Department: Compliance	**Effective Date:** 02/14/2014
Unit: Special Investigations	**Most Recent Revision Date:** 10/21/2020
Policy and Procedure Title: Sales Allegations Investigation Process for Independent Agents	**Applies to:** ☑ MCS Advantage, Inc.
Approved by: Corporate Compliance Committee	

PURPOSE

To ensure that MCS Advantage Inc. (MCS) Independent Agents comply with all CMS and MCS policies and procedures related to sales and marketing and communication practices.

PROCEDURES

Phase I (Intake/Classification Process)

A. Marketing and sales incidents, also referred to as "marketing allegations", may be received by the Enrollment Department, Appeals & Grievances Unit, Tele-Marketing Unit, Call Centers, or any other MCS employee or contractor, as a complaint filed directly with the plan or through 1-800-MEDICARE.

B. Timeframes set forth in this procedure serve as guidance for handling investigations however; non-compliance with these timeframes does not invalidate the complainants' allegation, the investigation process, or the determination.

C. The sales allegations are sent to the Special Investigations Unit (SIU) via the following means:

   1. Designated email addresses marketing.incidents@medicalcardsystem.com and/or mcscompliance@medicalcardsystem.com;
   2. Mail;
   3. Fax;
   4. Telephone; and
   5. In person.

D. The SIU Technician and/or Specialist retrieves the sales allegations from the designated email address marketing.incidents@medicalcardsystem.com. The sales allegations received through mcscompliance@medicalcardsystem.com are retrieved by Regulatory and Operational Compliance Unit and routed to the SIU AVP through Compliance 360. The Special Investigations AVP forwards these allegations and any other allegation received through alternate means (mail, fax, telephone, in person, etc.) to the Special Investigations Technician and/or Specialists. The allegations are handled and documented no later than two (2) weeks upon receipt at MCS.

   1. The marketing incidents referrals that are dismissed are registered in the database and flagged as dismissals. A dismissal is a decision indicating that the complaint does not meet MCS's requirements to be considered as marketing incident. The SIU Specialist evaluated the potential marketing allegations, including the case registers

as dismissals by the Grievances and Appeals Unit to determine if the case is dismissed by the SIU based on the following criteria's:

a. The beneficiary requested a withdrawal (a verbal or written request to rescind or cancel a grievance and/or complaint) and the SIU Specialists evaluated the documentation submitted by the Sales Agent as part of the enrollment process (e.g. enrollment form, scope of appointment and any other document as applicable) and did not identify any potential noncompliance issue.

b. The allegation is related to an inquiry and it is not considered a potential marketing incident. For example, any verbal or written request for information to MCS that does not express dissatisfaction with the sales performed by the Sales Agent and/or the grievance and/or complaint is not related to the information provided during the sales process.

c. The referral does not include enough evidence to proceed with an investigation such as

   i. Insufficient documentation to uphold the allegation;

   ii. Insufficient documentation related to the beneficiary; and/or

   iii. The beneficiary's allegation is unclear, incomplete or not well documented and the beneficiary cannot be contacted to receive more information.

   iv. The SIU Specialist reviews the marketing allegations to determine the type of complaint/issue. Any complaint/issue not related to marketing/sales conduct will be categorized as dismissed and returned to the department that routed the issue for appropriate follow up and/or routed to another area that can handle it (e.g. Customer Service, Grievances and Appeals Unit and other applicable departments. The Sales Agent's name is not presented.

E. If the complaint is related to the sales and marketing process, it will be categorized as a "sales allegation" and assigned to the SIU Specialists for evaluation.

   1. The sales allegations that are incomplete (e.g. unable to determine the issue due to poor documentation) will be returned to the originating department for clarification or for obtaining additional information. The complaint/issue will be categorized as "dismissed" until clarification and/or additional information is obtained.

   2. During Phase I, the SIU Specialist identifies whether the access to services or the beneficiary's enrollment process was or will be affected. These cases are categorized as "urgent" and handled according to the beneficiary's necessities.

F. The SIU Specialist evaluates all documentation related to the sales allegation and all information related to the sales process, as applicable, pursuant to MCS policies and procedures. If any issue of non-compliance is identified during the evaluation of the sales allegation and/or sales process not directly related to the sales allegation, the SIU will consider it as an incidental finding and categorize the incidental finding according to the marketing allegations categories detailed in this Procedure.

