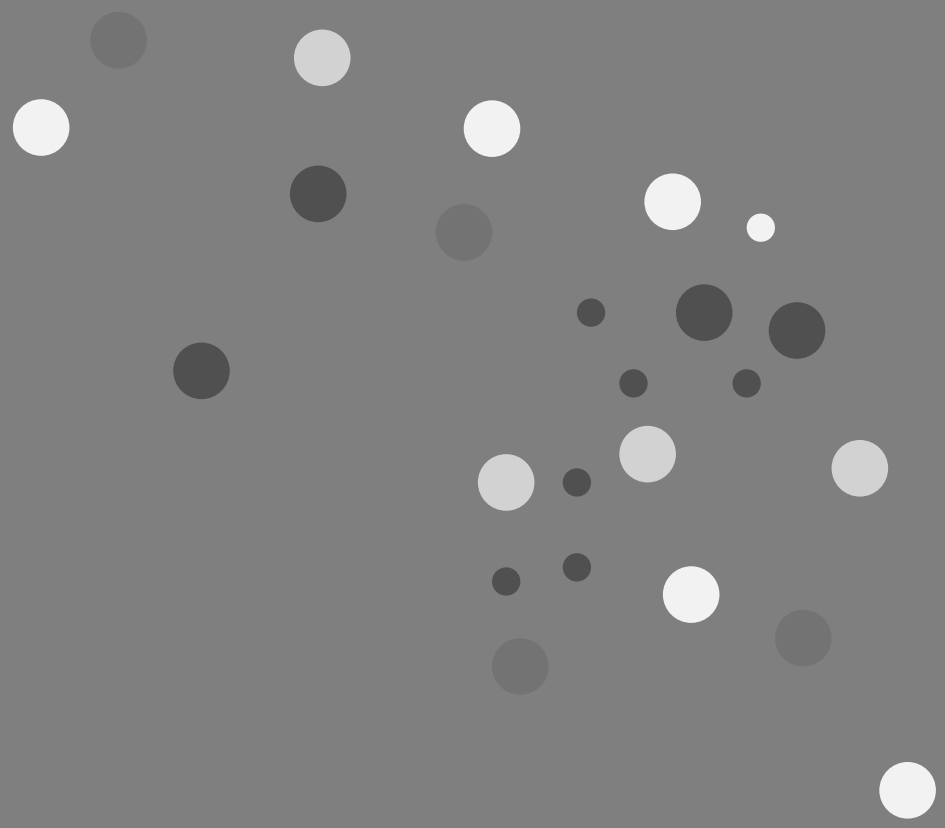
2027

Call Quality Reference Guide

Innovative Financial Group

The following reference guide will provide guidance on the IFG Sales Integrity Call Quality requirements for licensed sales agents on calls where the primary product of interest is MA, MAPD, or PDP products.



IFG Sales Integrity
Innovative Financial Group
9/30/2026

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DOCUMENT DESCRIPTION:

- This document will serve as the **primary resource** for the agent and evaluator in understanding how calls are evaluated.
- An evaluator is defined as a certified associate authorized to provide feedback to licensed sales
- agents. Examples include:
    - Call Quality Managers and Professionals
    - Sales Leadership Team
    - Sales Integrity Senior Compliance Professionals
- It will be important to note that the document will provide an **essence** of what agents can do on the call(s) but will not provide every example due to the varying nature of telephonic call types.
- This document is designed to adapt to **'Situational Sales'** meaning it will provide examples on various agent sales styles and beneficiary dynamics.
    - Agents are **not** required to display every example type. The evaluator must consider the individual situation and beneficiary interactions throughout the evaluation process.

COMPLIANCE/BUSINESS PROCESS (FORMAT AND SCORING DYNAMICS)

Format: The description below provides details on the formatting of the definitions and insights for the compliance and business section of the form.

- **1st Section:**
    - **Question:** States the question as it would appear on the form including weighted points.
        - If you click on the blue text, it will take you back to the Table of Contents.
- **2nd Section:**
    - **Intent/Purpose:** This is an explanation provided by IFG Sales Integrity that outlines the reason an element is required along with the value. It will explain the WHY behind the WHAT.
- **3rd Section:**
    - **Required Components:** This will provide insight into what the specific requirements are for each question and evaluator notes.

Scoring Dynamics: The compliance and business process sections are scored using Yes, No, or Not Applicable relating to minimally required actions.

After all questions are answered, the agent will receive the following range of scores:

Scoring Range	Opportunity Level	Description
85% - 100%	**On Target**	This is the goal and expectation for all Telephonic Sales Agents relating to their Compliance score. **Agent's Leader recommended course of action:** • Review form for details on any missed elements. • Discuss sales presentation feedback with agent.
Scores Below 85%	**Attention Needed**	Scores in this range indicate coaching opportunity and highlight an immediate need to review findings with the agent. **Agent's Leader recommended course of action:** • All agent deficiencies identified in the Individual Call Reports must be coached by the Agency using a documented coaching form.

Call Auto-Failed: Scored as Zero	**Attention Needed**	**Agent Call of Concern:** Through the call audit process, if the evaluator identifies any situation that requires immediate remediation based on egregious or non-compliant behavior, or a call recording is not provided, it is cared for as a Call of Concern where the call is auto-failed and immediate remediation is required. • **ACE Coaching (IFG Internal Process):** serves as the IFG escalation path for deficiencies identified during call audits, specifically those flagged as calls of concern based on egregious or non-compliant behavior. • **Downline Agencies:** will be expected to take immediate remedial actions, including but not limited to removal of the agent from the sales environment, training, additional call audits, and termination.

CONSUMER EXPERIENCE (FORMAT AND SCORING DYNAMICS)

This section will be measuring the effectiveness and proficiency of specific call behaviors. This section is not measuring if minimum expectations were met.

- **1st Section:**
  - **Question:** States the question as it would appear on the form including weighted points.
    - If you click on the blue text, it will take you back to the Table of Contents
- **2nd Section:**
  - **Intent/Purpose:** This is an explanation provided by the IFG Sales Integrity team that outlines the reason this is a required element, along with the value. It will explain the WHY behind the WHAT.
- **3rd Section:**
  - **Possible Examples:** This section provides details on how to demonstrate the specific element along with suggested verbiage. By providing multiple examples, this allows the agent to customize their approach based on the situation and the consumer's need.
    - It will be important to note that not ALL examples are required, nor should these examples be used as a checklist towards accomplishing a demonstrating score.
  - **Avoid/Limit:** A listing of different behaviors that an agent needs to avoid. This behavior does not automatically mean the agent does not receive credit. The evaluator will need to determine if the presence of behavior caused a negative consumer experience or business outcome.

Scoring Dynamics: All scored components in this section include a range between 0-3 points.

