CMS Medicare Manual System
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Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
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NEW/REVISED MATERIAL - EFFECTIVE DATE:

IMPLEMENTATION DATE: August 1, 2003

Section 20.3 – Streamlined Marketing Review Process - New section added to make the streamlined marketing review process a permanent process.

Section 10 – Introduction - Added information about health education material that was previously found in Section 30.1, "Other" Item # 2.

Section 20 - Marketing Review Process - Clarified that marketing review can also consist of retrospective review of marketing materials approved under the streamlined review process. Also clarified that given the streamlined marketing review process, only the Evidence of Coverage (EOC) (and no longer the Summary of Benefits [SB] and Annual Notice of Change [ANOC]) is affected by the 10-day marketing review when the material is submitted prior to ACR approval (i.e., we can approve the SB and ANOC prior to Adjusted Community Rate (ACR) approval, but not the EOC).

Section 30 – Guidelines for Advertising Materials - Added introductory information that was previously included in Section 30.1.

Section 30.1 - Guidelines for Advertising (Pre-enrollment) Materials.

- Assigned headings to each item for ease of reference.

- Under Operational Items #12 – Clarified that notification of changes is not necessary for provider directory changes. Also clarified that if a search function is used on the web for the provider directory, then as long as the information that comes up on a specific provider is the same information as what is contained in the hardcopy format, the Internet provider directory would be considered to be the same as the hardcopy format and would not need additional CMS approval.

- Under Special Situations #3 – Pointed out that in addition to verifying the accuracy of non-English marketing materials through monitoring review, CMS will also periodically conduct marketing review of non-English materials on an "as needed" basis. If materials are found inaccurate, health plans/M+C organizations may not distribute materials until revised materials have been approved.

- Added new section on requirements specific to Preferred Provider Organizations and Demonstrations.

- Under Editorial Items #1 – Added exception to 12-point font rule to state that notices to close enrollment in the Public Notice section of a newspaper need not be in 12-point font.

Section 40 - Guidelines for Beneficiary Notification Materials - Deleted reference to the review process, since this is not addressed in this section.

Section 40.1.3 - Model Annual Notice of Change - Added the option for organizations to include their own introductory language and still receive the 10-day marketing review if they follow the model without modification.

Section 40.4.1 - General Guidance on Dual Eligibility - Updated monthly income requirements.

Section 40.4.2 - Guidelines for Outreach Program - All outreach materials no longer need to include eligibility information on QI-2 levels. Added requirement that M+C organizations develop contacts with the appropriate State Agency/agencies that determine eligibility and handle eligibility appeals for Medicare Savings Programs. Clarified that if the member requests to be removed from the M+C organization's contact list, the M+C organization may not provide further outreach unless the member requests it. Added prohibition of contacting members who asked to be removed from outreach lists.

Section 40.4.3 - Submission Requirements - Added items that the organization must provide to CMS to aid in its review of outreach programs.

Section 40.4.4 - CMS Review/Approval Process - Clarify that if a proposal incorporates states in regions other than those represented, the PCT ensures that the appropriate regional office plan manager receives a copy of the proposal for comment from the National Account Representative (NAR) for the state(s).

Section 40.4.5 - Model Direct Mail Letter - Updated model letter.

Section 40.5.1 - Summary of Benefits for Medicare+Choice Organizations – Technical correction made to Section F, since the list of benefits is not included in this Chapter.

Section 50.1.2 - Referral Programs – This section was inadvertently deleted from the prior update and is being re-inserted into Chapter 3.

Section 50.1.3.3 - Allowable Actions for Medicare + Choice Organizations – Removed the term "Enrollment by Mail Forms" and replaced it with "application forms."

Section 50.3 - Specific Guidance About the Use of Independent Insurance Agents – No change in requirement. This material was moved from section 50.1.2.

Section 50.4 - Answers to Frequently Asked Questions About Promotional Activities. This material was previously located in section 50.3.

Section 60.2 - Marketing of Multiple Lines of Business. Expanded multiple product marketing requirements to allow M+C organizations to market a family of products as long as the products are clearly distinguished from one another.

Endnotes. Updated endnotes:

- Number 12 to include explanation of CMS' policy to not pay Medicaid adjustment factor for QI-1 group; and

- Number 17 to change "EBMF" to "application form."

Medicare Managed Care Manual

Chapter 3 - Marketing

Last Updated - Rev. 28, 08-01-03

Table of Contents

10 - Introduction

(Rev. 28, 08-01-03)

This chapter explains requirements for marketing. [1] The intent of this chapter is to:

- Expedite the process for CMS' review of marketing materials;

- Conserve resources by avoiding multiple submissions/reviews of a document prior to final approval;

- Ensure consistent marketing review across the nation; and

- Enable *Medicare + Choice organizations (M+C organizations) and cost-contracting health plans (cost plans)* to develop accurate, consumer friendly, and marketing information that will assist beneficiaries in making informed health care choices.

Marketing materials, in general, *are* informational materials targeted to Medicare beneficiaries that promote the *health plan/M+C organization* or any plan offered by the *health plan/M+C organization*, or communicate or explain an M+C *or cost* plan.[2] (See 42 CFR 422.80(b).) The definition of marketing materials extends beyond the public's general concept of advertising materials to include notification forms and letters used to enroll, disenroll, and communicate with the member on many different membership scenarios. *Health education materials are generally not under the purview of CMS marketing review. However, if such materials are used in any way to promote the M+C organization or explain benefits or plan rules, then they are considered marketing materials and must be approved before use. If there is any "commercial message" (defined previously in this section) or beneficiary notification information in a health education piece, it must be reviewed by CMS.*

General guidance regarding the marketing review process, including the process for review of materials submitted by national organizations, is provided in §20. In addition, this chapter contains two separate sections devoted to the discussion of guidelines for marketing materials. Section 30 addresses requirements for advertising or "pre-enrollment" materials, and §40 addresses requirements for beneficiary notification materials that are provided for beneficiaries currently enrolled in the plan. Materials relating to promotional activities, including health fairs and sales presentations, are also included in the general definition of marketing materials and are discussed in §50. *Guidelines for other marketing activities, including marketing value added items and services and marketing multiple lines of business, are addressed in §60.*

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20 - Marketing Review Process

(Rev. 28, 08-01-03)

Marketing review consists of:

- Pre-approval of marketing materials before they are used by the health plan/M+C organization;

- Review of on-site marketing facilities, products, and activities during regularly scheduled contract compliance monitoring visits;

- Random review of actual marketing pieces as they are used in/by the media;

- *Retrospective review of marketing materials approved under the streamlined marketing review process; and*

- "For cause" review of materials and activities when complaints are made by any source.

This chapter deals primarily with the pre-approval of marketing materials. As outlined in regulations at 42 CFR 422.80(a) *and* 417.428(a)(3)*, health plans/M+C organizations* may not distribute any marketing materials or election forms or make them available to individuals eligible to elect a *plan offered by a M+C organization/cost* plan unless such materials have been submitted to CMS at least 45 days prior to distribution and CMS has not disapproved the materials. A *health plan/M+C organization* may also distribute materials before 45 days have elapsed if prior approval has been granted by CMS. There is a limited exception to this requirement for model beneficiary notices, as outlined in §40 of this chapter. Guidelines for CMS review are further described at 42 CFR 422.80(c) *for M+C organizations and 417.428(a) for cost plans*. Marketing materials, once approved, remain approved until either the material is altered by the *health plan*/M+C organization or conditions change such that the material is no longer accurate. The CMS may, at any time, require a *health plan/*M+C organization to change any previously approved marketing materials if found to be inaccurate, even if the original submission was accurate at the time.

Exception to the 45-day marketing review rule:

- ***M+C organization Exception:*** *When an M+C organization follows CMS model language without modification, CMS must review the material within 10 days (as opposed to the usual 45 days). The CMS must make a determination on the material within 10 days or else the marketing material is deemed approved.*

- ***Cost Plan Exception:*** *While not required by law, CMS will review materials prepared by cost plans within 10 days if they have followed CMS cost plan model language without modification. However, while CMS intends to review the cost plan marketing materials within 10 days, the cost plan must not consider the material deemed approved if 10 days pass, and it has not received approval or disapproval from CMS since, by law, 45 days must pass before the material may be deemed approved.*

To alert the CMS reviewer to the need for a 10-day review, the health plan/M+C organization must indicate on the submission that it has followed the CMS model without modification and is requesting a 10-day review.

The 10-day review period only applies when the health plan/M+C organization has followed the CMS model without modification. "Without modification" means the health plan/M+C organization used CMS model language verbatim, and only used its own

language in areas where we have given them license to include their own information (such as where they are asked to include their plan-specific benefits). It also means that the *health plan/M+C organization* has followed the sequence of information provided in the model in its own marketing material. In these cases, the regional office may only need to review the *health plan's/M+C organization's* language in order to make a determination on the marketing material within the 10-day time frame.

