Molina Healthcare

2023 Medicare Telephonic and Enrollment Call Guide – Inbound

Intent/Purpose:

This document was created to ensure [Molina Healthcare] telephone representatives cover all required information Medicare beneficiaries need. As a representative of [Molina] your role is to help each beneficiary find the most suitable health plan for them and, for those who are ready for it, assist them in completing enrollment over the phone.

Everything in RED TYPE is model language and must be spoken exactly as written.

Reminder:

You're speaking to someone who may be confused or even afraid. This is your chance to provide a positive experience and the best solution to protect their health. Please speak slowly with the same patience and kindness you'd want someone to give your own loved ones.

SECTION 1:

Greeting:

Rep:

- Thank the person for calling and let them know you appreciate talking to them
- Explain that they may qualify for extra benefits with our Medicare Advantage Plans and additional allowances for vision, dental, transportation and hearing
- Tell them you'd like the opportunity to help them understand how Medicare works

Medicare Disclaimer (words in red are REQUIRED)

Rep: Let them know, before you go any further, you need to say:

Rep: This call is recorded for quality assurance purposes. You are not required to provide any health-related information unless it will be used to determine eligibility for enrollment into a Health Plan. I'm going to continue now if that's all right. May I continue?

[If YES, continue to Determine Beneficiary, below.]

[If NO, they do not consent to being recorded, skip to In-Home Appointment Offering (Pg. 9).]

Determine Beneficiary

Scope of Appointment (SOA) Scripting (REQUIRED)

Rep: Before we proceed, I want to let you know that [Molina Healthcare] [Passport by Molina Healthcare] [Senior Whole Health] [Senior Whole Health of New York] offers Medicare Part C plans. There is no obligation to enroll in our plans, and this phone call will not affect your current or future enrollment, or automatically enroll you in a Medicare plan. Do you confirm and understand what was just read to you?

SECTION 2: ELIGIBILITY

Determine Service Area
Determine Medicare Status
Determine Medicaid Status
Determine Enrollment Period

SECTION 3: PLAN PRESENTATION

Needs Assessment
Benefits Coverage and Comparison
Verify Provider Network
Verify Medications
Verify Pharmacy Network

SECTION 4: ENROLLMENT PROCESSES

Telephonic Enrollment

***Double Enrollment:* If you are signing up a couple you can obtain consent from one giving the other permission to go through the telephonic enrollment process on their behalf.**

Confirm Intent to Enroll

Rep: I understand you are interested in enrolling in [Plan Name] Medicare Advantage plan over the phone today, is this correct?

[TX H7678-003 (HMO I-SNP) only]

[Molina Medicare Comfort Care (HMO-I-SNP)] is an Institutional Special Needs Plan that is tailored to meet the needs of those who reside in a skilled nursing or assisted living facility and require an institutional level of care.]

[FL H8130-008 (HMO C-SNP) only]

[Molina Medicare Connect Care (HMO C-SNP)] is a Chronic Special Needs Plan that is tailored to meet the needs of those living with specific chronic and disabling mental health conditions. By enrolling in this plan, you are certifying that you meet the criteria of having one or more of these chronic conditions:

- *Bipolar Disorder*
- *Major Depressive Disorders*
- *Paranoid Disorder*
- *Schizophrenia*
- *Schizoaffective Disorder*

An enrollment application authorizes [Molina Healthcare] to verify that you meet eligibility requirements directly with your provider. You are also authorizing your provider to confirm that you have one of the chronic conditions that makes you eligible to join this plan.]

Authorization

Rep: Am I speaking to the person who wants to enroll?

[If YES, skip down to the →→→]

[If NO, refer to this flow chart]:

Ask if they are authorized under state law to complete the enrollment application for the beneficiary…

If YES: Ask if they can send documentation of their authority to [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] . *See YES or NO below.*	***If NO, See NO bellow***	
If YES, they can send documentation, tell them you must verify 1. Their first and last name and phone number and 2. Their relationship to [Beneficiary's Name].	*If NO, they can't send documentation, explain that you must get verbal authorization from the beneficiary to continue. Ask if the beneficiary is present.*	
	If YES, the beneficiary is present, ask to speak to them. Follow the script below…	***If NO**, the beneficiary is not present, enrollment cannot be completed. **End call.***

Rep, to beneficiary: Hello [Beneficiary Name], my name is [Rep Name] with [Molina Healthcare] [Passport] [Senior Whole Health [of NY]]. [Authorized Individual's Name] is attempting to enroll you into our [Plan Name]. Do you understand this and does [Authorized Individual's Name] have your permission to release personal information on your behalf?