Point	Rating Name	Description/Definition
3 Points	**Exceptional/Modeling**	• Exceeded expectations on established behaviors within component. • No actionable feedback can be provided on an element.
2 Points	**Full/Demonstrating**	• The agent exhibited most of the expected behaviors outlined in 'Demonstrating Examples' but some coaching is needed. • Agent tried to complete expected behavior and when faced with a challenge/barrier, made attempts to overcome/address; however, their technique needs enhancement to increase success.
1 Point	**Inconsistent/Learning**	• Agent may have exhibited some expected behaviors outlined in 'Demonstrating Examples;' however, there were more opportunities than successes in the specific component.

		• The missed behavior has a larger scope of impact compared to the successful behaviors. • Agent tried to complete expected behavior and when faced with a challenge/barrier, the agent did not attempt to address or overcome.
0 Point	**Did Not Demonstrate**	• Agent did not attempt to exhibit any of the expected behaviors

After all consumer experience questions are answered, the agent will receive the following range of scores:

Scoring Range	Outcome
15 – 18 Points	Exceptional/Modeling Rating
11 – 14 Points	Full/Demonstrating Rating
6 – 10 Points	Inconsistent/Learning Rating
Below 6 Points	Immediate Attention Required

FORM ELEMENTS SUMMARY (COMPLIANCE):

#	Question	Weight
C1	Did the agent use the required call opening?	1
C2	Did the agent follow guidance from CMS as it relates to the Scope of Appointment (Telephonic)?	4
C3	Did the agent identify the name of the primary beneficiary?	1
C4	Did the agent determine if beneficiary is able to make their own healthcare decision?	4
C5	Did the agent obtain and document permission from the beneficiary prior to accessing Medicare Eligibility Verification tools to determine eligibility on their behalf?	4
C6	Did the agent determine valid election period eligibility?	3
C7	Did the agent fully qualify each interested party?	3
C8	Did the agent determine the reason the beneficiary is inquiring about a different plan with focus on experiences with current coverage?	2
C9	Did the agent determine which benefits are a priority for the beneficiary?	2
C10	Did the agent review the Summary of Benefits prior to completion of the enrollment?	4
C11	Did the agent offer to review (1) provider (PCP and Specialist) network status (2) current prescriptions for plan coverage and pharmacy network status (3) preferred hospital network status and (4) preferred facility network status?	4
C12	Did the agent explain how enrolling will affect current coverage including being disenrolled from their current plan? As applicable did the agent confirm that this is a full plan and not a rider or add on?	3
C13	Did the agent read all required disclosures for the determined plan of interest?	2
C14	Did the agent confirm the caller was ready to complete his/her enrollment which includes stating plan name and effective date?	3
C15	Did the agent accurately complete the caller's application and review the following: 1) contact information; 2) payment options, 3) language preference, and 4) alternate format election.	2
C16	Did our agent follow the appropriate steps to obtain a compliant signature?	3
C17	Did the agent refrain from claiming to be endorse or work for Medicare?	8
C18	Did the agent refrain from asking health related questions in an attempt to steer beneficiary away from IFG option (cherry-picking)	2
C19	Did the agent refrain from engaging in high pressure sales tactics?	8
C20	Did the agent avoid disclosing health PI information to the wrong party?	4
C21	Did the agent refrain from cross selling Non-Health plans (i.e. Life insurance) on a Medicare plan call?	4
C22	Did the agent refrain from cold calling for MA/MAPD/PDP interest without a valid permission to contact?	8
C23	Did the agent provide compliant call closing?	2

Total Possible Points: 81 points

Form Elements Summary (Business Process):

#	Question	Weight
BP1	Did the agent collect the applicant's email address?	2
BP2	Did the form address all concerns identified during the Call Audit?	2

Total Possible Points: 4 points

Form Elements Summary (Consumer Experience):

#	Question	Weight
CE1	Needs Analysis Technique	Scale of 0-3
CE2	Presenting a solution	Scale of 0-3
CE3	Call to Action	Scale of 0-3
CE4	Understanding and addressing the gaps/barriers/concerns	Scale of 0-3
CE5	Expanding AOR Relationship	Scale of 0-3
CE6	Demonstrating active listening skills throughout the call	Scale of 0-3

Total Possible Points: 18 points

COMPLIANCE:

Question C1: Did the agent use the required call opening? *(1 Point)*

Required Components
• Agent provides their first and last name • Identifies self as Licensed Agent • States name of Agency they are affiliated with (**can be in IVR prior to call**) • Recorded line (**can be in IVR prior to call**)

Intent/Purpose: **42 CFR § 422.2274(b)** requires that agent be licensed and trained, which necessitates agent identification. **MMCM CH 2: 40.1.3** (Enrollment via Telephone) states that "MA organizations may accept requests for enrollment into their MA plans via an incoming (in-bound) telephone call to a plan representative or agent." It also requires that telephonic enrollment requests be "recorded (audio)" and include a statement of the individual's agreement to be recorded. **MMCM CH 2: 40.2** (Processing the Enrollment Request) requires that agent information be included in application submissions.

Question C2: Did the agent follow guidance from CMS as it relates to the Scope of Appointment (Telephonic)? *(4 Points)*

Required Components
• A **Scope of Appointment** (SOA) must be obtained and documented before any marketing appointment or sales discussion begins (inbound and outbound). For all calls, only discuss plans that fall within the noted SOA. Once the SOA has been completed, the agent may immediately proceed with the sales presentation and enrollment process. No waiting period is required. • The agent must reference the approved script, which includes all required elements that must be covered during the SOA.   ○ **TSOA Verbiage**: "*I work for [Agency Name], and in your area, we have a wide variety of plans such as [Medicare Advantage plans, Medicare Advantage Prescription Drug plans, Stand-alone Prescription Drug plans, Medicare Supplements Insurance Plans, Optional Supplemental Benefits (OSBs), Stand-Alone Vision and Stand-Alone Dental]. Would you like to discuss all of these options or are you only interested in certain ones?"*

Intent/Purpose: **42CFR§422.2264(c)(3)(i), (iii)** requires that MA organizations and their agents secure and record a Scope of Appointment agreement prior to marketing, and that marketing remain within that scope. **42CFR§422.2274(b)(3)** requires that agents "secure and document a Scope of Appointment prior to meeting with potential enrollees." **42 CFR § 422.2274(c)(9)(ii)** requires that MA organizations "establish and maintain a system for confirming that agents/brokers appropriately complete Scope of Appointment records for all marketing appointments (including telephonic)".

Question C3: Did the agent identify the name of the primary beneficiary? *(1 Point)*

Required Components
• Collect the first and last name of the primary beneficiary and/or caller as applicable   ○ If the beneficiary is different from the caller, the agent should at minimum obtain/establish name/relationship of who is calling.

