

TPMO (Third Party Marketing Organization) Telephonic Sales and Enrollment and Scripting Oversight

The purpose of this document is to provide communication and marketing guardrails around sales and enrollment scripts to all Third-Party Marketing Organizations (“TPMOs”), Field Marketing Organizations (FMOs), Managing General Agencies (MGAs) or other organizations and individuals who are compensated to perform lead generation, marketing, sales, and enrollment related functions

The guardrails are not inclusive of all applicable TPMO laws and regulations, do not constitute and must not be construed as legal advice. Spark does not represent that compliance with these guidelines will ensure that any communication or marketing material or activity will comply with all applicable laws, rules, or regulations. Instead, the guidelines are intended to help TPMOs meet CMS standards.

Carriers and TPMOs are required to have oversight of their agents’ and any downlines’ telephonic sales and enrollment activity.

This includes:

- Ensuring compliance for telephonic sales
- Current CMS-filed scripting is used
- Calls are recorded

Spark has CMS-filed and approved sales and enrollment scripts that any of our downline agencies can use. The scripts are located on the Spark Help Center Compliance Page [HERE](#).

If an agency creates their own sales and enrollment scripts, there are guidelines and processes that must be followed.

1. All Call Centers and Field Agent/Agency TPMOs are required to use a CMS approved sales script. Scripts must be reviewed annually and adhere to all CMS guidance. All Sales & Enrollment Scripts used must be filed with and approved by CMS prior to using.

- a. Follow CMS guidelines when creating a script.
- b. Submit to Spark Compliance for review.
- c. Spark will submit to a carrier for review and opt-in
- d. Once a carrier opts in, Spark will submit to CMS on the agent/agency’s behalf.

IMPORTANT: Allow at least 6 weeks to get through the approval process for sales and enrollment scripts.

2. When creating and/or updating sales and pre-enrollment scripts, remember the following:

- Sales/Pre-enrollment scripts are considered marketing and must be filed with CMS as file and use. The script must contain a SMID (see #7 below).
- The TPMO disclaimer must be conveyed within the first minute of the sales call.
- The Federal Contracting Statement must be stated on all sales/pre-enrollment calls.
- Advise that the call is being recorded.
- The only information needed from a beneficiary to provide plan options is zip code, county, and/or state.
 - A sales agent may ask if the beneficiary would like to provide additional information (i.e., date of birth, gender, Medicare ID number, Part A or Part B effective dates, etc.), but the beneficiary can say no
 - If the beneficiary declines to provide this information agent must continue the call and provide plan options
 - The agent cannot end the call if the beneficiary does not disclose this information

3. Ensure all Scope of Appointment requirements are met prior to the personal marketing appointment.

4. Prior to an enrollment, CMS requires certain questions and topics are fully discussed. Required topics include:

- What kind of health plan does the beneficiary wish to enroll in (such as low premium and higher copay (or vice versa)?)
- Preferred primary care providers, specialists, pharmacies, hospitals, and any other facilities (that is, whether or not the beneficiary's current providers are in the plan's network). If not, explain they will need to pick a new one.
- Prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered).

- Costs of health care services, premiums (plan and Part B), copays, deductibles, benefits, and specific health care needs such as needing durable medical equipment or physical therapy.
- Does the beneficiary require hearing, dental and/or vision coverage? Discuss the costs and limitations on those benefits.
- The right to cancel this enrollment and the specific date through which cancellation may occur.
- Review coverage outside of the United States.
- Explain potential effect enrolling in this plan will have on other current coverage.
- Explain that this is not a hearing/dental/vision “rider” but a full plan.
- Explain that plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
- Explain that Evidence of Coverage provides all of the costs, benefits, and rules for the plan.
- Review how to file a complaint.

When applicable:

- Review PPO or PFFS out-of-network coverage.
- Review the need to qualify for chronic/disabling condition requirement for C-SNPs
- Review the need to have Medicaid to qualify for D-SNP.
- Review the need to remain in an institutional skilled nursing facility in order to qualify for I-SNP.

5. Enrollment Scripts

Enrollment scripts must contain the required elements for completing an enrollment request as described in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual and must be filed with CMS prior to use.

These requirements include the following:

- Sales agents must obtain a compliant signature from the beneficiary. A signature is only compliant if the sales agent provides all required disclosures and disclaimers (i.e., verbally or via a recording in a clear and understandable fashion) and collects agreement and understanding from the beneficiary (or his or her POA/authorized representative).
- All disclosures required on the Model Enrollment Forms in Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual must be provided either verbally or in writing to the beneficiary.

- For telephonic enrollments, the contents of the Pre-enrollment Checklist (PECL) must be reviewed with the prospective enrollee prior to the completion of the enrollment. The PECL is required to include “Effect on Current Coverage”, and agents must ensure they discuss this element, along with all listed elements, with the prospective enrollee and answer any questions to the prospective enrollee’s satisfaction, prior to enrollment.
- Add a check box under the “Important Rules” header with the following information:
- “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. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.”

Version for use with all PDP contracts: “Effect on Current Coverage.

- If you are currently enrolled in a Medicare Prescription Drug plan, your current Medicare Prescription Drug healthcare coverage will end once your new Medicare Prescription Drug coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Prescription Drug coverage starts. Please contact Tricare for more information.”
- Sales agents must complete the relevant Medicare Product application in its entirety, asking every question on the application, and read all applicable disclaimers and disclosures clearly and understandably (not in a rushed or hurried fashion), with special attention to the following:
 - 1) Confirm first and last name
 - 2) Capture all application contact information
 - 3) Capture selected payment option.

If a beneficiary has questions during the signature portion or appears to be confused or hesitant about enrolling into the plan, the sales agent must stop the enrollment process, ensure all questions are answered, and confirm that the member would like to enroll prior to proceeding.

6. Licensed/Unlicensed Agents

All scripts must clarify either within a single script or by separating out two distinct scripts, what specifically is being said by licensed sales agents and what is being said by non-licensed representatives.

- Agent's Role: Call scripts must clearly identify at the beginning of the conversation whether the agent is a licensed sales agent or non-licensed representative.
- Non-licensed representatives may only conduct activities as permitted by state law. State law determines activities that require a licensed agent/broker. Unless required by state law, the following do not require the use of state-licensed marketing representatives:
 - Providing factual information
 - Fulfilling a request for materials; or
 - Taking demographic information in order to complete an enrollment application.

To ensure beneficiaries are not misled or confused, licensed agents/brokers who are customer service representatives cannot act simultaneously as both a customer service representative and a sales/marketing agent/broker. The agent/broker must clearly state to the beneficiary when their role changes to a marketing/sales role.

7. All sales and enrollment scripts are classified as Marketing Material and must have a SMID (ID Identifier) on the script. CMS has specific guidelines around the SMID. If it's a Marketing material, the SMID must end in "M". If representing more than one carrier, the piece must have "Multiplan" in the SMID. SMID's are limited to 50 characters.

For Example: MULTiPLAN_PY2025Script_[Agencyname or initials]_M

Please reach out to Compliance@Sparkadvisors.com with any questions or for assistance in getting a script approved for use.