NOTE: *An organization's Evidence of Coverage (EOC)* cannot be approved until an M+C organization's Adjusted Community Rate (ACR) is approved. *If an organization submits its EOC for review early in the year (prior to ACR approval),* the Regional Office (RO) will review and approve all non-ACR-related information within the 10-day review period, and will conduct a cursory review of all ACR-related information based on the M+C organization's ACR submission. However, the Regional Office (RO) will need to disapprove the release of ACR-related marketing material within the 10-day window, since there is no basis for approving it, and indicate that the material will be approved upon approval of the ACR. The Regional Office will need to promptly review and approve these marketing materials upon approval of the ACR.

20.3 – Streamlined Marketing Review Process

(Rev. 28, 08-01-03)

The CMS offers a streamlined marketing review process to M+C organizations and demonstrations for certain marketing materials in order to ensure that the materials can be available to Medicare beneficiaries in time to make decisions about their health insurance coverage. In particular, the streamlined marketing review process only applies to marketing materials developed for the Fall campaign (i.e., the Annual Notice of Change (ANOC), the Summary of Benefits (SB), and materials necessary to develop an annual enrollment period marketing package in the Fall to encourage members to join the plan) and marketing materials developed to notify members of any mid-year benefit enhancements.

An organization may choose one of two ways to have materials reviewed and approved under the streamlined process.

Option 1: M+C organizations can obtain approval of their plan marketing materials based on submitted ACRPs.

Under this option the CMS RO will review the materials based on the submitted (i.e., not yet approved) ACRP information. Organizations are encouraged to begin submitting the marketing materials for review by the date that M+C organizations may submit ACRPs to CMS. If the organization follows the ANOC model without modification (including, as required, using the standard SB), the final date to send the ANOC and SB is 10 days prior to the date that M+C organizations may submit ACRPs to CMS.

Option 2: ***An M+C organization can submit materials without cost sharing/benefit information contained in the "template" material.***

Under this option the RO will review the template and the organization will be responsible for inserting the accurate cost sharing/benefit information after approval is received. Organizations can submit the marketing materials for review before the date that M+C organizations may submit ACRPs to CMS, since these materials would not contain the ACRP information. If the M+C organization follows the ANOC model without modification (including, as required, using the standard SB), the final date to send the ANOC and SB is 10 days before the date that M+C organizations may submit ACRPs to CMS.

Regardless of which option is chosen, keep in mind the following:

- *The organization must use the "pending Federal approval" disclaimer on the materials until the ACR is approved by CMS. Once the ACR is approved, the M+C organization must remove the disclaimer.*

- *If the organization resubmits an ACRP that includes changes/corrections that affect marketing materials already approved or under review, the organization is responsible for correcting all marketing materials to reflect these ACRP changes. The material does not need another approval by CMS.*

- *Any organization that uses marketing materials containing errors (e.g., the benefit or cost sharing information differs from that in the approved ACRP) will be required to correct those materials for prospective members and send errata sheets/addenda to current members before January 1. The CMS will conduct a retrospective review of a sample of M+C plan materials and will notify the organization if corrections are necessary. The M+C organization will be expected to conduct a self review of all other marketing materials for plans not included in the sample and to issue CMS-approved correction notices as necessary.*

30 - Guidelines for Advertising Materials

(Rev. 28, 08-01-03)

This section provides guidance to health plans/M+C organizations regarding sales packages and language that may be used in pre-enrollment marketing materials. Pre-enrollment material may be defined as material that is intended primarily to attract or appeal to M+C eligible non-members, and to promote membership retention by providing general information to enrollees about the health plan. This includes all ads (print as well as radio, TV, and Internet ads) and certain other material such as sales scripts, sales presentation flyers, and direct mail pieces that contain information of interest to all potential and current enrollees of the plan.

Section 30.1 provides guidance for advertising materials which tend to make up the bulk of pre-enrollment materials. Section 30.2 provides guidance on minimum information requirements for sales packages. Section 30.3 includes a matrix describing marketing language that health plans/M+C organizations "Must Use/Can't Use/Can Use."

30.1 - Guidelines for Advertising (Pre-enrollment) Materials

(Rev. 28, 08-01-03)

These guidelines were created by identifying required language frequently omitted by health plans/M+C organizations or revised by CMS. Acceptable language was created to meet both CMS requirements and the needs of the health plans/M+C organizations. Although use of suggested "Can Use" language is not required, its use will expedite the review process and achieve greater consistency among marketing materials. Please note that the specific language and format used in all standardized marketing materials like the standardized Summary of Benefits (SB) is required. Please also note that the language provided in the "Must Use" column of the "Must Use/Can't Use/Can Use Chart" (see §30.3 of this chapter) is required for all the marketing materials as specified in the chart.

Some phrases in this document may not apply to your health plan's/M+C organization's benefit package or marketing strategy. We caution you to apply the information contained in this document with the understanding that it must be evaluated for applicability to your health plan/M+C organization.

Listed below are items that apply to the various pre-enrollment/member retention marketing scenarios experienced by Medicare managed care contracting entities:

Operational Items

1. ***Lock-In Statement:*** The concept of "lock-in" must be clearly explained in all materials. For marketing pieces, which tend to be of short duration, we suggest: "You must receive all routine care from plan providers" or "You must use plan providers except in emergent care situations or for out-of-area urgent care/renal dialysis." However, in all written materials used to make a sale, a more expanded version is suggested: "If you obtain routine care from out-of-plan providers neither Medicare *nor* [name of health plan/M+C organization] will be responsible for the costs." Modify materials if the health plan has a Point-of-Service (POS) or Visitors' Program benefit or is a cost *plan,* Private Fee-For-Service Plan (PFFS)*, or PPO*.

2. ***Networks and Sub-networks:*** All marketing materials must clearly explain the concept of networks and sub-networks and the process for obtaining services including referral requirements.

3. ***Hours of Operation:*** Health plans/M+C organizations must list the hours of operation for customer services and other health plan services anywhere that these

phone numbers are provided. This requirement does not apply to any numbers included on advertising materials for persons to call for more information.

4. ***Disclaimers- Exception for*** **Outdoor Advertising (ODA):** ODA is marketing material intended to capture the quick attention of a mobile audience passing the outdoor display (e.g., billboards, signs attached to transportation vehicles, etc.). ODA is designed to catch the attention of a person and influence them to call for detailed information on the product being advertised. Due to the nature of ODA, CMS is willing to waive the disclaimer information required with other forms of marketing media (e.g., lock-in and premium information).[3]

5. **Marketing Material Identification Systems:** Health plans/M+C organizations must use the system mandated by the reviewing RO for identifying marketing materials submitted to CMS. If the reviewing RO does not have a system, health plans/M+C organizations may use their own system for identifying marketing materials. The health plan identifier should appear on the lower left or right side of the marketing piece. After the RO approves the marketing piece, the approval date (month/year) should always be posted to the marketing piece. The approval date is the date on the CMS approval *notice*. This requirement is *also* applicable to all approved Internet pages and paper advertisements (e.g. brochures, newspaper ads). Approved radio, television, *and billboard* marketing materials need not include mention of the approval date*/ID number*.

6. ***Identification of All Plans in Materials:*** Where M+C organizations may file separate/distinct Adjusted Community Rate (ACR)s Proposals and the Plan Benefit Package (PBP)s covering the same service area (or portions of the same service area), there is no requirement that all plans be identified in all of the health plan's/M+C organization's marketing materials, although M+C organizations may do so at their discretion. M+C organizations must disclose whether other plans are available in their Annual Notice of Change letter.

7. ***Marketing to Members of Non-Renewing Medicare Plans:*** The M+C organizations may market plans directly to beneficiaries of former Medicare plans that have chosen not to renew their contracts as long as the following requirements are met:

    - No such marketing is permitted until after the date the beneficiary has received the plan termination letter; and

    - In addition to the targeted message, the marketing piece must contain a statement indicating that the plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area.

8. ***Sales Scripts:*** Sales scripts, both for in-home and telephone sales use, must be reviewed by CMS prior to use. However, health plans/M+C organizations are not

required to adhere to a specific format for submission (i.e. verbatim text or bullet points).

9. ***Member Lists:*** Health plans/M+C organizations may not use Medicare member lists for non-plan-specific purposes. If a health plan/M+C organization has questions regarding specific material, which it wishes to send to its Medicare members, the material should be submitted to CMS for a decision.

10. ***Banner and Banner-Like Advertisements:*** *Health plans/M+C organizations are not required to include the disclaimer information that is required with other forms of marketing media (e.g., lock-in and premium information) for banner or banner-like advertisements. "Banner" advertisements are typically used in television ads, and flash information quickly across a screen with the sole purpose of enticing a prospective enrollee to call the organization for more information. This type of ad does not contain benefit or cost sharing information. A "banner-like" advertisement is usually in some media other than television, is intended to very briefly entice someone to call the organization or to alert someone that information is forthcoming and, like a banner ad, does not contain benefit or cost sharing information*

11. ***Member ID Cards:*** *The CMS recommends that all health plans/M+C organizations, especially PPOs and PFFS Plans, include the phrase "Medicare limiting charges apply" on Member ID cards. However, use of this phrase is optional. The CMS believes that use of this phrase on a card that most providers will see is a reliable method of informing providers of the billing rules for the plan, and thus could reduce the chance for incorrect or inappropriate balance billing.*

    The CMS also recommends that PFFS Plans include the statement that the provider should bill the PFFS organization and not Original Medicare. The CMS believes this statement will help prevent claim processing errors. However, use of this statement is optional.