Intent/Purpose: **MMCM CH 2: 40.1.3** (Enrollment via Telephone) states that "for all telephonic enrollment requests, the MA organization must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his or her authorized representative. **MMCM CH 2: 40.2** (Processing the Enrollment Request) states that "for telephonic enrollment requests, all required elements listed in Appendix 2 must be included," which includes "beneficiary name." **MMCM CH 2: 40.2.1** (Who May Complete an Enrollment Request) states that only a beneficiary or legal representative may complete an enrollment request.

Question C4: Did the agent ask if the beneficiary makes his/her own healthcare decisions and/or has an authorized representative, such as a Power of Attorney? *(4 Points)*

Required Components
• Agent must inquire as to whether the beneficiary makes his/her own healthcare decisions • If the beneficiary indicates that they do not make their own healthcare decisions, the agent must confirm if they have a POA, or authorized representative prior to the review of the Summary of Benefits, disclosures, and application completion as outlined in the script. **Evaluator Notes**: The agent may identify the need for a representative or decision-making support through direct questioning or information volunteered during the conversation.

Intent/Purpose: **MMCM CH 2: 40.2.1** (Who May Complete an Enrollment Request) states that only a beneficiary or authorized representative may complete an enrollment request, and outlines scenarios where, e.g., a POA (Power of Attorney) necessitates the involvement of an authorized representative. **MMCM CH 2: 10** defines Authorized/Legal Representative. **MMCM CH 2: 40.1.3** (Enrollment via Telephone) states that "for all telephonic enrollment requests, the MA organization must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his or her authorized representative."

Question C5: Did the agent obtain and document permission from the beneficiary prior to accessing Medicare Eligibility Verification tools to determine eligibility on their behalf? *(4 Points)*

Required Components
If the agent accesses a Medicare Eligibility Verification tool (e.g., MARx or another tool), the following disclosure must be read prior to access: • *"I would like to look up your Medicare eligibility. This will help me determine what type of plan might be right for your needs. In order to do that, I will need: Medicare ID from Red, White, and Blue card, OR First and Last Name, DOB, and SSN* • *"If you provide consent, I will be able to see your personal and health information within your Medicare profile.* ***Do I have your consent to check your eligibility status?"*** **Evaluator Notes:** Medicare Eligibility Verification disclosure only required IF information is accessed during the interaction. Mark N/A if the agent does not access a verification tool, because the disclosure would not be required. **Disclosure doesn't need to be read verbatim, however we cannot change the meaning.**

Intent/Purpose: **HHS Rules of Behavior - D. Privacy** provides that, amongst other requirements, users will "not access information about individuals unless specifically authorized and required as part of assigned duties."

Question C6: Did the agent determine valid election period eligibility? *(3 Points)*

Required Components
• Agent must either ask questions or make clear statements that advise which election period is being used to include the plan's effective date. • Agent must use a valid election period following guidelines established by CMS. **Evaluator Notes:** If invalid election period is used to complete enrollment, this question should be marked as NO with applicable comments. Evaluator to follow the call of concern process. Invalid election period is determined by taking the logic of why the election period was used by the agent and if it would be valid based on that - barring any obvious standout rationale.

Intent/Purpose: **MMCM CH 2: 20** (Eligibility for Enrollment in MA Plans) outlines MA plan eligibility requirements. **MMCM CH 2: 30** (Election Periods and Effective Dates) states that "in order for an MA organization to accept an election, a valid request must be made during an election period. It is the responsibility of the organization to determine the election period of each enrollment or disenrollment request." The section goes on to outline additional election period guidance and details. **MMCM CH 2: 30.6** (Effective Date of Coverage) states that "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." **MMCM CH 2: 40.2** (Processing the Enrollment Request) requires that in "processing all enrollment requests, the MA organization must verify Medicare entitlement" and the "MA organization must determine the effective date of coverage for all enrollment requests."

Question C7: Did the agent fully qualify each interested party? *(3 Points)*

Required Components

- Agent must establish the following
    1. Determine Medicare eligibility, including enrollment in **Parts A and/or B** as required by the plan type.
    2. Confirm the beneficiary resides within the **plan's service area**.
    3. Understand the beneficiary's current medical and prescription drug coverage, including Employer Group Health Plans (EGHP), union or retiree coverage, and Veteran benefits **(including VA, TRICARE, and CHAMPVA), to determine whether enrollment could affect existing coverage or benefits.**
    4. Determine if the beneficiary may be eligible for **LIS/Extra Help** or other applicable assistance programs.
    5. Verify any additional plan-specific eligibility requirements, such as Medicaid level for DSNP plans or qualifying chronic conditions for CSNP plans.
    6. If applicable, the agent must fully qualify the caller by asking additional health-related questions required for CSNP enrollment.
    7. Ensure the proposed enrollment is suitable and does not result in the loss of important coverage or benefits for which the beneficiary may currently qualify.

Evaluator Notes: To establish eligibility, an agent must receive an applicable response from the beneficiary for each qualifying question. If an applicable response is not provided the first time the question is asked, then we must ask again until we determine eligibility. The agent is allowed to ask one combined question to identify any other health coverage the beneficiary may have: "*Do you have other coverage currently such as an Employer, Individual Major Medical, Employer Group Medicare plan, retirement benefits for healthcare, VA benefits or TRICARE for Life/CHAMPVA?"* If yes, probe to determine which one following the script. Medicare Parts A and B qualification may be established through direct questioning, Medicare eligibility verification tools, enrollment application data, or information otherwise provided during the interaction.

Intent/Purpose: **MMCM CH 2: 20** (Eligibility for Enrollment in MA Plans) outlines MA plan eligibility requirements. **MMCM CH 2: 40.1.3** (Enrollment via Telephone) states that "the MA organization must ensure that all MA eligibility and enrollment requirements provided in this chapter are met. **MMCM CH 2: 40.2** (Processing the Enrollment Request) requires that in "processing all enrollment requests, the MA organization must verify Medicare entitlement."

Question C8: Did the agent determine the reason the beneficiary is inquiring about a different plan with focus on experiences with current coverage? *(2 Points)*

Required Components
• Agents must gain understanding of what benefits their current plan meets or does not meet their needs. **Evaluator Notes:** Agent must ask at least one (1) question that provides an understanding of what the customer likes and/or dislikes of their current coverage (even if it is Original Medicare). If the beneficiary provides information in the call through general conversation that allows the evaluator to assess the likes/dislikes of their current coverage, mark this as a YES.

Intent/Purpose: **42 CFR § 422.2262(a)(1)(i), (iii)** and **42 CFR § 422.2268 (a)(1), (2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries. **42 CFR § 422.2264(c)(3)(ii)(D)** permits MA organizations to "review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns." **42 CFR § 422.2267(e)(4)** requires the contents of the PECL be reviewed during telephonic enrollments, to include EOC, providers, medications, premiums/copayments/coinsurance, emergency/urgent, plan-type rules, and effect on current coverage.