G. If the allegation is related to a potential signature forgery or identity theft, the referral is handled as a potential fraud, waste, or abuse (FWA) case and are handled pursuant to

procedure number CA-FWA-004 *Investigation Management Process of Suspected Fraud, Waste and Abuse/Integrity Program*

H. Under no circumstance will the company tolerate that any individual, without distinction of the position, formulates false or malicious grievances or complaints, and/or maliciously fabricates or modifies information or documentation of any kind. In case that the results of an investigation show that any individual filed the complaint: knowingly and/or intentionally without fundamentals or based on false or manipulated information; given false testimony; created false documentation; modified or destroyed documentation or evidence of any kind; intervened in any investigative process without the prior and express consent of an authorized representative of the SIU; and/or has interfered somehow in any investigative process, disciplinary corrective measures may be applied upon him/her, indistinctively of his/her rank, title or hierarchy level.

1. It can be considered interference any unauthorized communication about the case under investigation with the individual who presented the referral or is being affected by the situation, with any witnesses and/or any individuals involved in the case.

I. The SIU Specialists maintain the confidentiality of the marketing investigations and share the minimum necessary information only with the parties involved in the investigation process. General information pertaining to the marketing investigations, the one that does not contain elements that may identify the involved parties, may be shared in trainings and meetings for educational purposes.

J. There is no conflict of interest between the parties involved and the SIU Specialist who is conducting the investigation, which may intervene or affect the results of the investigation. The SIU Specialist informs the SIU AVP if any potential conflict of interest is identified prior to issuing a determination for each marketing investigation.

Phase II (Investigation)

A. The SIU Specialist completes the following actions as part of the investigation process:

1. Reviews the documentation in the marketing allegation file;
2. Listens to the available call(s) recording(s);
3. Obtains an interview with the beneficiary; and
4. Coordinates and conducts an interview to the Independent Agent as well as records the statements presented during the interview(s);

B. The electronic file of the marketing allegation includes the following information (as applicable):

1. Sales Incident Formulary (See Attachment 1);
2. Copy(ies) of the Eligibility Screen(s);
3. Scope of Appointment;
4. Durable Medical Equipment Formulary;
5. Copy of the Enrollment Form and any other documentation pertaining to the enrollment (e.g. previous Enrollment Forms); and

6. Additional documents related to the investigation.

Phase III (Final Result and Determination)

A. The SIU Specialist submits a final report to the SIU AVP for review and determination of "founded" or "not founded". This report should be submitted within thirty (30 days the receipt of a beneficiary's complaint or within forty-five (45) days for any case identified through MCS's internal monitoring or processes.

B. Determinations of the marketing allegations are categorized as follows:

1. Founded Level 1 – The MCS' Independent Agent committed a crass violation to CMS and/or MCS guidelines;
2. Founded Level 2 – The MCS' Independent Agent; committed a significant fault;
3. Founded Level 3 – The MCS' Independent Agent committed a minor infraction;
4. Not Founded – The MCS' Independent Agent did not commit a fault; and

C. The following factors are considered to determine the category of the marketing incident or allegation:

1. Level 1: The MCS' Independent Agent committed a crass violation to CMS and/or MCS guidelines; or committed an infraction with the purpose of lying or receiving a benefit in exchange. This may include, but is not limited to:
    a. Retention of beneficiary's documents without his/her consent (e.g. Medicare card, MA-10, etc.);
    b. Unsolicited contact, including door to door solicitation; leaving information such as leaflet or flyer at a residence; approaching potential enrollees in common areas (e.g. parking lots, hallways, lobbies, sidewalks or use telephone solicitation, including text messages and leaving electronic voice mail messages, made calls based on referrals)
    c. Misrepresentation of Medicare/Social Security Agent;
    d. Knowingly enrolling a mentally disabled beneficiary;
    e. Holding applications (that impacts the members desired effective date);
    f. Offering gifts or inducements to enroll;
    g. Using providers or provider groups to distribute information comparing benefits or different health plans;
    h. Accepting plan applications in provider offices or facilities where health care is delivered (other than plan approved locations in accordance with the MMG, *i.e.* common areas, cafeterias, etc.);
    i. Offering false information during the investigation process, being negligent in the management of the investigation information, or obstructing or not cooperating with the investigation process;
    j. Failure to forward a request for withdrawal or disenrollment request (referring these requests to the MCS Call Center is acceptable);

k. Use of marketing or communication materials not previously approved by MCS or the applicable regulatory agency;

l. Incorrect enrollment (witness/translator/power of attorney);

m. Enrollment without the beneficiary's consent;

n. Misrepresentation of the plan (e.g. benefits, providers' network, copayments, enrollment process, effective date) with the purpose of misleading the beneficiary.

o. Having received, in a 6-month period, three (3) or more referrals and/or findings of marketing incidents related to the same allegation and/or finding and a Level 3 and Level 2 was assigned for this situation during the past 6-month period, and the pattern related to the same allegation continued after receiving the Level 3 and Level 2.