12. ***Option to Choose Media Type:*** *With respect to the SB, the EOC, and the Provider Directory, health plans/M+C organizations have the option of contacting members to determine in what format they would like to receive the materials (e.g., hardcopy, CD ROM, Internet Web pages, etc.). Health plans/M+C organizations must contact members in writing (e.g., by letter, postcard, newsletter article, etc.) to determine whether they would like to receive the SB, EOC, and/or the Provider Directory in another format. If the organization does not receive a response from the member, then the organization must assume that the member wants to receive the information in hardcopy.*
    If the organization sends one provider directory to an address where up to four members reside (as allowed in §40.2), then it may send one written notice regarding choice of media type to that address (if it is notifying members by

letter), rather than one notice to each individual member at that address. A reply from one member at that address constitutes a reply for the entire address.

The following would also apply:

- *The member must receive the materials in the required time frames, regardless of the format.*

- *For the EOC and the SB, if the organization will be providing any of these marketing materials via an Internet Web page, then it must establish a process for informing members when that Web page has been updated. For example, the organization could notify members by newsletter article, by E-mail, by postcard, etc. Often any change in the EOC or SB is communicated to all members by newsletter and notification that the change has been made on the web page could be made at the same time. This requirement does not apply to provider directories since provider directory updates can occur far more frequently than updates to the EOC or SB.*

- *The non-hardcopy format should match the approved hardcopy format, and if it does, it will not need additional CMS approval. If anything is added or deleted, the non-hardcopy format must receive separate CMS approval.*

  ***Note:** Some health plans/M+C organizations use a database/search function for their provider directory on the Internet. In this case, as long as the information that comes up on a specific provider is the same information as what is contained in the hardcopy format, then the Internet provider directory would be considered to be the same as the hardcopy format and would not need additional CMS approval.*

Affiliation Acknowledgements

1. ***Contracting Statement:*** All marketing materials must include a statement that the health plan/M+C organization contracts with the Federal government. One possible statement is "A Federally Qualified HMO with a Medicare contract." Cost-contractors may use "An HMO with a Medicare contract" and/or "An M+C organization with a Medicare contract" if they are State licensed as HMOs. Medicare+Choice organizations may identify Medicare products as "An HMO with a Medicare+Choice contract" if they are Federally Qualified or State licensed as HMOs. M+C organizations may also identify their Medicare plans as "An M+C plan with a Medicare+Choice contract," or "A Coordinated Care Plan with a Medicare+Choice contract," if the health plan/M+C organization meets the requirements of §1851(a)(2)(A) of the *Social Security* Act. In addition, an M+C organization may describe its Medicare product as a "Medicare+Choice plan offered by [name of M+C organization], a Medicare+Choice Organization".

2. ***Provider Sponsored Organizations (PSO):*** An M+C organization may only identify itself as an "M+C *Provider Sponsored Organization (*PSO*)*" or imply that it is one of the PSO options for Medicare beneficiaries under M+C if it has received a State licensure waiver from CMS in accordance with 42 CFR 422.370 - .378. State licensed M+C organizations may identify themselves in marketing materials as a "Provider Sponsored Organization (PSO)," a "State licensed PSO with a M+C contract," or any other term generally applied to managed care organizations that are sponsored by health care providers as long as they do not use the specific term "M+C PSO" or imply that they are one of the specific PSO options for Medicare beneficiaries defined by the Balanced Budget Act of 1997 and implementing regulations at 42 CFR 422.350 - .356.

3. ***Ethnic and Religious Affiliations:*** The M+C organizations are permitted to use ethnic and religious affiliation in their plan names, as long as the legal entity offering the plan has a similar proper name/affiliation. For instance, if a plan were affiliated with the Swedish Hospital of Minnesota, it would be permissible for the plan to use the tag line, "Swedish Plan, offered by Swedish Hospital System of Minnesota."

Special Situations

1. ***Disability Population:*** Beneficiaries with disabilities must be considered part of the audience that any marketing strategy is intended to reach. Specifically, and in light of the publication of the final M+C regulation, health plans/M+C organizations may not use plan names that suggest that a plan is available only to Medicare beneficiaries age 65 or over, rather than to all beneficiaries. This prohibition generally bars plan names involving terms such as "seniors," "65+," etc. In fairness to M+C organizations with an existing investment in a plan name, CMS will allow the "grandfathering" of M+C plan names established before the final rule took effect *(i.e., before June 29, 2000).*

2. ***TDD/TTY Numbers:*** TDD/TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TDD/TTY number must also appear along with the hours of operation, if the inclusion of hours of operation are required (as outlined under "Operational Items," item #3). The font size/style rule is required for all media with the exception of television ads. The CMS recognizes that the requirement that the TTY/TDD number be the same font and style as other numbers can result in confusion on a television ad, resulting in some prospective enrollees calling the wrong phone number. Therefore, health plans/M+C organizations are allowed to use various techniques to sharpen the differences between TTY/TDD and other phone numbers on a television ad (such as using a smaller font size for the TTY/TDD number than for the other phone numbers).

3. **Review of marketing materials in non-English language or Braille:** For marketing with non-English or Braille materials the health plan/M+C organization must submit the non-English or Braille version of the marketing piece, an English version (translation) of the piece, and a letter of attestation from the health plan/M+C organization that both pieces convey the same information. Health plans/M+C organizations will be subject to verification monitoring review and associated penalties for violation of this CMS policy. *In addition to verifying the accuracy of non-English marketing materials through monitoring review, CMS will also periodically conduct marketing review of non-English materials on an "as needed" basis. If materials are found inaccurate, health plans/M+C organizations may not distribute materials until revised materials have been approved.* If national health plans/M+C organizations have submitted materials in English to the lead RO and these have been approved, the same materials in other languages or Braille may be used provided that health plans/M+C organizations submit attestation letters vouching that the non-English or Braille version contains the same information as the English language version.

Section 1876 Cost Contracts Only

1. For §1876 of the Social Security Act, cost-contracting health plans only - In all marketing materials (e.g., brochure narratives and introductions to side-by-side comparisons) the health plan must indicate that it meets Medicare regulatory requirements for providing enrollment opportunity and benefit packages for both Part A and B and Part B-only eligible beneficiaries.[4]

2. Cost-contracting health plans must market a low option or basic benefit package that is identical to the Medicare fee-for-service benefit package (except for any additional benefits the health plan may offer at no charge, for which the health plan claims no reimbursement). Information on the availability of this package must appear in all of the health plan's marketing materials. The health plan/M+C organization may also offer additional optional enriched benefit packages for an additional charge to the extent they wish.

Preferred Provider Organizations (including PPO Demonstrations) Only

1. ***Cost Savings Described in Marketing Materials:*** *If a PPO states in marketing materials that prospective enrollees will save money if they join the plan, it must also acknowledge the added cost of accessing services out-of-network.*

2. ***Preferred and Non-Preferred Benefits****: If a PPO offers benefits for which the coinsurance is the same percentage both in and out of network, the PPO must make it clear in all non-advertising pre-enrollment material that the member's responsibility may be greater out of network since the coinsurance is based on the Medicare allowed amount and not the contracted amount.*

3. ***Mandatory Supplemental Benefits:*** *If a PPO offers benefits, including mandatory supplemental benefits (such as prescription drugs or dental services) that are limited to in-network providers and facilities, marketing materials that mention these benefits must state that not all benefits are offered at the non-preferred benefit level. The EOC must specifically explain which benefits are offered at the non-preferred benefit level and any limitations that may apply.*

4. ***Prior Notification / Authorization Requirements:*** *Some PPOs may require or request that members notify them prior to receiving certain services. In these cases, the organization must clearly define the requirement in marketing materials. It must also include the information in the PBP Notes section so that the appropriate language regarding the penalty may be used in marketing materials. If there is a penalty for not receiving prior referral/notification/authorization, marketing materials that mention these services must clearly describe the penalty.*

Editorial Items

1. **Font Size Rule for Member Materials:** Readability of written materials is crucial to informed choice for Medicare beneficiaries. All member materials that convey the rights and responsibilities of the health plan/M+C organization and the member must be printed with a 12-point font size or larger. Materials subject to this requirement include, but are not limited to, the EOC or member brochure and contract, the enrollment and disenrollment applications, letters confirming enrollment and disenrollment, notices of non-coverage (NONC) and notices informing members of their right to an appeals process. The CMS is cognizant of the fact that, when actually measured, font size 12 point may vary among different fonts with the result that some font types may be smaller than others. Times New Roman font type is the standard by which font size is measured. Therefore, if health plans/M+C organizations choose to use a different font type, it is their responsibility to ensure that the font used is equivalent to or larger than Times New Roman 12 point.