Question C9: Did the agent determine which benefits are a priority for the beneficiary? *(2 Points)*

Required Components
• Agents must gain an understanding of what benefits a priority would be or are important in the new plan of interest. **Evaluator Notes:** Agent must ask at least one (1) question that provides an understanding of what the beneficiary is looking for in a different plan. This question is not assessing the effectiveness but the minimum needed call behaviors. If the beneficiary provides information in the call through general conversation that allows the evaluator to assess the wants and needs of a new plan, mark this as a YES.

Intent/Purpose: **42 CFR § 422.2262(a)(1)(i), (iii)** and **42 CFR § 422.2268 (a)(1), (2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries. **42 CFR § 422.2264(c)(3)(ii)(D)** permits MA organizations to "review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns." **42 CFR § 422.2267(e)(4)** requires the contents of the PECL be reviewed during telephonic enrollments, to include EOC, providers, medications, premiums/copayments/coinsurance, emergency/urgent, plan-type rules, and effect on current coverage.

Question C10: Did the agent review the Summary of Benefits prior to completion of the enrollment? *(4 Points)*

Required Components

• Per CMS regulations, the agent is required to discuss all items on the Pre-Enrollment Checklist prior to enrollment, including what the impact will be on their current coverage based on the plan they are planning to enroll in.
• Agent provides accurate information on plan details described in the SOB per approved script requirement (list below):
  ○ Monthly Plan Premium (standard amount or subsidized amount if the beneficiary has LIS). This one only applies if there is a premium > $0
  ○ Part B premium reduction (If applicable)
  ○ Medical deductible cost (If applicable)
  ○ Pharmacy (Part D) deductible and applicable tiers (can provide subsidized amount if

beneficiary has LIS)
    - Maximum Out of Pocket (MOOP) responsibility, both in and out-of-network, and explain this is for medical services only.
    - In Network Benefits (and out of network if PPO/PFFS plans) copays and coinsurances for:
        - Inpatient Hospital copay/coinsurance
        - Primary Care Provider copay/coinsurance
        - Specialist copay/coinsurance
        - Preventive care (provide 2-3 examples)
        - Emergency Room, including the explanation
        - Urgently Needed Services
        - Review whether the plan provides coverage outside the United States.
        - Explain that this is not a hearing/dental/vision “rider” but a full plan. Discuss the costs/limitations.
    - Review coverage for out-of-network providers and services (e.g., except in emergency or urgent situations, plan does not cover services by out-of-network providers (i.e., doctors who are not listed in the provider directory).
    - Explain that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
    - Explain that the Evidence of Coverage provides all of the costs, benefits, and rules for the plan.
    - Present any other benefits not listed that were identified as a need by the beneficiary.
- **Upon request from the beneficiary**, additional benefits should be reviewed. Inform the caller of any specific networks, vendors, or providers that must be used to access these benefits.
    - Transportation, if applicable
    - Over the Counter Benefits, if applicable
    - Podiatry Benefits
    - Chiropractic Benefits
    - Medical Equipment Benefits
    - Rehabilitation Benefits
    - Part D Coverage Phases

Review any other copays for services/items the beneficiary needs. Inquire as to whether the beneficiary is interested in reviewing any other benefits included in the EOC or SOB. If additional benefits are reviewed, review all applicable limitations, frequencies, allowances, and access requirements. If multiple allowances are discussed, advise the beneficiary that allowance amounts cannot be combined with other benefit allowances.

Agent accurately answers all additional questions asked by applicant or their legal representative before proceeding.

Evaluator Notes: If a beneficiary does not want the agent to review the plan presentation, the agent should try to overcome this request. After attempts are made to provide a compliant presentation, the beneficiary is still advising they do not want to hear the benefits, the agent must ask if they are waiving their right to reviewing the Summary of Benefits. If these steps are followed, the evaluator will mark this question as a YES. At no point is it acceptable to encourage or proactively advise a beneficiary to waive their right to a compliant plan presentation. If this behavior is observed, the evaluator will mark this question as a NO. Evaluator to follow the call of concern process. If the plan benefits are read AFTER the application is submitted, the evaluator will mark this as a NO. Agent must ensure that the plan presentation is being provided directly to the beneficiary or their authorized representative (per CMS guidelines) such as a Healthcare POA. If completed by an unauthorized party, the evaluator will mark this as a NO. Evaluator to follow the call of concern process. When reviewing this element, the evaluator should expect agents to provide a high level overview of the benefits outlined above.

Intent/Purpose: **42 CFR § 422.111(a),(b)** requires that MA organizations disclose information, to include the benefits offered under a plan, in "clear, accurate, and standardized form." **42 CFR § 422.2262(a)(1)(i),(iii) and 422.2268 (a)(1),(2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries. **42 CFR 422.2267(e)(5)** requires, for telephonic enrollments, that the beneficiary must be

verbally told where the Summary of Benefits can be accessed. **42 CFR § 422.2264(c)(3)(ii)(D)** permits MA organizations to "review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns." **42 CFR § 422.2267(e)(4)** requires the contents of the PECL be reviewed during telephonic enrollments, to include EOC, providers, medications, premiums/copayments/coinsurance, emergency/urgent, plan-type rules, and effect on current coverage. **42 CFR § 422.2274(c)(9)(i)** requires that MA organizations "establish and maintain a system for confirming that beneficiaries enrolled by agents or brokers understand the product, including the rules applicable under the plan."

Question C11: Did the agent offer to review (1) provider (PCP and Specialist) network status (2) current prescriptions for plan coverage and pharmacy network status (3) preferred hospital network status and (4) preferred facility network status? *(4 Points)*

Required Components

- Agent needs to offer a good faith review of and disclose (as appropriate) provider network status for selected plan for all plan types. The evaluator will be assessing if the following providers are reviewed:
  - Primary Care Provider (even for non-HMO plans)
  - Specialists (as applicable)
  - Pharmacy
  - Hospital
  - Any other provider of importance to the beneficiary
- If out-of-network, confirm beneficiary's understanding of the impacts to using OON (Out of Network) provider.
- If the network requires referrals within specified provider affiliation, the agent must discuss this requirement.
- Agent offered to review prescriptions to determine if they are in or out of the plan's formulary.
  - If the plan requires a prescription to obtain Prior Authorization, Step Therapy, etc., the agent must advise the applicant of this (or any other) requirement.
  - Agent must also confirm dosage/frequency info as part of this review
- Agent provides accurate information on plan details described.

Evaluator Notes: The minimum expectation is that the agent will try to review PCP, Specialists, Pharmacy, Hospital (even with PPO/Preferred Provider Organization/PFFS plans) and prescription coverage with the consumer.

- If this is met and the information provided is accurate and not misleading, the evaluator will mark this as YES.
- If any of these elements are missed or are not discussed, the evaluator will score this as a No.