[Beneficiary must clearly way Yes to continue. Now you can proceed call with Authorized representative]

Confirmation of Presentation

Rep: Can you please confirm that I explained the health plan benefits, and checked our formulary to verify your prescription drugs are covered?

Rep: Can you please confirm that I verified that your primary care physician and specialists are participating in [Molina Healthcare] [Passport] [Senior Whole Health [of NY]]'s network?

Are you an existing patient?

PCP/Health Center

NPI

Medical Group/IPA

PCP Address

Verify Demographics

[NOTE: If HIPAA verification was successful, representative can read this information back to the Beneficiary to confirm]

Rep: I need to verify all your general information:

- May I please have your title [Mr., Mrs., Ms.]?
- May I please have your first name as it appears on your Medicare card?
- May I please have your last name as it appears on your Medicare card?
- May I please have your Date of birth?
- What is your gender?
- Would you like to provide a phone number that you would like [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] to have on file? (This is optional.) Is this a mobile number?
    - [If YES] By providing your phone number you consent to be called or texted by us regarding [Molina] [Passport] [Senior Whole Health [of NY]] plans, benefits and healthcare information. Text messages are not encrypted and can be read by unauthorized persons. Message and data rates may apply. Please refer to our SMS Terms and Conditions on our website for more details.

- Would you like to provide an e-mail address (This is optional)? By providing your e-mail address, you are giving [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] permission to send non-enrollment plan health materials via e-mail.
- May I please have your permanent address? This is the address you have on file with Medicare. (Permanent resident address is required for enrollment):
    - Street Address
    - City
    - State
    - Zip Code
- Do you have a mailing address that differs from the permanent resident address you recently provided?
- Would you like to provide an emergency contact?

[For Telephonic Enrollment Support Team only]:

Rep: [I show the agent that is assisting you is _____, is this correct?]

Verify Eligibility

[NOTE: If HIPAA verification was successful, representative can read this information back to the beneficiary to confirm]

Rep: Do you currently have Medicaid?

Rep: At this point we will be collecting information from your Medicare card, the red, white and blue card.

- May I have your Medicare Beneficiary Identification, or MBI number?
- May I have the Hospital Part A effective date?
- May I have the Medical Part B effective date?

Rep: You qualify to enroll for a [state proposed effective date] because of [state the election period that was identified].

Rep: Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical assistance programs. Will you have other Prescription drug coverage in addition to [Plan Name]?

Other Information

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a or Spanish origin
- Puerto Rican
- Another Hispanic, Latino or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

What's your race? Select all that apply.

- American Indian or Alaska Native
- Asian Indian
- Black or African American
- Chinese
- Filipino
- Guamanian or Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other Asian

- Other Pacific Islander
- Samoan
- Vietnamese
- White
- I choose not to answer

Rep: Do you or your spouse work?

Rep: Would you prefer us to send you information in a language other than English or in another format, such as audio or large print?

Enrollment Disclosures

[*For Full LIPS prospects don't read any of the following disclosures (Premium, Extra Help, Part D-IRMAA, Late Enrollment Penalty.

****For Partial-No LIPS read all disclosures (If Plan is zero premium don't read Premium disclosure)***

Premium

Rep: You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by Mail, Electronic Funds Transfer (EFT), or by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you don't select a payment option, you will get a coupon book each month.

- **Rep:** Would you like to get a monthly bill?
- **Rep:** Would you like to get Electronic Funds Transfer (EFT) from your bank account each month?
- **Rep:** Would you like to get an automatic deduction from your monthly Social Security benefit check or your Railroad Retirement Board (RRB)?

  Rep: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Extra Help

Rep: People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

Rep: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Part D-IRMAA

Rep: If you are assessed a Part D-Income Related Monthly Adjustment Amount, or Part D-IRMAA, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board (RRB). Do NOT pay [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] the Part D-IRMAA.

Late Enrollment Penalty

Rep: You may owe a Late Enrollment Penalty (LEP) if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and if you didn't have other prescription drug coverage that met Medicare's minimum standards; OR if you had a break in coverage of at least 63 days.

Rep: Do you have a Late Enrollment Penalty?

Rep: If you currently have a Late Enrollment Penalty, we need to know how you would prefer to pay it. You can pay by mail, [insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”] each month [insert optional intervals, if applicable, for example “or quarterly”]. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

Rep: Would you like to get a monthly bill?