   Exceptions:

   - *Due to the size of the member ID card, the member ID card need not have all information in a 12-point font size or larger.*

   - *If an organization publishes a notice to close enrollment (as required in Chapter 2) in the Public Notices section of a newspaper, the organization need not use 12-point font and can instead use the font used by the newspaper for its Public Notices section.*

2. **Font Size Rule for Notice and Non-Notice Materials:** *The 12-point font size or larger rule also applies to any footnotes or subscript annotations in notices. In all non-notice material (e.g., TV advertisements) the footnote and any text appearing*

in the material must be the same size font as the commercial message. The term "commercial message" refers to the material, which is designed to capture the reader's attention regarding the health plan/M+C organization. The term does not refer to the commercial membership (i.e., non-Medicare/Medicaid members) of the health plan/M+C organization. All non-notice materials must have the same font size for both the commercial message and footnotes. The size is left to the discretion of the health plan/M+C organization and can be smaller than size 12-point font, but the commercial message and footnotes must be the same size font.

3. ***Footnote Placement:*** Health plans/M+C organizations must adopt a standard procedure for footnote placement. Footnotes should appear either at the end of the document or the bottom of each page and in the same place throughout the document. In other words, for example, the health plan/M+C organization cannot include a footnote at the bottom of page 2 and then reference this footnote on page 8; the footnote has to also appear at the bottom of page 8.

Other

1. **Marketing through the Internet:** The CMS considers the Internet as simply another vehicle for the distribution of marketing information. Therefore, all regulatory rules and requirements associated with all other marketing conveyances (e.g., newspaper, radio, TV, brochures, etc.) are applicable to health plan/M+C organization marketing activity on the Internet. The CMS marketing review authority extends to all marketing activity (both advertising and beneficiary notification activity) the health plan/M+C organization pursues via the Internet.

2. ***Reference to Studies or Statistical Data:*** M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, etc. as long as specific study details are given (at a minimum source, dates, sample size, and number of plans surveyed). M+C organizations may not use study or statistical data to directly compare their plan to another. If M+C organizations use study data that includes information on several other M+C organizations, they will not be required to include data on all organizations. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

3. ***Logos/Tag Lines:*** The CMS recognizes the difference of purpose and intent between company logos/product tag lines and other advertising marketing materials. The guidelines regarding specifically the use of unsubstantiated statements that apply to advertising materials do not apply to logos/taglines. Contracting health plans may use unsubstantiated statements in their logos and in their product tag lines (e.g., "Your health is our major concern," "Quality care is

our pledge to you," "First Care means quality care," etc.). This latitude is allowed only in logo/product tag line language. Such unsubstantiated claims cannot be used in general advertising text regardless of the communication media employed to distribute the message. Not withstanding the ability to use unsubstantiated statements as indicated above, the use of superlatives is not permitted in logos/product tag lines (e.g., "First Care means the first in quality care" or "Senior's Plus means the best in managed care"). Refer to the Must Use/Can't Use/Can Use chart in §30.3 of this chapter for full information on restrictions associated with the use of superlatives.

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40 - Guidelines for Beneficiary Notification Materials

(Rev. 28, 08-01-03)

The definition of marketing materials includes all notification forms and letters and sections of newsletters that are used to enroll, disenroll, and communicate with the member on many different membership operational policies and procedures. These materials are also described as beneficiary notification materials and subject to specific CMS requirements. Section 40.1 of this chapter provides general guidance with respect to beneficiary notification materials. Section 40.2 provides specific guidance with respect to provider directories. Section 40.3 provides specific guidance about the use of drug formularies.

40.1.3 - Model Annual Notice of Change

(Rev. 28, 08-01-03)

All M+C organizations are required to give members notice of Medicare program and health plan changes taking place on January 1 of the upcoming year, by October 15 of the current year. Cost plans must give notice within 30 days of the effective date of the Medicare program and health plan changes (i.e., by December 1 for January 1 changes). This requirement applies to all plan enrollees, including employer group enrollees. "Give notice" means that members must have ***received*** *the notice by the required date. This notice is known as the "Annual Notice of Change," or "ANOC."*

The ANOC must be member specific. This means that the notice must have the member's own name either on the envelope addressed to the member or on the ANOC itself. The following is a model ANOC for M+C organizations and cost plans.

MODEL ANNUAL NOTICE OF CHANGE

Dear [member name] - or - [Member]:

[Note: The organization may modify this introductory paragraph to tailor it to its needs, as long as the paragraph is kept brief.] This is the time of year when we like to thank you for your membership and inform you of new plan changes for the upcoming year.
Beginning January 1, [insert upcoming year], there will be some changes to [insert plan name]. These changes are described in this letter.

How will my monthly premiums change?

Starting January 1, [insert upcoming year], the monthly premium that you pay to [insert plan name] will [increase/decrease] from $____ to $____ OR stay the same at $____.

How will my benefits and costs change?

[Clearly describe all benefit changes, including changes in cost sharing, annual drug cap, drug coverage, and any new benefits that will be offered by the plan in the coming year or that will be covered by Medicare. Also describe any benefits offered in the current year that will no longer be offered by the plan in the upcoming year. When describing benefit changes, do so by comparing the current year benefit with the upcoming year benefit.]

We have enclosed a summary of your benefits, premiums and copays that will be effective January 1, [insert upcoming year]. [M+C organizations: Insert whichever of the two following sentences is appropriate for your circumstance: (1) "Medicare has reviewed and approved the changes in benefits, premiums, and other costs included in this letter and on the enclosed Summary of Benefits" or, (2) "The changes in benefits, premiums, other costs included in this letter and on the enclosed Summary of Benefits are pending Federal approval."] [Cost plans insert the following sentence: Medicare has reviewed the changes in benefits, premiums, and other costs included in this letter and on the enclosed Summary of Benefits"] We will send you an [insert: "Evidence of Coverage" or whichever name is used by your MCO as the name for the EOC] [insert either "by [date]" or "at a later date"]. All changes begin January 1, [insert upcoming year], and will be in effect through December 31, [insert upcoming year]. Rest assured that you will be a member of [insert plan name] for the coming year if you do nothing to change your Medicare coverage.

[If the organization lists more than one plan offering on the enclosed SB, the organization must identify the specific plan in which the member will be enrolled. In addition, if the organization lists only one plan in the SB but offers multiple plans in the service area, the ANOC must notify beneficiaries that additional plans are available and include specific information on how beneficiaries can obtain more information.]

Are there other benefits I can get?

[Include this section if the plan offers optional supplemental benefits.]

[Clearly describe any optional supplemental benefits and the premiums for those benefits. A description of the process that the member must follow to elect optional supplemental benefits must also be included.]

Where can I get more information?

Please call our Member Services Department [insert days and hours of operation], at [insert phone number] if you have any questions. TTY users should call [insert TTY phone number].

You can contact us if you need additional information, including:

- *Information about how we control the use of services and costs;*

[Cost plans do not need to include the remaining three bullets]

- *Information on the number of appeals and grievances filed by our members;*
- *A summary description of how we pay our doctors;*
- *A description of our financial condition, including a summary of our most recently audited statement.*

You can also get information about the Medicare program and Medicare health plans from the www.medicare.gov Web site or by calling 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare customer service representatives are available, 24 hours a day, including weekends, to answer questions about Medicare.

We look forward to serving you now and in the future.

Sincerely,

Plan Representative

ENCLOSURE - Summary of Benefits

40.4.1 - General Guidance on Dual Eligibility

(Rev. 28, 08-01-03)

There are several categories of dual eligibility, each having specific income requirements and providing different levels of financial assistance to those who qualify at that level. The categories are outlined in the following chart:

Additional information is available at http://www.cms.hhs.gov/medicaid/. Income Requirements for Hawaii and Alaska specifically noted. Resource and Income Limits shown below may vary by state; contact the state for specific resource amounts.

Eligibility Category	Monthly Income Requirements	Medicaid Benefits	Provider	Medicaid Liability for Services
QMB only Qualified Medicare Beneficiary without other Medicaid	$*769* – individual $*1,030* – couple Alaska: $*955* –individual $*1,282* – couple Hawaii: $*881* – individual $*1,182* – couple	Medicare premiums, deductibles, and coinsurance. No Medicaid services.	Medicare	QMB rates for Medicare deductibles and coinsurance
QMB Plus Qualified Medicare Beneficiary with Full Medicaid	$*769* – individual $*1,030* – couple Alaska: $*944* – individual $*1,282* – couple Hawaii: $*881* – individual $*1,182* – couple	Medicare premiums, deductibles, and coinsurance. Medicaid services.	Medicare Medicaid	QMB rates for Medicare deductibles and coinsurance Medicaid rates for Medicaid services only.
SLMB only Specified Low-Income Medicare Beneficiary without other Medicaid	$*918* – individual $*1,232* – couple Alaska: $*1,141* – individual $*1,534* – couple Hawaii: $*1,053* – individual $*1,414* – couple	Medicare Part B premiums. No Medicaid services.	Medicare	No liability for Medicare deductibles and coinsurance.