If an agent makes a general statement about the network status of a provider (pharmacies and hospitals included), the evaluator will score this as a No only if there is clear evidence that the provider is not accepting. If an agent adds a provider on an enrollment without consent or the member's intention to see this provider, mark this component NO and follow the Call of Concern process. If the agent provides inaccurate information relating to network status (Providers include Pharmacies) then the evaluator will mark No. If the applicant is enrolling in a PDP-only plan, the agent does not need to ask to review providers (except for Pharmacies). If the agent is enrolling in a MA plan, the agent does not need to ask to review prescriptions.

Intent/Purpose: **42 CFR § 422.111(a), (b)** requires that MA organizations disclose information, to include the benefits offered under a plan, in "clear, accurate, and standardized form." **42 CFR § 422.2262(a)(1)(i),(iii) and 422.2268 (a)(1), (2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries. **42 CFR § 422.2264(c)(3)(ii)(D)** permits MA organizations to "review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns." **42 CFR § 422.2267(e)(4)** requires the contents of the PECL be reviewed during telephonic enrollments, to include EOC, providers, medications, premiums/copayments/coinsurance, emergency/urgent, plan-type rules, and effect on current coverage. **42 CFR § 422.2274(c)(9)(i)** requires that MA organizations "Establish and maintain a system for

confirming that beneficiaries enrolled by agents or brokers understand the product, including the rules applicable under the plan."

Question C12: Did the agent explain how enrolling will affect current coverage including being disenrolled from their current plan? *(3 Points)*

Required Components
• The agent must explain the potential effect that enrolling in this plan will have on other, current coverage, which may in some cases mean that the individual is disenrolled from the beneficiary's current health coverage (e.g., another MA plan, Medigap, TFL/ChampVA). • If the call initiates with interest in dental/vision/hearing benefits, the agent must explain that this is not a hearing/dental/vision "rider" but a full plan.

Intent/Purpose: **42 CFR § 422.2262(a)(1)(i), (iii) and 422.2268 (a)(1), (2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries. **42 CFR § 422.2262(a)(1)(xiv)** prohibits MA organizations from implying that an MA plan operates as a supplement to Medicare. **42 CFR § 422.2267(e)(4)** requires the contents of the PECL be reviewed during telephonic enrollments, to include effect on current coverage. **42 CFR § 422.2274(c)(9)(i)** requires that MA organizations "establish and maintain a system for confirming that beneficiaries enrolled by agents or brokers understand the product, including the rules applicable under the plan."

Question C13: Did the agent read all required disclosures for the determined plan of interest? *(2 Points)*

Required Components
• All relevant disclosures as outlined in IFG Multi-Plan approved script were completed (i.e., verbally or via IVR (INTERACTIVE VOICE RESPONSE)) and collecting agreement/understanding. • This includes all disclosures and required statements presented within the application (e.g., pop-ups and enrollment disclosures). Agents must ask every question and read all required content verbatim. Sunfire provides the applicable plan disclosures based on the specific plan selected for enrollment. **Core Disclosures:** These are examples of core disclosures that should be reinforced during the sales process but do not replace any required Sunfire enrollment disclosures. • **TPMO Disclaimer:** The TPMO disclaimer must be completed prior to the discussion of plan-specific benefits: "*We do not offer every plan available in your area. Currently we represent [X] organizations which offer [X] products in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options*." • **Effect on Current Coverage**: *"If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts."* • **Right to Cancel Enrollment**: *"You have the right to cancel this enrollment prior to the plan effective date."* **Evaluator Notes:** If additional disclosures are read, this will not negatively impact the agent. If one disclosure is missed, then the entire element is impacted as NO. If the plan disclosures are read AFTER the application is submitted, the evaluator will mark this as a NO. Agent must ensure that the disclosures are being provided directly to the beneficiary or their authorized representative (per CMS guidelines) such as a Healthcare POA.

Intent/Purpose: **42 CFR § 422.2262(a)(1)(i), (iii)** and **42 CFR § 422.2268 (a)(1), (2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries. **42 CFR § 422.2267(e)(41)** requires, within the first minute of a sales call, that a TPMO states whether they do or do not represent every plan in the area. **42 CFR § 422.111** contains numerous disclosure requirements. **42 CFR § 422.2274(c)(9)(i)** requires that MA organizations "establish and maintain a system for confirming that beneficiaries enrolled by agents or brokers understand the product, including the rules applicable under the plan." **MMCM CH 2: 40.1.3** (Enrollment via Telephone), **40.2** (Processing the Enrollment Request), **40.4.1** (Prior to the Effective Date of Coverage),

Appx 2 (Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests), and Exhibits 1, 3 provide numerous disclosure requirements.

Question C14: Did the agent confirm the beneficiary was ready to complete his/her enrollment which includes stating plan name and effective date? *(3 Points)*

Required Components

• Agent completed the following:
  ○ Provided the plan name.
  ○ Advised of the plan's effective date.
  ○ Confirmed the beneficiary was ready to complete his/her enrollment.
 	
Evaluator Notes: The agent must ensure that the applicant or authorized representative is aware that they are about to complete the enrollment process. This is accomplished by asking the beneficiary if they understand that they are enrolling and receiving an affirmative response. If an affirmative response is not received, the evaluator would mark this as a NO. If the enrollment is not completed with full knowledge of the applicant or authorized party, Evaluator to follow the call of concern process.
 	
Although preferred, all three components are not required to be stated within the same statement or portion of the call.

Intent/Purpose: **42 CFR § 422.2262(a)(1)(i), (iii)** and **42 CFR § 422.2268 (a)(1), (2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries.

PLAN NAME **42 CFR § 422.2262(a)(1)(x)** and **42 CFR § 422.2268(a)(6)** prohibit MA organizations from using "a plan name that does not include the plan type." **42 CFR § 422.2274(c)(9)(i)** requires that MA organizations "establish and maintain a system for confirming that beneficiaries enrolled by agents or brokers understand the product." **MMCM CH 2: 40.1.3** (Enrollment via Telephone), **40.4.1** (Prior to the Effective Date of Coverage), and Appx 2 (Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests) together require that plan information, to include plan name, be provided.

EFFECTIVE DATE **MMCM CH 2: 30** (Election Periods and Effective Dates) states that "once the election period is identified by the MA organization, the MA organization must determine the effective date." **MMCM CH 2: 40.2** (Processing the Enrollment Request) states that the "MA organization must determine the effective date of coverage for all enrollment requests," and that "the MA organization must notify the member of the effective date of coverage prior to the effective date."

BENEFICIARY READY TO ENROLL **MMCM CH 2: 40.1.3** (Enrollment via Telephone) states that "individuals must be advised that they are completing an enrollment request." Additionally, it states that "each telephonic enrollment request must include a verbal attestation of the intent to enroll." **MMCM CH 2: 40.2** (Processing the Enrollment Request) references "verbal attestation of intent to enroll."

