation is made, an in-network PCP will be assigned.
- Explain that the enrollee must cancel any employer group or Medicare Supplement plan.
- Explain the effect enrolling in the plan will have on current coverage.
- Explain cancellation and disenrollment procedures.
- Explain when the member should expect to receive their new ID card and post-enrollment materials.
- Confirm the plan/plan type selection and intent to enroll prior to accepting the completed enrollment form.
- Explain premium payment options including electronic payments.
- Explain how the beneficiary can receive confirmation of their enrollment and/or a copy of their enrollment information.
- Review the Pre-Enrollment Checklist prior to the completion of the enrollment.

  Note: Should additional information be required to complete the enrollment process, both the agent and the member will receive a notification from the health plan.

Protecting Our Member's Privacy

- Don't forget to secure emails that contain PHI or PII!
- Do not include PHI or PII in the subject line or body of an email.
- Shred documents that contain PHI or PII using appropriate means.
- Immediately report any data privacy or security incident involving member PHI to the appropriate payer.
- Do not download or save copies of the application. This is a potential security risk. Once the application is submitted to the health plan, it becomes the property of the health plan. Enrollment information is maintained and available in the applicable systems.
- Explain that the member may opt out of both written and verbal communications at any time by contacting Member Services.