SLMB Plus Specified Low-Income Medicare Beneficiary with Full Medicaid	$*918* – individual $*1,232* – couple Alaska: $*1,141* – individual $*1,534* – couple Hawaii: $*1,053* – individual $*1,414* – couple	Medicare Part B premiums. Medicaid services.	Medicare Medicaid	No liability for Medicare deductibles and coinsurance. Difference between Medicare payment and Medicaid rates for Medicaid services.
QI-1 Qualifying Individuals - 1	$*1,031* – individual $*1,384* – couple Alaska: $*1,282* – individual $*1,725* – couple Hawaii: $*1,183* – individual $*1,589* – couple	Medicare Part B premium.	Medicare	No liability for Medicare deductibles and coinsurance.
QDWI Qualified Disabled and Working Individuals	$*3,078* – individual $*4,125* – couple Alaska: $*3,822* – individual $*5,132* – couple Hawaii: $*3,528* – individual $*4,732* – couple	Medicare Part A premium.	Medicare	No liability for Medicare deductibles and coinsurance.

40.4.2 - Guidelines for Outreach Program

(Rev. 28, 08-01-03)

In order to assure CMS that M+C organizations' outreach programs effectively assist members while protecting them from undue pressures or privacy violations, M+C organizations[13] must adhere to the following guidance.

The M+C organizations MUST:

1. Provide outreach to all levels of dual eligibles, including those levels that do not provide M+C organizations with additional capitation amounts from CMS. All outreach materials (e.g., member letters (see §40.4.5 for a model Direct Mail Letter), telephone scripts) must include eligibility information that includes *the* QI-1 *level*. [See footnote 12 for clarification.]

2. Clarify in outreach materials that the member may voluntarily offer information, including financial information, but that the member is not obligated to provide this information.

3. Clarify in outreach materials and discussions with members that the member's failure to provide information will in no way adversely affect the beneficiary's membership in his or her health plan.

4. State in materials and discussions with members that the M+C organization will not share the information with any other entity not directly associated with determining eligibility or under contract to participate in the outreach process.

5. Clarify in outreach materials that the M+C organization is only providing an initial eligibility screening and that only the appropriate State Agency can make a final eligibility determination.

6. Provide guidance to a member on how to proceed with the application process even if the M+C organization's screening process indicates that the member is probably not eligible for assistance under any of the dual eligibility programs.

7. Provide adequate training to staff conducting the outreach. If the M+C organization subcontracts this effort to another entity, it must ensure that the subcontractor's staff is adequately trained to provide outreach.

8. Include alternate sources of information in *all* outreach materials. Member letters and/or brochures that contain outreach information telephone numbers must also include the telephone number for the State Health Insurance Assistance Program (SHIP) and the appropriate State Agency. Outreach materials may also include the telephone number for the Medicare Service Center (1-800-MEDICARE).

9. Include privacy guidelines in outreach materials, telephone scripts, and internal processes and/or contracts with entities performing outreach for the M+C organization. Contractual privacy guidelines must clearly state that all financial information collected from members of the M+C organization will not be used for any other purpose by the entity collecting the data. Privacy guidelines must also state that entities involved in the outreach will not share member information with anyone not involved in the outreach process.

10. Ensure that contracts with entities taking part in some aspect of outreach activities meet M+C Administrative Contracting requirements listed in the Medicare Managed Care Manual Chapter 11, §100.5.

11. Work closely with CMS' regional office staff during the outreach submission and review process so that CMS can work cooperatively with stakeholders (e.g.,

SHIPs, State Agency) to ensure better education and preparation prior to the outreach process initiation.

12. *Develop contacts with the appropriate State Agency/agencies that determine eligibility and handle eligibility appeals for Medicare Savings Programs.*

The M+C organizations MAY:

1. Conduct outreach for only a portion of its plan membership. Selection of the focus population may be based upon demographic data and/or may focus on a specific geographic area. However, the organizations must provide outreach to all individuals within those pre-identified population segments. Additionally, if the organization receives an inquiry from a Plan member not previously identified in the targeted group, it must provide assistance to that member as if he or she had been included on the outreach list.

2. Provide hands-on assistance to the member in completing all necessary applications for financial assistance including submitting the paperwork to the appropriate State office. This assistance can be in the member's home only if the member requests such a visit.

3. Use the "Authorization to Represent" limited to the specific purposes of completing and submitting paperwork on behalf of the member, discussing the member's case with case workers, representing the member in cases of appeal, and gather information from and on behalf of the Plan member. The "Authorization to Represent" form must specify that the authorization is limited to securing benefits under "the Medicare savings program" or "the Medicaid Program" and cannot extend to other programs unless agreed upon and noted by the member. "Authorization to Represent" shall not give the outreach specialist the authority to sign any documents on behalf of the member nor make any enrollment decisions for the member.

4. Follow-up with members who do not respond to the initial member letter. This follow-up may be in the form of a second and/or third letter or telephone calls. If the member does not respond to the third effort, the M+C organization *must* refrain from contacting the member for at least six months following the last outreach attempt. *If the member requests to be removed from the contact list, the M+C organization may not provide further outreach unless the member requests it.*

5. Provide assistance to members reapplying for financial benefits if and when required to do so by the state agency.

6. Subcontract all outreach efforts to another entity or entities. In such cases, while the M+C organization retains all responsibility for meeting CMS' requirements, it must still submit all documentation to CMS for approval including contracts held

by the subcontractor with all entities related to the program. The M+C organization must also coordinate changes and revisions between the subcontractor and CMS.

The M+C organizations Shall NOT:

1. Conduct door-to-door solicitation or outreach prior to receiving an invitation from the member to provide assistance in his or her home.

2. Share any member information, financial or otherwise, with any entity not directly involved in the outreach process.

3. Store or use member financial information for any purpose other than the initial screening eligibility, the submission and follow-up of an application for benefits, for recertification purposes, and as required by law.

4. Contact any member who has refused outreach assistance or who has not responded to the telephone call or follow-up letter until at least six months following the last outreach attempt.

5. *Contact the member who has requested to be removed from the outreach list.*

6. Infer in any written materials or other contact with the member that the organization has the authority to determine the member's eligibility for state assistance programs.

40.4.3 - Submission Requirements

(Rev. 28, 08-01-03)

To facilitate CMS' review of outreach programs, an M+C organization must submit one copy of the *materials* listed below to its Central Office Plan Manager, one copy to the Regional Office Plan Manager, *one electronic copy to the Dual Eligibility Outreach Product Consistency Team (PCT),* [15] *and the Regional Office Plan Manager.*

1. Detailed description of each step in the outreach process and the entity responsible for each step. (CMS recommends a flow chart showing the result of each action.)

2. Timeline showing the proposed dates of outreach activities, the number of members involved in each activity, and the service area (e.g., county) included in the activities. This is to allow CMS to more accurately coordinate outreach activities with its partners (e.g., SHIP, State Agencies).

3. *Executed c*ontracts with all external entities involved in the outreach process. This includes contracts with any subcontractors taking part in the activities.

4. *Supporting documentation from the appropriate State Agency providing specific state income requirements for each savings program level, and names and contacts within the appropriate State Agency/agencies.*

5. Outreach letters and other materials (e.g., brochures, *Authorization to Represent form*) going to plan members.

6. Internal training programs the organization is using to educate staff involved in outreach.

7. Telephone scripts or other outreach assistance scripts that will guide representatives in answering members' questions or discussing the assistance available to them. Such scripts must include a privacy statement clarifying that the member is not required to provide any information to the representative and that the information provided will in no way affect the beneficiary's membership in the plan.

8. Internal plan for protecting the confidentiality of the member's financial or other personal information gathered in the outreach process.

In some instances, an M+C organization may chose to submit an outreach proposal that CMS has already approved for use by another M+C organization. This is common when an M+C organization is part of a national organization with multiple contracts, each of which is conducting its own outreach. This is also common when a subcontracting entity designs and conducts the outreach. These subcontractors often seek to contract with multiple M+C organizations and conduct the same outreach programs for each of their clients.

If an M+C organization submits an outreach proposal that (a) CMS previously approved on or after April 1, 2002; (b) That CMS approved within the twelve months prior to the submission; and (c) That does not contain substantive changes [14] to qualify it as an "initial" proposal, the M+C organization must submit the items listed above (1 - *8*) in addition to the following:

> An attestation from either the M+C organization or its contracted outreach vendor stating (a) That the proposal has been approved by CMS, (b) The date of that approval, and (c) That the new submission does not contain substantive changes to the approved program.

Section 40.4.4 contains a description of CMS' review process and time frames for both initial and previously approved proposals.

40.4.4 - CMS Review/Approval Process

(Rev. 28, 08-01-03)

NOTE: The CMS review process for new outreach proposals differs from the review process or previously approved outreach proposals. The processes for both submissions are stated below.

Reviewing New Outreach Programs

1. The M+C organization is responsible for submitting the outreach proposal to CMS and working with CMS through the review and approval process even if a subcontractor developed the proposal. The CMS will hold the M+C organization fully responsible for all the provisions of the outreach program and for assuring the members of their rights and protections outlined in the M+C program regulations.