Question C15: Did the agent accurately complete the beneficiary's application and review the following: 1) contact information; 2) payment options, 3) language preference, and 4) alternate format election? *(2 Points)*

Required Components

• Agent must complete application in its entirety, with special attention to the following:
  ○ Capture all application contact information.
  ○ Ask and capture selected payment option.
  ○ Ask and capture language preference
  ○ Ask and capture alternate format election.

Evaluator Notes: Contact information may include Member Name, MBI, DOB, Gender, physical address, and email address.

Intent/Purpose:

CONTACT INFORMATION: **MMCM CH 2: 40.1.3** (Enrollment via Telephone), Appx 2 (Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests), and Exhibits 1, 3 together pertain to agent collection of beneficiary contact information. **MMCM CH 2: 40.2.1** (Who May Complete an Enrollment or Disenrollment Request) requires contact information for authorized representatives. **2022 MCMG** (Required Materials and Content - Scope of Appointment) requires that beneficiary contact information be obtained on the recorded call.

PAYMENT OPTIONS: **MMCM CH 2: 40.1.3** (Enrollment via Telephone), **40.2** (Processing the Enrollment Request), and Appx 2 (Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests) together provide guidance as to the presentation of payment options and collection of payment information.

LANGUAGE PREFERENCES/ALTERNATIVE FORMATS: **42 CFR § 422.111(h)(1)** requires that an MA organization have a toll-free customer service number that includes interpretation and adaptive/TTY services. **MMCM CH 2**: Introduction states that "organizations are required to provide information to individuals in accessible/alternate formats (for example, Large Print, Braille), upon request and thereafter, as outlined in **Section 504 of the Rehabilitation Act of 1973** (and subsequent revisions)." See also Appx 2 (Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests).

Question C16: Did the agent follow the appropriate steps to obtain a compliant signature? *(3 Points)*

Required Components
• Agent completed appropriate steps to sign the enrollment electronically/verbally. • Agent read all disclosures for telephonic signature available in Sunfire. **Evaluator Notes**: Agent must ensure that the signature is being completed by the beneficiary or their authorized representative (per CMS guidelines) such as a Healthcare POA. If completed by an unauthorized party, the evaluator will mark this as a NO.

Intent/Purpose: **MMCM CH 2: 40.1.3** (Enrollment via Telephone), **40.2** (Processing the Enrollment Request) and Appx 2 (Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests) together address and require telephonic signatures.

Question C17: Did the agent refrain from claiming to be endorsed by or work for Medicare? *(8 Points)*

Required Components
• Agent represented themselve as a licensed agent from their company and made no indication that they are employed by Medicare or otherwise affiliated with Medicare to provide enrollment services.

Intent/Purpose: **42 CFR § 422.2262(a)(1)(i),(iii),(xi)** and **42 CFR § 422.2268 (a)(1),(2),(3)** require that MA organizations refrain from providing inaccurate or misleading information, engage in activities that could mislead or confuse beneficiaries, or misstate the organization's relationship/status regarding CMS or Medicare.

Question C18: Did the agent refrain from asking health related questions that could be perceived as targeting a specific subset of members (cherry-picking)? *(2 Points)*

Required Components
• Agent did not ask any health-related questions unless it was part of their suitability/needs assessment or was required for enrollment in the plan (i.e., CC-SNP)

Intent/Purpose: **42 CFR § 422.2262(a)(1)(vi)** prohibits targeting potential enrollees based on health status. **42 CFR § 422.2264(c)(2)(iii)** states that "MA organizations holding or participating in marketing events may not conduct activities, including health screenings, health surveys, or other activities that are used for or could be viewed as being used to target a subset of members (that is, 'cherry-picking')." **MMCM CH 2: 40.2** (Processing the Enrollment Request) states that "MA organizations may not ask health screening questions during completion of the enrollment request. MA organizations are only permitted to send health assessment forms after enrollment. However, MA organizations may ask very limited health status questions related to a beneficiary's eligibility to join an MA plan, such as whether the individual is enrolled in Medicaid, or is currently admitted to a certified Medicare/Medicaid institution."

Question C19: Did the agent refrain from engaging in high pressure sales tactics? *(8 Points)*

Required Components
• Agent presented and enrolled beneficiary in a plan based on the needs of the beneficiary without overwhelming the applicant's resistance with fear, doubt, confusion, or intimidation.
Evaluator Notes: Note that the applicant agreeing to the enrollment DOES NOT mean there was no high-pressure sales tactics. If at any time, the sale was completed unethically such as forcing decision making where the buyer is not making an informed decision, this question is to be marked NO. Evaluator to follow the Call of Concern process.

Intent/Purpose: **42 CFR § 422.2262(a)(1)(i)**, **(iii)** and **42 CFR § 422.2268 (a)(1)**, **(2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries.

Question C20: Did the agent avoid disclosing health PI information to the wrong party? *(4 Points)*

Required Components
• Agent did not disclose any information deemed as Protected and Confidential as it relates to the applicant to any non-authorized individual.
Evaluator Notes: Authenticate all inbound and outbound telephone calls before discussing any protected health information. Only impact this component if PI information is released, not if the call was not authenticated. General benefit information is not PI. Verify the identity of the person requesting the information and the authority to access the information. Agent provides support without collecting protected or personal information unless it's essential for completing the enrollment.

Intent/Purpose: **45 § CFR 164.502** prohibits disclosure of protected health information except as specifically permitted.

Question C21: Did the agent refrain from cross selling non-Health plans (i.e., Life insurance) on a Medicare plan call? *(4 Points)*

Required Components
• Agent did not discuss non-health products to prospective enrollees during an MA or Part D sales activity. If a non-health inquiry is made by the beneficiary, the agent will provide the beneficiary with the inbound toll-free number for non-health related information. **Evaluator Notes**: Non-health care products are defined as any insurance product that does not involve medical or health coverage. Examples of non-health care products include Annuities, Life, FPP (Financial Protection Products). Examples of health-related products include but are not limited to: Dental, Vision, Hospital Indemnity, Cancer, Critical Illness.

Intent/Purpose: **42 CFR § 422.2262(a)(1)(i), (iii)** and **42 CFR § 422.2268 (a)(1), (2)** require that MA organizations refrain from providing inaccurate or misleading information or engage in activities that could mislead or confuse beneficiaries. **42 CFR § 422.2264(c)(3)(iii)** states that "MA organizations holding a personal marketing appointment may not market non-health related products, such as annuities." **42 CFR § 422.2268(b)(3)** states that "MA organizations may not market non-health care related products to prospective enrollees during any MA or Part D sales activity or presentation. This is considered cross-selling and is prohibited."