2. Level 2: The MCS' Independent Agent committed a significant violation, including, but not limited to:

   a. Holding applications (beyond internal timeframes; does not impact the members desired effective date);

   b. Not establishing the scope of the appointment appropriately before the sales appointment, including the submission of the scope of appointment with missing and/or inaccurate information;

   c. Using incorrect (obsolete) marketing or communication materials;

   d. Using the option of cancelling the enrollment as a way to close a sale;

   e. Comparing one insurance agency to another using misleading information;

   f. Not following proper enrollment procedures;

   g. Not following internal sales procedures and standards; and

   h. Offering incorrect information to the beneficiary about the plan in a way in which it impacts the beneficiary's coverage (e.g. encouraging the exception of services or medications).

   i. Having received, in a 6-month period, three (3) or more referrals and/or findings of marketing incidents related to the same allegation and/or finding, and a Level 3 was assigned for this situation during the past 6-month period, and the pattern related to the same allegation continued after received the Level 3.

3. Level 3: The MCS' Independent Agent committed a minor violation or provided incorrect information about MCS' benefits, services or coinsurances including, but not limited to:

   a. His/her presentation was not clear or incomplete and may have caused confusion;

   b. Failed to present the plan or the product correctly;

   c. Failed to present the enrollment and disenrollment periods correctly;

d. Failed to present the plan benefits or premium correctly (incorrect coinsurance or explanation of benefits/services);

e. Failed to present the physicians network correctly (provider terminations, availability of network, provider groups);

f. Failed to complete or incorrectly completed the internal sales documents (e.g. "in-home" report);

g. Failed to complete or incorrectly completed the enrollment documents and/or any other document related to the enrollment process as required by regulation; and

h. Having received, in a 6-month period, three (3) or more referrals and/or findings of marketing incidents related to the same allegation and/or finding.

Corrective Action

A. The Independent Agent, as per contract, has 10 points related to marketing investigations. The purpose of the points system is that the Independent Agent knows the seriousness of the committed violation. The system is ruled as follows:

a. If a Level 1 determination is given, four (4) points are deducted and a retraining will be provided and a chargeback from the sales commission or sales related to the investigation is performed.

b. If a Level 2 determination is given two (2) points are deducted and a retraining is given.

c. If a Level 3 determination is given one (1) point is deducted and a retraining is given.

d. If a founded determination of any level (1, 2 or 3) is given related to a violation for which the authorized representative has already been trained or for which he/she already received a corrective action, applying a higher level will be considered.

e. The Compliance Department may recommend applying a higher level if a marketing violations pattern is identified.

f. If an unfounded determination is given, no points are deducted.

Below is a sample table for reference for a case in which the Compliance Department assigned to an Independent Agent the following levels in a 12month period.

Determination Date	**Determination Result**	**Points (Starting with 9 pts)**
February 2021	Unfounded	10 points remaining (No points are subtracted)
March 2021	Level 3	9 remaining pts and retraining (1 point is subtracted, remaining with 9 points)
May 2021	Level 2	7 remaining pts and chargeback (2 points are subtracted, remaining with 7 points, l

		retraining and/or other actions may be implemented as applicable)
December 2021	Level 1	3 points remaining and may include termination of contract and/or other actions as applicable (4 points are subtracted remaining 3 points)

B. The points system is measured from the 12 natural months prior to the date of referral for investigation until the date of such referral. For example, if the referral was received in February 2021, the evaluation of the authorized representative's file will be performed from February 2020.

C. The Compliance Department evaluates, as requested, the list of the marketing investigations, referrals and dismissals for new candidates prior to contracting by the Membership Department. The Membership Department awaits the final determination of the investigations in progress in order to contract an authorized representative as instructed by the Compliance Department.