2. In that CMS considers outreach materials to be a form of marketing, CMS will review outreach proposals according to current time frames for reviewing marketing material. The agency will conduct its initial review and provide comments to the M+C organization within 45 days of receipt of a new (not previously approved) proposal.

3. As noted in §40.4.3, M+C organizations must submit one complete copy of the materials listed in §40.4.3 to the CMS Central Office Plan Manager, a second copy of the same materials to the CMS Regional Office Plan Manager, and an electronic copy of the materials to the Dual Eligibility Outreach (PCT)[15]. *If a proposal incorporates states in regions other than those represented above, the PCT ensures that the appropriate Regional Office Plan Manager receives a copy of the proposal for comment from the National Account Representative (NAR) for the state(s).*

   The Dual Eligibility PCT will review all the enclosed documentation in conjunction with the Plan Managers and will provide comments to the Central and Regional Office Plan Managers. The Regional Office Plan Manager will relay CMS comments back to the M+C organization will gather revisions (when necessary) and will finish the review and approval process based upon the M+C organization's revisions.

4. The Regional Office Plan Manager will share outreach materials with the appropriate *NARS and state representatives*. *The NARS and state representatives should, at a minimum, share the member letters with the* State Agency as a way to verify the accuracy of the information contained in the proposal and to receive input from state partners.

5. Upon final approval of the proposal and outreach materials, the Regional Office Plan Manager will send an approval letter to the M+C organization.

6. The Regional *Office* will then contact its partners (SHIPs, State Medicaid Offices, etc.) to notify them of the outreach effort and possible increase in beneficiary inquiries. The Regional office will share copies of outreach letters with the State Agencies to prepare them for incoming questions.

Reviewing Previously Approved Outreach Programs

If an M+C organization submits an outreach proposal that CMS has already approved and that does not contain substantive changes (outlined in §40.4.3), then the CMS Regional Plan Manager*, in conjunction with the appropriate NARs,* will only review the targeted membership information (audience number and outreach dates), the contract(s) between the M+C organization and its outreach subcontractor(s), the updates to benefit levels and income and resource criteria, and the attestation. The CMS will respond to the M+C organization within the 10-day time frame CMS has established for reviewing standardized marketing materials. The CMS' Regional office will file the outreach proposal for future reference. The CMS recognizes that the M+C organization will have to make simple periodic changes to their outreach programs in order to update minimum income levels, etc. As stated previously (*in footnote 14*), CMS does not consider these updates to be "substantive changes" in that they do not prompt a full review of an outreach proposal. However, the M+C organization is still responsible for submitting such changes to the appropriate CMS regional office for marketing review to ensure accuracy of such changes.

If the M+C organization wishes to make substantive changes to the outreach process, it must submit those changes to the appropriate CMS Central Office and Regional Office Plan Managers for review through the PCT according to the review process above.

40.4.5 - Model Direct Mail Letter

(Rev. 28, 08-01-03)

(Data valid for 200*3*)

August 25, 200*3*

Mr. Frank Smith
123 Maple Lane
Anywhere, USA 12345

Dear Mr. Smith,

Did you know you may be able to save up to *$704.40* a year on Medicare expenses?

States have programs that pay some or all of Medicare premiums, may also pay Medicare deductibles and coinsurance, and Medicare health plan premiums. These programs are administered as part of the State Medical Assistance Program.

If you answer "yes" to ALL three of these questions, then you may qualify for Savings for Medicare Beneficiaries.

- Do you have Medicare Part A, also known as hospital insurance? If you are eligible for Medicare Part A, but do not have it because you cannot afford it, you may still qualify because there is a program that will pay the Medicare Part A premium.

- Are you an individual with a monthly income of less than *$1,031* or a couple with a monthly income of less than *$1,384?*

- Are you an individual with savings of $4,000 or less or a couple with savings of $6,000 or less? Savings include things like money in a checking account or savings account, stocks, or bonds. When you are figuring out your savings, do not include your home, a car, burial plots, up to $1,500 for burial expenses, furniture, or $1,500 worth of life insurance.

If you have a disability and lost your Medicare because you returned to work and are eligible to purchase Medicare Part A benefits, you should also apply. To qualify, you must be an individual with a monthly income of less than $3,078 and resources of $4,000 or less. Or, you must be a couple with a monthly income of less than $4,125 and resources of $6,000* or less.*

** Individual states may have more generous requirements.*

Enclosed is a brochure that gives you more information about the programs that can help you save on your medical expenses, information on who qualifies, and how to apply for the programs.

I hope you will call me between 9 a.m. and 5 p.m. Monday through Friday at (your phone number here) for more information or for help joining one of these programs. All information that you share will only be used to determine if you may be able to get help with your medical expenses. I will not share the information with anyone else. I encourage you to call to see if you can receive help with your medical expenses, but the choice is yours. You are not required to call. If you like, you can also receive information about the programs by calling a representative of the State Health Insurance Assistance Program at XXX or a State representative at XXXX. Deaf or hearing-impaired people who use a TTY/TDD can call Medicare's national help line at 1-800-486-2048. When you call, ask about programs that can help with Medicare expenses.

40.5.1 - Summary of Benefits for Medicare+Choice Organizations

(Rev. 28, 08-01-03)

Medicare+Choice organizations and Demonstration projects are required to use a standardized SB.

A. General Instructions

1. *M+C organizations must adhere to the language and format of the standardized SB and are only permitted to make changes if approved by CMS. Changes in the language and format of the SB template will result in the disapproval or delayed approval of the SB.*

2. *The title "Summary of Benefits" must appear on the cover page of the document.*

3. *All three sections of the SB must be provided together as one document and may not be bound separately or placed in a folder in separate sections. M+C organizations may also describe several plans in the same SB package by displaying them in separate columns in the comparison matrix section of the SB.*

4. *Front and back cover pages are acceptable.*

5. *Printing font size of 12-point or larger must be used for the SB (including footnotes).* ***NOTE:*** *Since sections 1 and 2 will not be generated from the PBP in 12-point font, the M+C organization should change the font to ensure that the font size is 12 point. M+C organizations may enlarge the font size and also use bold or capitalized text to aid in readability, provided that these changes do not steer beneficiaries to, or away from any benefit items or interfere with the legibility of the document.*

6. *Colors and shading techniques, while permitted, must not direct a beneficiary to or away from any benefit items and must not interfere with the legibility of the document. There is no requirement regarding the type of paper used.*

7. *It is acceptable to print the SB in either portrait or landscape page format.*

8. *It is acceptable for M+C organizations with multiple plans and PBPs (separate ACRPs) to include more than one plan in the benefit comparison matrix (section 2). However, since the PBP will only print section 1 and 2 reports for one plan, the M+C organizations will have to create a side-by-side comparison matrix for two (or more) plans by manually combining the information into a chart format.*

9. *It is acceptable for M+C organizations to display more than one plan together in the same columns of the benefit comparison matrix, provided all of the benefits are the same and only the service areas are different. Plans may identify the*

*service areas at the top of the plan column of section 2. **NOTE:** if anything beyond the service area is different, the plans must be displayed separately.*

10. *If the SB includes only one of several plans offered, the availability of other plans must be noted in the Annual Notice of Change (ANOC). If the M+C organization lists more than one plan offering, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB.*

11. *If an M+C organization wants to include mandatory supplemental benefits beyond those benefits found in the benefit comparison matrix, the M+C organization must place the information in section 3 of the SB. The M+C organization must include a brief description of the benefits and any copay requirements.*

12. *If an M+C organization includes additional information about covered benefits in section 3, the M+C organization may include a page reference to this information in the appropriate box in the benefit comparison matrix using the following sentence: "See page___for additional information about (Enter the benefit category exactly as it appears in the left column)."*

13. *M+C organizations may include additional information about covered benefits in a separate flyer or other material and mail this with the standardized SB and the Annual Notice of Change Letter.*

14. *Enrollees whose source of enrollment is through an employer-sponsored group are not currently included in the mandated use of the standardized SB for either annual notification or initial marketing purposes.*

B. Section 1 - Beneficary Information Section

1. *This section is incorporated into your SB exactly as it is generated by the PBP. **NOTE:** M+C organizations have the option of indicating at the top of this section a geographic name, for example, "Southern Florida." If used, the geographic name must match the geographic label indicated in the Health Plan Management System (HPMS).*

2. *Section 1, as generated by the PBP, will include the applicable H number and plan number at the top of the document. M+C organizations must delete this information.*

3. *The fourth paragraph (How can I compare my options?) contains a sentence "We also offer additional benefits, which may change from year to year." If this is not applicable to your plan, you must remove this sentence.*

4. *The second question and answer in section 1 includes the plan's service area; the PBP will generate a list of counties, with an * indicating those counties that are partial counties. The M+C organization may list the zip codes of these counties in*

*this section or provide a cross-reference in section 3 and list the zip codes here. The M+C organization must also explain in section 1 that the * indicates a partial county.*

5. *The second question and answer in section 1 lists the plan's service area, but does not indicate that the information listed represents counties. Therefore, the M+C organization must amend the SB so that the answer reads, "The service area for this plan includes the following counties: [list of counties automatically generated by the PBP].*

6. *The last sentence in section 1 on page 2 states, "If you have special needs, this document may be available in other formats." M+C organizations contracting with CMS are obligated to follow the regulatory requirements of the American with Disabilities Act and the Civil Rights Act of 1964. Compliance with these requirements satisfies the intent of the above referenced SB sentence. No additional requirements are imposed by the above referenced SB sentence.*

C. Section 2 - Benefit Comparison Matrix

The SB benefit comparison matrix will be generated by the PBP in chart format with the required language. Therefore, the information included in the PBP must first be correct in order for the SB comparison matrix to be correct. M+C organizations should review the comparison matrix to ensure that all of the information presented is correct. Information presented in the benefit comparison matrix must match the information presented in the PBP, with the exception of the permitted and/or necessary changes discussed below. If any changes are required, the M+C organization must make these changes in the PBP prior to the deadline date for submission of the ACRP, generate a revised SB benefit comparison matrix, and include this matrix in its SB. The CMS reviewers will have the benefit comparison matrix that is generated by the PBP and will compare this with the matrix provided as part of the plan's SB. Any discrepancies between the matrix generated by CMS and that provided by the plan (with the exception of those permitted below) will result in disapproval of the SB.