Question C22: Did the agent refrain from cold calling for MA/MAPD/PDP interest without a valid permission to contact? *(8 Points)*

Required Components

- Agent did not conduct unsolicited contact which is defined as discussing CMS regulated products on an outbound call with a consumer that does not have a documented/recorded permission to contact or have an established business relationship.

Evaluator Notes: In general, during Outbound calls, agents may:

- Call individuals who have expressly given permission for a plan or sales agent to contact them via a permission to contact form, online contact form, business reply card, verbal recording, and the like.
- Discuss CMS regulated plans if the customer clearly initiates discussion.
- Return/reply to phone calls, messages, or emails initiated by prospects or enrollees.
- Call their current MA and non-MA enrollees or use third parties to contact their current MA and non-MA enrollees about MA/Part D plans.
- Call their current enrollees, including via a pre-recorded automated telephone notification, to discuss/inform them about general plan information such as Annual Enrollment Period (AEP) dates, availability of flu shots, upcoming plan changes, educational events, and other important plan information. Please note if marketing related and using pre-recorded messages, TCPA (Telephone Consumer Protection Act) rules may apply.
- Call their current enrollees to conduct normal business related to enrollment in the plan, including calls to enrollees who have been involuntarily disenrolled to resolve eligibility issues.

In general, agents may not do the following:

- Make unsolicited calls to non-members about other business as a means of generating leads for CMS regulated plans (i.e., MA, MAPD, PDP, or OSB (OPTIONAL SUPPLEMENTAL BENEFITS))
- Solicit referrals of friends or relatives to market/discuss CMS regulated products
- Contact enrollees who are known to be in the process of voluntarily disenrolling from a plan for sales purposes or to ask for consent in any format for further sales contacts.

Intent/Purpose: **42 CFR § 422.2264(a)(2)** prohibits MA organizations from, without prior request, "telephone solicitation (that is, cold calling), robocalls, text messages, or voicemail messages." This includes "calls based on referrals, calls to former enrollees who have disenrolled or those in the process of disenrolling, except to conduct disenrollment surveys for quality improvement purposes, calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission to be contacted, and calls to prospective enrollees to confirm receipt of mailed

information." However, "calls are not considered unsolicited if the beneficiary provides consent or initiates contact with the plan." In addition, **42 CFR § 422.2264(b)** outlines permissible contact for plan business. **42 CFR § 422.2268(b)(13)** prohibits MA organizations from soliciting "Medicare beneficiaries through unsolicited means of direct contact, including calling a beneficiary without the beneficiary initiating the contact."

Question C23: Did the agent provide compliant call closing? *(2 Points)*

Required Components

• Agent must provide the following:
  ○ Carrier name and customer service phone number
  ○ Application confirmation number/ enrollment code
 	
Evaluator Notes: Providing the confirmation number via email capture is sufficient if the agent states it will be sent via email and still offers to read it. If an agent tries to provide the details listed in required components but is stopped by the consumer or the customer hangs up, please mark this component as a YES.

Intent/Purpose:

CARRIER NAME AND PHONE/TTY: **42 CFR § 422.111(h)(1)** requires that an MA organization have a toll-free customer service number that includes a TTY service. **42 CFR § 422.2274(c)(9)(i)** requires that MA organizations "establish and maintain a system for confirming that beneficiaries enrolled by agents or brokers understand the product."

CONFIRMATION NUMBER: **MMCM CH 2: 40.1.3** (Enrollment via Telephone) requires the inclusion of "a tracking mechanism to provide the individual with evidence that the telephonic enrollment request was received (e.g., a confirmation number)." See also **MMCM CH 2: 40.4.1** (Prior to the Effective Date of Coverage).

BUSINESS PROCESS:

Question BP1: Did the agent request the applicant's email address? *(2 Points)*

Required Components
• Agent asks the beneficiary for their email address. **Evaluator Notes**: It is recommended that the agent explain the purpose of providing an email address, that providing it is optional, and that the customer may opt out at any time. Credit is given if the agent tries to obtain it, even if unsuccessful.

Intent/Purpose: As consumers pivot to completing more activities online, it will be important to help consumers do business within a variety of channels. Collecting email address will help retention as digital onboard will engage a member early, and even through enrollment submission confirmation emails.

Question BP2: Did the form address all concerns identified during the Call Audit? *(2 Points)*

Intent/Purpose: This element will be used to note any concerns identified in the call that were not addressed under other elements in the form.

CONSUMER EXPERIENCE:

Question CE1: Needs Analysis Technique *(Minimum Requirement: 2 Points)*

Intent/Purpose: IFG highly encourages the use of a consultative selling approach in helping consumers. We do not start with products. Instead, we first invite prospects to describe their situation. This dialogue is key to identifying the plan type that may be suitable.

The first objective on a call is to build a relationship which creates value and trust with the consumer. Agents have a limited amount of time to engage consumers and the ability to provide consumers with the right solution is based on understanding their needs/wants. Agents need to ask the right questions to help focus on the consumer's area(s) of interest.

Possible Examples/ Methods:	• Gather enough information from the beneficiary so the agent can present a specific plan; however, consideration will be provided when the beneficiary provides all information necessary to understand their initial healthcare needs.
	  ○ Example: *The agent presented a PPO option because the beneficiary advised that they routinely receive care in two different states (snowbird).*
	• Keep questions simple by asking questions that uncover one need at a time. Examples include but are not limited to:
	  ○ Example: *"What benefits are important to you as you consider your healthcare options?"*
	• Uses of different question techniques (open-ended/target options) to have the beneficiary explain their current gaps/likes/dislikes. Examples include but are not limited to:
	  ○ Example: *"Do you prefer a plan with low out-of-pocket cost which allows you to stay in network or do you prefer a plan that allows you to go in and out of network but may have a higher premium?"*
	• Ask questions based on previous information provided by the beneficiary to gain clarity and acceptance. An example can include but not limited to:
	  ○ Example: "*You said you wanted a plan that had transportation benefits, is that correct?"*

Avoid/Limit:	• Presenting a plan prior to understanding the primary healthcare needs of the beneficiary • Asking multiple questions at a time does not provide the beneficiary with an opportunity to answer questions. • Asking yes or no questions limits the agent's ability to understand the beneficiary's specific needs.

Question CE2: Presenting a solution based on an objective assessment of the beneficiary's needs. *(Minimum Requirement: 2 Points)*

Intent/Purpose: When an agent presents a solution, it needs to focus on addressing the beneficiary's needs/wants objectively without favoring a particular carrier and how the solution will meet those needs. We are looking for agents to display value rather than the price. This involves a balance of confidence, trust, and knowledge. Presenting an appropriate solution aligns the needs expressed by the beneficiary and not working on one plan fits all mentality.