D. Other considerations for the cases and the corrective actions include:

   a. Seriousness of the offense;

   b. Circumstances related to the particular case;

   c. Trainings completed by the Independent Agent;

   d. Orientation and instructions provided to the Independent Agent; and

   e. Other corrective actions present in the Independent Agent's file.

Discussion of Findings Declaration Formulary

1. The SIU Specialist sends the Findings Declaration Formulary to the Director and/or Manager of the Independent Agent.
2. The Sales Manager or Director of Independent Agents discusses the Findings Declaration Formulary with the Independent Agent on or before five (5) business days upon receiving the report from the Special Investigations Specialist.
3. A signed copy is sent through email to the SIU Specialist immediately after it was discussed and signed by both parties. The original copy is included in the Independent Agent's file.

Request for Appeal

A. The Independent Agents who wish to appeal a determination made by the Compliance Department will notify their AVP and/or Director of Medicare Independent Agent Sales in writing no later than two (2) business days after having discussed the Findings Declaration Formulary with the Agent

being investigated. In order to request the appeal, the Independent Agent completes the Appeal Request Formulary (Attachment 2) and provides it to AVP and/or Director. If the Independent Agent does not complete the Appeal Request within the allotted timeframe, it will not be accepted.

B. The AVP and/or Director of Medicare Independent Agent Sales sends a copy of the Appeal Request Formulary via email to marketing.incidents@medicalcardsystem.com or to the SIU AVP and/or Specialist, no later than two (2) days of receiving the Formulary.

C. The SIU Specialist sends the request through email to the Marketing Investigations Committee, including the Appeal Request Formulary, Appeal Review Formulary (Attachment 3) and the Findings Declaration Formulary. The Marketing Investigations Committee meeting is coordinated as soon as possible after receiving the documents.

D. The voting members of the Committee are selected by the Compliance Department.

E. The Compliance Department ensures that the voting members for each case are not part of the investigation performed for the applicable case and do not have any conflict with the person who presented the appeal or with the process performed as part of the sales process and/or investigation. If a potential conflict is identified, the Compliance Department will designate another member to evaluate the appeal.

F. If a new member is selected in this Committee, the Compliance Department must ensure that the selected member is independent of the investigation process conducted by the Compliance Department. The Committee reviews the Findings Declaration Formulary, the appeal request submitted by the Independent Agent or any other documentation necessary to sustain or revoke the initial determination from the Compliance Department.

G. The voting members of the Committee vote using the Appeal Review Formulary to sustain or revoke the initial determination.

H. If the initial determination is sustained, the SIU Specialist notifies the AVP and/or Director of Medicare Independent Agent Sales no later than three (3) business day after the Committee's meeting. The AVP and/or Director of Medicare Independent Agent Sales notifies the Independent Agent and begins the disciplinary action process.

I. If the initial determination is revoked, the SIU Specialist reviews the Findings Declaration Formulary according to the Committee's decision no later than three (3) business days after the Committee's meeting.

J. The reviewed Findings Declaration Formulary is sent to the AVP and/or Director of Medicare Independent Agent Sales (and other recipients in the original email) and they proceed with the discussion and signatures as previously explained. (See section **Discussion of Findings Declaration Formulary)**

Development of Reports

A. On a monthly basis (no later than the 20th of each month), the Compliance Department submits to the attention of the Membership Department Management and to the Chief Executive Officer a report. Such report contains, at a minimum, the number of referrals received during the previous month, from where they were received, the number of referrals received related to Independent Agents and the nature of the allegations of those referrals.

B. The Compliance Department conducts monthly and/or ad hoc meetings with the Membership Department Senior Management to discuss marketing trends and/or any risk identified during the investigation process.