D. Section 3 - Plan Specific Features

This section is limited to a maximum of four pages of promotional text and graphics and is not standardized with regard to format or content. The 4-page limit means that the information is limited to four single-sided pages or 2 double-sided pages. ***However, there are two exceptions to this limit:***

1. *PPOs will be allowed to use up to two more pages (i.e., for a total of up to six pages) to describe out of network benefits or to describe out of network benefits with the in-network benefits that are described in section 3; and*

2. *When an M+C organization is translating the SB to a foreign language, it may add pages as necessary to ensure the translation matches the English language version.*

Section 3 is used by the M+C organization to describe special features of the M+C organization beyond information contained in sections 1 and 2 of the SB. Section 3 may contain non-standardized language, graphics, pictures, maps, etc.

The M+C organizations may use this section to further describe mandatory and optional supplemental benefits that appear in the benefit comparison matrix. If an M+C organization chooses to do this, they may reference the information in the relevant section of the benefit comparison matrix using the following sentence: "See page___ for additional information about (Enter the benefit category exactly as it appears in the left column.)"

E. Permitted Changes To SB Language and Format

M+C organizations are only permitted to make changes to the benefit matrix or Hard Copy Summary of Benefits on a limited basis. ***Any changes*** *must be approved by CMS. Please refer to the Requests to Change Hard Copy Summary of Benefits for further detail.*

F. Footnotes

The comparison matrix generated by the PBP will not contain the required footnotes. Therefore, the M+C organization must include the following footnotes provided below. Please note that the footnote number must appear in the text of the column and the footnote must appear at the bottom of each page.

NOTE: *For review purposes, the M+C organization can list all of the footnotes at the end of section 2, but the final proof copy must include the footnotes at the appropriate points in the text. If the M+C organization chooses this option, the M+C organization must notify the CMS Regional Office conducting the review and must indicate in the SB where the footnotes will actually appear in the final printed version.*

1. *Each year, you pay a total of one $100 deductible.*

   This footnote must be referenced after every statement in the Original Medicare (OM) column that describes the required Medicare coinsurance, e.g., "You pay 20% of Medicare approved amounts." Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column. This footnote must also appear at the bottom of each page.

2. *If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.*

This footnote must be referenced, where applicable, after every statement in the OM column that describes Medicare benefits and after footnote (1). The text of this footnote must appear at the bottom of each page.

3. *A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.*

4. *This footnote must be referenced after the words "benefit period" in the OM column describing Inpatient Hospital Care and Skilled Nursing Facility and the text of this footnote must appear at the bottom of the page on which these benefits are described. Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column.*

Lifetime reserve days can only be used once.

This footnote must be referenced after the statement, "Days 91-150: $ (The Medicare amount may change each year) each lifetime reserve days" in the OM column describing Inpatient Hospital Care. Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column. The text of this footnote must appear at the bottom of the page on which these benefits are described.

50.1.2 - Referral Programs

(Rev. 28, 08-01-03)

The following general guidelines apply to referral programs under which health plans/M+C organizations solicit leads from members of new enrollees. These include gifts that would be used to thank members for devoting time to encouraging enrollment. Gifts for referrals must be available to all members and cannot be conditioned on actual enrollment.

- *Health plans/M+C organizations may not use cash promotions as part of a referral program.*

- *Health plans/M+C organizations may offer thank you gifts of less than $15 nominal value (e.g., thank you note, calendar, pen, key chain) when an enrollee responds to a health plan/M+C organization solicitation for referrals. These thank you gifts are limited to one gift per member, per year.*

- *A letter sent from the health plan/M+C organization to members soliciting leads cannot announce that a gift will be offered for a referral.*

50.1.3.3 - Allowable Actions for Medicare + Choice Organizations

(Rev. 28, 08-01-03)

Medicare + Choice Organizations may do the following:

- Assist in the planning of local Health Fairs;
- Distribute health plan brochures and *application forms*, while at the Health Fair.[17] They may also include in their handouts a reply card which may be given to interested beneficiaries for return to the organization via mail;
- Have a booth at the Health Fair;
- Distribute items with a total retail value of no more than $15. These items MUST be offered to everyone, (e.g., organizations can not give gifts to only those individuals who show interest;
- Have any personnel present (i.e., marketing personnel, customer service personnel) as long as they adhere to these guidelines;
- Contribute funding for any Health Fair costs (i.e., purchasing of food; drawings, raffles, or door prizes for attendees which exceed the $15 nominal value requirement) as long as the recognition of the donation is to a number of entities (not just one particular M+C organization); and
- Market multiple lines of business in Medicare + Choice.

Medicare+Choice Organizations may not do the following:

- Give sales presentations;
- Collect enrollment applications. (Although *application forms* may be distributed, they may not be collected during CMS-sponsored Health Fairs);
- Collect names/addresses of potential enrollees. However, as noted above, they may distribute *application forms* and reply cards;
- Compare their benefits against other health plans. However, they may use comparative information which has been created by CMS (such as information from CMS' Web site) or information/materials which have been approved by CMS (i.e. the standardized Summary of Benefits);
- Third party created materials may not be used, unless they have been approved by CMS in advance; and

- Give individual gifts with a retail value of more than $15.00.

50.3 - Specific Guidance About the Use of Independent Insurance Agents

(Rev. 28, 08-01-03)

The CMS recognizes that independent insurance agents can provide a necessary service to Medicare beneficiaries and potential enrollees. They can also be a valuable resource in helping to reach low-income and rural populations, persons with disabilities, and other special populations. Therefore, CMS urges health plans/M+C organizations to consider requiring specific cost/M+C training for their contracted agents. This will ensure that appropriate information is being delivered to Medicare beneficiaries and potential enrollees.

Please note that CMS is aware that sales by independent insurance agents are typically tied to compensation, and that agents are often given incentives to steer enrollees towards the carrier offering the most compensation. Further, independent insurance agents may be in a unique position to "cherry pick," given their often longstanding relationships with clients. Additional operational guidelines to address these concerns will be forthcoming.

50.4 - Answers to Frequently Asked Questions About Promotional Activities

(Rev. 28, 08-01-03)

1. **Q** - We purchased books on health maintenance that we plan to give away to anyone attending one of our marketing presentations, regardless of whether or not they enroll in our health plan/M+C organization. Because we purchased a large number of these books, we were able to buy them at a cost of $14.99 per book. However, on the inside jacket, the retail price is shown as $19.99. May we give these books away at our marketing presentation?

   A - No. The retail purchase price of the book is $19.99, which exceeds CMS' definition of nominal value.

2. **Q** - We are participating in a health fair during which we will have marketing staff present. During the fair, we will offer a number of free health screening tests to people who attend. The value of these tests, if purchased, would be considerably more than $15. Is this permissible?

   A - No. You may not offer these tests for free because their value exceeds CMS' definition of **nominal** value.

3. **Q** - At our health plan/M+C organization, we offer gifts of nominal value to people who call for more information. We then offer additional gifts if they come

to marketing events. Each of the gifts meets CMS' definition of nominal value, but taken together, the gifts are more than nominal value. Is this permissible?

A - Yes.

4. **Q** - Listed below are some possible promotional items to encourage people to attend marketing presentations. Are these types of promotions permissible?

    - Meals
    - Day trips
    - Magazine subscriptions
    - Event tickets
    - Coupon book (total value of discounts is less than $15)

    A - **Yes**. All these promotional items are permissible as long as they are offered to everyone who attends the event regardless of whether or not they enroll and as long as the gifts are $15 or less. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount.

5. **Q** - Can a health plan/M+C organization advertise eligibility for a raffle or door prize of more than nominal value for those who attend a marketing presentation if the total value of the item is less than $15 per person attending?

    A - No. You cannot have a door prize of more than nominal value. Such gifts or prizes are prohibited by CMS. However, the raffle or door prize can exceed the $15 limit if the M+C organization is jointly sponsoring the prize with other health plans/M+C organizations at a health fair. See §50.1 for a discussion of rules pertaining to health fairs.