Possible Examples/ Methods:	• Present a plan option with specific examples on how it will meet the needs/wants expressed in the call.
	  ○ Example: "The [NAME OF PLAN] will help meet the needs you expressed such as low out of pocket costs. It has a $0 monthly premium, and your PCP (Primary Care Physician) copayment is just $5."
	  ○ Example: "While this plan costs a few dollars more than what you are currently paying, it provides you with embedded dental and vision that you don't have now."
	• Use techniques to help engage the beneficiary throughout the plan presentations such as:
	  ○ Speaking clearly

	○ Routinely pausing to gauge the beneficiary's understanding/approval of plan being presented (tie-back) ○ Adjusting the pace to meet the beneficiary's needs • Provide accurate information on the plan options that are being discussed • Being mindful of your pace and tone
Avoid/Limit:	• Presenting a plan, the beneficiary does not qualify for or is not in the service area. • Automatically offering the lowest cost plan, without having uncovered the beneficiary's needs and preferences • Providing too much information in a short period of time confuses the beneficiary. ○ Examples or indications given by the beneficiary that they did not understand include: ▪ "Can you repeat that?" ▪ "I'm confused and not sure how this plan will help." • Discussing benefits in a checklist manner without engagement from the beneficiary. • Using acronyms or internal jargon that the beneficiary is not familiar with that creates confusion. • Use statements or word choices that do not convey confidence in product, plan, or service such as "I'm not sure," "I do not know," "I'm pretty, sure," or "I think" unless followed up with a statement indicating what can be done (i.e., "I'm not sure, but I will research that for you")

Question CE3: Call to Action *(Minimum Requirement: 2 Points)*

Intent/Purpose: A call to action refers to the direction the agent provides that leads the beneficiary to take immediate action. Because agents handle a variety of call types, the call to action can vary based on the business needs and circumstances of the call. Agents must always provide a beneficiary with a call to action.

Possible Examples/ Methods:	• Setting the stage ○ Example: "I will be happy to review those options with you and if we find a plan that meets your needs, we can discuss what options you have available from there." • Explaining the value of the call to action and how it will benefit the beneficiary • Addressing questions as it relates to how the call to action will benefit the beneficiary's needs • If the agent is unable to meet their needs (i.e., the beneficiary does not have an election period), the agent must provide next steps such as the dates of the next annual enrollment period or how to qualify for extra help.
Avoid/Limit:	• Providing multiple options as a call to action ○ Example: "I will be more than happy to complete the enrollment over the phone, or I can call you back another time if that's better."

Question CE4: Understanding and addressing the gaps/barriers/concerns *(Minimum Requirement: 2 Points)*

Intent/Purpose: From time to time, a beneficiary may have either a gap in understanding, a barrier that prevents them from deciding, or concern about how the plan will meet their needs. A proactive agent will ensure that these gaps, barriers, and/or concerns are addressed as they progress through their plan presentation. Remember that these gaps, barriers, and concerns are not necessarily a sign that the beneficiary is not interested. Overall, as a buyer, people want to make sure they made the right decision. Agents should consider this an opportunity to solidify the reason for the plan selection.

Examples

Gap	Barrier	Concern
• Is this a supplement? • Why is this $0?	• Spouse not available and helps make decisions • I do not have any money until next week	• How do I use it when I go out of town? • Are my doctors in the network?

Possible Examples/ Methods:	• Throughout the conversation, the agent proactively addresses potential gaps, barriers, and/or concerns.
	• Use a combination of techniques to help address their gaps, barriers, and/or concerns such as:
	  ○ Give the beneficiary the opportunity/chance to explain
	  ○ Ask questions to determine what is causing the beneficiary to not see the value of the option presented
	  ○ Summarize their concerns and explain how the plan may be able to meet their needs
	  ○ Take a moment to confirm that you have answered the beneficiary's concerns through simple check-in statements
	  ▪ Example: *"Does that make more sense?"*
	  ▪ Example: *"Have I answered all of your concerns?"*

Avoid/Limit:	• Addressing the concern by over-talking or interrupting the beneficiary during their explanation • Not acknowledging gap, barrier, or concern and proceeding with call to action • Advising the beneficiary to locate their answers via the website

Question CE5: Expanding AOR Relationship *(Minimum Requirement: 2 Points)*

Intent/Purpose: Enhancing relationships with the beneficiary is important in establishing trust. When trust is established, this can lead to increased beneficiary satisfactions, quality scores, and retention.

Possible Examples/ Methods:	○ Creating a differentiating experience with an AOR relationship
	  ▪ Example: "Please take down my name and number. As your agent, it is my responsibility to ensure that I help connect the dots between your plan and your best health. While customer service can help with many things, if you find yourself with questions about your plan, wanting to understand how it compares to other plans you have seen, or are not sure who to turn to with questions, please call me."
	○ Referrals
	  ▪ Example: "Make sure to ask the member to provide your information to others who may benefit from a conversation with you. These referrals help you build your book of business."

Avoid/Limit:	• Asking for names or phone numbers for referrals

Question CE6: Demonstrating active listening skills throughout the call? *(Minimum Requirement: 2 Points)*

Intent/Purpose: There are numerous ways to tell whether someone is not paying attention during face-to-face contact; however, it is not as easy during a phone interaction. The main indicators that can impact a consumer's experience while on the phone are based on the effectiveness and/or quality of the verbal exchanges. In this environment, it is critical to minimize the impacts of external influences to prevent them from negatively impacting the consumer's experience. By directing your attention to the current call, this ensures the beneficiary knows their call is your top priority.

Possible Examples/ Methods:	• Ask/clarify the issue/concern at the start of the call, if not already communicated by the beneficiary.
	• Use of the beneficiary's name throughout the conversation
	  ○ Trying to address a Beneficiary by their title if provided
	  ▪ Example: "Good afternoon, Dr. Smith."
	• Personalize the conversation based on specific information learned about the Beneficiary and their unique situation.
	  ○ Example: Discussing the weather, pets, or children/grandchildren
	• Utilize clarifying questions to ensure that the correct message has been received to help gain control of the call.
	• Repeat or paraphrase what the Beneficiary has said to show comprehension
	• Display a willingness to assist the Beneficiary to find a solution to their concern
	• Acknowledge and/or provide empathy as appropriate
	• Display appreciation for membership or Veteran Service

	• Provide a summary of what has been conveyed back to the beneficiary • Provide periodic updates to maintain engagement with the beneficiary while researching the beneficiary's issue. • Acknowledging hardship through use of empathy and tone
Avoid/Limit:	• Agent repeatedly requested information that the beneficiary has already provided. Consideration will be given when a beneficiary's communication is difficult to understand, etc. • Interrupting the beneficiary to obtain information needed to document records without reasoning or explanation • Periods of unexplained silence negatively impact the consumer's experience.

Summary of Changes

Date	Changes
11/26/2024	• Document created.
9/30/2025	• Document updated.
9/30/2026	• Document updated.

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