Definitions

- CMS (Centers for Medicare and Medicaid Services): The federal agency that regulates and monitors the benefits provided to the Medicare and Medicaid populations.
- Communications: Activities and use of materials to provide information to current and prospective enrollees. This means that all activities and materials aimed at prospective and current enrollees, including their caregivers and other decision makers associated with a prospective or current enrollee, are "communication".
- Founded: A sales allegation determination and category when the sales agent is held responsible for the allegation.
- Initial Coverage Election Period (ICEP): A period when individuals newly eligible for Medicare may make an initial enrollment request to enroll in an MA plan.
- Marketing: A subset of communications and includes activities and use of materials by MCS with the intent to draw a beneficiary's attention to a plan or plans and to influence a beneficiary's decision – making process when selecting a plan for enrollment or deciding to stay enrolled in a plan. (that is, retention-based marketing).
- Marketing Incident: Any complaint in which there is an alleged violation of marketing guidelines and/or internal standards (also referred to as a "sales allegation").
- OEV: Outbound Enrollment and Verification Calls to all new enrollees.
- Prospect: A Medicare beneficiary who contacts the Sales Agent to request a sales orientation.
- Special Election Period (SEP): Time periods outside the ICEP, AEP, or Medicare Advantage Disenrollment Period (MADP) when a Medicare beneficiary may elect a plan or change his or her current plan election.
- Unfounded: A sales allegation determination and category when the Sales Agent is not at fault.

REFERENCES

- Medicare Managed Care Manual, Chapter 2 – Medicare Advantage Enrollment and Disenrollment
  - Section 40.2.1 - Who May Complete an Enrollment or Disenrollment Request
- Medicare Communications and Marketing Guidelines (MCMG)
- MCS Independent Agent Training Manual
- 42 CFR § 422.2268
- Membership Policies and Procedures
- Marketing Materials for the current year – Approved by Compliance Department
- MCS Code of Conduct and Compliance Program

Related Policy and/or Procedure

- MCS-Policy-007 Prompt Response to Compliance Issues
- MCS-Policy-010 – Document Retention and Access to Records by Federal and Commonwealth Regulatory Authorities
- CA-FWA-004 Investigation Management Process of Suspected Fraud, Waste and Abuse/Integrity Program.

Attachments

Please Note: Utilizing a printed copy of this document does not ensure that you are utilizing the most current version. For the latest version of this document, always utilize the electronic version of Policies and Procedure in Compliance 360°.

- Attachment 1 – Marketing Incident Form
- Attachment 2 – Appeal Request Formulary
- Attachment 3 – Appeal Review Formulary

Policy and Procedure Reviews

DATE	CHANGE(S)	REASONS
10/21/2020	To clarify definitions related to dismissed cases, communications and marketing. To eliminate that ESRD beneficiaries cannot be enrolled based on CMS changes for 2021. Other changes to clarify timeframes of the investigation process and importance of the independent role of the appeal committee voting members.	Ad-hoc Review based on changes in regulations
05/29/2020	To clarify the reasons to dismiss a case and to include re-training to Sales Agent in case a finding of Level 1 is assigned (previously was optional)	Ad-hoc review based on the results of the Agent/ Broker Oversight performed by the Compliance Department
11/06/2019	Clarify that a Level 1 will be assigned if the Scope of Appointment has missing or inaccurate information. Establish that patterns will be evaluated for a period of 6 months instead of 12 months. Clarify that allegations related to falsification (potential fraud, waste and/or abuse) will be managed according to the Procedure CA-FWA-004 Investigation Management of Suspected Fraud, Waste and Abuse/ Integrity Program. Clarify the points assigned by the Compliance Department depending on the level of the finding. Establish that failure to complete correctly documents related to the enrollment process is a Level 3. Eliminate the request of recording the call when the Compliance Specialist contacts a beneficiary who is not enrolled to validate the complaint.	Annual Review

11/07/2018	Clarify the definition of unsolicited contact based on Marketing Guidelines, clarify that comparisons between plans can't be made using misleading information. Eliminate the category of others to dismiss an allegation. Clarify the points when the allegation was unfounded. Include appeal process for Independent Agents.	Annual Review
12/20/2017	Clarify roles, include new provisions specify actions to be implemented when a pattern is identified for the same allegation and a Level 3 was already assigned to the employee. Eliminate request of documenting the 48 hours waiting period when a SOA is completed based on new Marketing Guidelines.	Annual Review
08/17/2016	Include MCS Healthcare Holdings, LLC. Make applicable changes based on the transfer of the Marketing Incident Unit to the Compliance Department. Make some changes to the investigations time frames and other changes. Clarify names of applicable policies related to this procedure and clarify wording in some instances.	Annual review
08/13/2015	No changes	Review of changes contained in chapters 2 and 3 CY 2016 of the Medicare Managed Care Manual
02/13/2015	Language related to the documentation of investigations within two weeks from receipt was included. Change of corrective action's management.	Audit and final review
03/19/2014	Information was included	Ad hoc review
02/14/2014	Create policy and procedure	To comply with policy CA-COMP-001.