Rep: Would you like to get Electronic Funds Transfer (EFT) from your bank account each month?

Rep: Would you like to get an automatic deduction from your monthly Social Security benefit check or your Railroad Retirement Board (RRB)?

Rep: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Rep: If you don’t select a payment option, they will get a bill each month.

STOP – Please Read This Important Information

Rep: If you currently have health coverage from an employer or union, joining [Plan Name] could affect your employer or union health benefits. You could lose your employer or union health coverage if you join. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn’t any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Agreement

Rep: We are processing this application for an effective date of [state effective date].

Rep: By completing this enrollment application, I agree to the following:

Rep: [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] is a Medicare Advantage plan and has a contract with the Federal Government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

Rep: Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example October 15 – December 7 of every year), or under certain special circumstances.

Rep: [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] serves a specific service area. If I move out of the area that [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of [Molina Healthcare] [Passport] [Senior Whole Health [of NY]], I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] when I get it to know which rules, I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren’t usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Rep: I understand that beginning on the date [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] coverage begins, I must get all my health care from [Molina Healthcare] [Passport] [Senior Whole Health [of NY]], except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] and other services contained in my [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] Evidence of Coverage document (also known as a member contract or subscriber agreement)

will be covered. Without authorization, neither Medicare nor [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] will pay for the services.

Rep: I understand that I must use network pharmacies to get prescription drug benefits.

Rep: Please see your [Plan Name] Evidence of Coverage document for a list of covered services. Some services require prior authorization. Without authorization (if applicable), neither Medicare nor [Plan Name] will pay for the services.

Rep: I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted [Plan Name], he/she may be paid based on my enrollment in [Plan Name].

Rep: Do you understand and agree to these statements?

Release of Information

Rep: I understand that I am enrolling in [Plan Name] plan. By joining this Medicare health plan, I acknowledge [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Rep: I understand that my verbal signature (or the verbal signature of the person authorized to act on my behalf under the laws of the State where I live) on this application to enroll in [Plan Name] plan means that I understand the contents of this application. If verbally signed by an authorized individual (as described above), this signature certifies that:

1. This person is authorized under State law to complete this enrollment, and
2. Documentation of this authority is available upon request by [Plan Name] or by Medicare.

Rep: Do you understand and agree to these statements?

SECTION 5: CONCLUSION

Rep:

- Thank the person for speaking to you
- Tell them the confirmation number: [Your confirmation number for this call is [Confirmation #].
- Inform them they will receive acceptance or denial in roughly [7 to 10 business days].
- Ask if they have friends or family members that could benefit from the plan
    - If so, let them know the friend or family can contact you through your direct number
    - Give them the number: [(866) 533-1050] ext. [XXXXXX], TTY: [711]
    - Tell them the days and times you're available

In-Home Appointment

Offering

Rep:

- Let them know you understand Medicare can seem complicated if they're not familiar with it but we're here to make it easy to understand
- In fact, there's a representative near them who is really great at explaining it all in person and even walking them through setting it up a Medicare plan
- Ask which day of the week works best for the rep to come help them?
    - If beneficiary elects to schedule an appointment, find a time/date that works for them and the external representative
    - Document and proceed to SCOPE OF APPOINTMENT
    - If beneficiary does NOT want to schedule an appointment, go to **Enrollment Materials**

Scope of Appointment (SOA) Scripting (REQUIRED)

Rep: Thank you. I want to confirm that your name is [Beneficiary Name] and that your Phone Number is [Phone Number], is this information correct?

[Beneficiary will confirm yes or no; correct information if needed and proceed]

Rep: During this appointment, [External Representative Name] will be discussing [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] Medicare Part C plans with you. There is no obligation to enroll in our plans, and this meeting will not affect your current or future enrollment, or automatically enroll you in a Medicare plan. Do you confirm and understand what was just read to you?

Rep: Thank you. I have a meeting set up with [External Representative Name] for [date/time], where you can further discuss the [Molina Healthcare] [Passport] [Senior Whole Health [of NY]] Medicare Part C plans.

Enrollment Materials

Rep: If you would prefer, I can send you our benefits packet and schedule a follow up call to make sure you have received it and answer any questions you may have. Would you like me to send you a benefits packet and schedule a follow up phone call with you?

Rep: Would you like me to send this by mail or by e-mail?

Thank you and have a wonderful day!