6. **Q** - What about post-enrollment promotional activities? Are there any rules prohibiting such items or activities as coupon books, discounts, event tickets, day trips, or free meals to retain enrollees?

    A - Currently, the Medicare Managed Care Manual states that health plans/M+C organizations may not offer post-enrollment promotional items that in any way compensate beneficiaries for lower utilization of services. Any promotional activities or items offered by health plans/M+C organizations, including those that will be used to encourage retention of members, must be of nominal value, must be offered to all eligible members without discrimination, and must not be in the

form of cash or other monetary rebates. The same rules that apply to pre-enrollment promotional activities apply to post-enrollment promotional activities.

7. **Q** - Can health plans/M+C organizations provide incentives to current members to receive preventive care and comply with disease management protocols?

   A - Yes, as long as the incentives are:

   - Offered to current members only;
   - Not used in advertising, marketing, or promotion of the health plan/M+C organization;
   - Provided to promote the delivery of preventive care; and
   - Are not cash or monetary rebates.

   NOTE: If these products are in the CMS approved contracted health plan/M+C organization benefit package (ACR and PBP) under "Preventive Services," the provision of such incentives are within the purview of the medical management philosophy of the M+C organization and do not require additional review by CMS for marketing accuracy/compliance. The nominal value rule **does not** apply.

8. **Q** - Can a health plan/M+C organization offer reductions in premiums or enhanced benefits based on the length of a Medicare beneficiary's membership in the health plan/M+C organization?

   A - No. Longevity of enrollment is not a basis for reductions in premium or enhanced benefits. [18]

9. **Q** - Can a health plan/M+C organization provide discounts to beneficiaries who prepay premiums for periods in excess of 1 month?

   A - No. Health plans/M+C organizations cannot provide any discounts to Medicare beneficiaries for prepayment of premiums in excess of 1 month.

10. **Q** - Can a health plan/M+C organization take people to a casino or sponsor a bingo night at which the member's earnings may exceed the $15 nominal value fee?

    A - No. The total value of the winnings may not exceed $15 and the winnings **cannot be in cash or an item that may be readily converted to cash**.

11. **Q** - Can M+C organizations send a $1 lottery ticket as a gift to prospective members who request more information?

A - Offering a $1 lottery ticket to prospective members violates the "no cash or equivalent" rule discussed above, whether or not the person actually wins since, generally, the "unscratched" ticket has a cash value of $1.

12. **Q** - Can *health plans/M+C organizations* pay beneficiaries that sign up to be "ambassadors" a flat fee for transportation?

    A - *The health plan/M+C organization may reimburse the beneficiary for any actual, reasonable transportation costs but must not pay the beneficiary a flat fee for transportation.* If the health plan/M+C organization employs a beneficiary to be an "ambassador" and travel reimbursement is part of the employment compensation, then CMS has no oversight over this issue.

13. **Q** - Can M+C organizations hold marketing presentations in clinics or hospitals?

    A - Yes, marketing presentations are allowed in clinics, hospitals or physicians offices (or other health care delivery locations) provided that the presentations are held in common areas (i.e., community or recreational rooms) and that patients being treated at the facility are not coerced in to attending.

14. **Q** - Can *health plans/M+C organizations* that own nursing homes conduct health fairs and distribute enrollment forms to nursing home residents?

    A - Yes, organizations that own nursing homes may conduct health fairs and distribute enrollment forms if the sales presentations are confined to a common area (i.e., community or recreational rooms) or if a member volunteered for an individual presentation. Promotional activities and sales presentations cannot be made in individual resident rooms without a prior appointment for a "home" visit. Such activities would be considered door-to-door solicitation and are prohibited. The organization is required to meet all health fair/sales presentation and enrollment requirements as currently outlined in *this chapter* and regulations.

15. **Q** - What information should an active member be asked to release to a health plan/M+C organization concerning a potential member lead?

    A - The health plan/M+C organization can ask for referrals from active members, including names and addresses, but cannot request phone numbers. Health plans/M+C organizations can then use this information for soliciting by mail.

16. **Q** - Can physician groups that contract with health plans/M+C organizations hire marketing firms to cold call from non-health plan/M+C organization member listings?

    A - Yes, as long as the marketing guidelines for provider marketing are followed.

60.2 - Marketing of Multiple Lines of Business

(Rev. 28, 08-01-03)

M+C organizations may market multiple lines of business in accordance with the following.

Direct mail: Direct mail *health plan/M+C organization* marketing materials sent to current members describing other lines of business should contain instructions describing how individuals may opt out of receiving such communications. *Health plan/M+C organizations* may apply this opt-out provision on an annual basis. *Health plan/M+C organizations* should make reasonable efforts to ensure that all individuals (including non-members) who ask to opt out of receiving future marketing communications, are not sent such communications.

NOTE: *These instructions regarding "opting out" of receipt of direct mail apply only to information that does not require prior authorization, as discussed in §60.2.1.*

With one exception (mentioned below), *health plans/M+C organizations* may advertise multiple lines of business in direct mail marketing materials within the same document as the one that is advertising the *plan* product, as long as the non-*plan* lines of business are clearly and understandably distinct from the *plan* product. For example, the document might highlight the name of the plan product in bold and underlined font and then include a paragraph to describe the product in "regular" font, then it would go on to highlight the name of a Medigap product in bold and underlined font followed by a paragraph describing the Medigap product in "regular" font. Please keep in mind that the direct mail materials advertising multiple lines of business still should allow the beneficiary the choice of opting out of receiving future notices about non-M+C products. Also, if a *health plan/M+C organization* advertises non-*plan* products with a *plan* product, it must pro-rate any costs so that costs of marketing non-*plan* products are not included as "plan-related" costs on Adjusted Community Rate (ACR) proposal submissions.

Organizations that offer more than one type of Medicare+Choice products (HMOs, PPOs) may market all of the products as a "family of products." In this case, the marketing materials must clearly distinguish between the type of product, eligibility requirements, how to obtain services (lock-in, preferred vs. non-preferred benefits), and any out-of-pocket maximums, and specify the benefits to which they apply. Furthermore, multiple product advertising may only be conducted in areas where those products share service areas. We recognize that service areas may not perfectly align. When this occurs, the M+C organization should make a reasonable effort to market the "family of products" only in counties that all products share.

Direct Mail **Exception**

While *health plans/M+C organizations* may mention non-*plan* lines of business at the time they send a plan nonrenewal notice, they may only do so using separate enclosures

in the same envelope. *Health plans*/M+C organizations *must* not include mention of the non-*plan* lines of business within the actual nonrenewal notice. The purpose of this exception is to ensure that the nonrenewal notice gives beneficiaries focused information only about the *plan* nonrenewal.

Health plans/M+C organizations must not include enrollment *applications* for non-*plan* lines of business in any package marketing its M+C products, as beneficiaries might mistakenly enroll in the other option thinking they are enrolling in a *health plan/M+C organization*. Also, if information regarding *cost*/M+C products and non-plan lines of business are included in the same package, postage costs must be prorated so that costs of marketing non-*plan* products are not included as "plan-related" costs on ACR proposal submissions.

Television: Health plans/M+C organizations may market other lines of business concurrently with plan products on television advertisements, as long as those products are separate and distinct from the plan product.

Internet: Health plan/M+C organizations may market other lines of business concurrently with *plan* products on the Internet, though to avoid beneficiary confusion, *the health plan/M+C organization* must continue to maintain a separate and distinct section of their Web site for plan information only.

The CMS will review the M+C organization's Web pages to ensure that M+C organizations are maintaining the separation between M+C plan information and information on other lines of business.

Endnotes

(Rev. 28, 08-01-03)

[1] The primary CMS/health plan contractual frame of reference in *Chapter 3* is *of a Medicare+Choice organization offering a* coordinated care plan. Where applicable, alternative language is provided for cost *plans* as well as scenarios involving the point-of-service (POS) and Visitor Program features which may be applicable for M+C an/or cost *plans*.

[2] The guidelines throughout this document apply to Medicare + Choice Organizations (M+C organizations) as well as Section 1876 of the Act cost contractors unless stated otherwise. Therefore, for ease of review and reference, the term "health plan" is used throughout the document to include requirements specific to both Medicare + Choice Organizations and §1876 cost contractors.

[3] See §30 of the chapter for specific application requirements for Outdoor Advertising (ODA.).

[4] Under M + C, individuals who are not already member - those that are grandfathered in - must have both Parts A and B of Medicare in order to eligible for enrollment.

[5] The health plan/M+C organization must be sure to offer adequate explanation of Medicare card use with out-of-plan utilization that is not an emergency or an urgently-needed service.

[6] Note to health plan/M+C organization - CMS has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in health plan/M+C organization operations.

[7] Note to health plan/M+C organization - A member of the health plan/M+C organization may use a superlative in relating their personal experience with the health plan/M+C organization so long as the testimonial is preceded with the phrase "in my opinion" (e.g., "I have been with the health plan/M+C organization for 10 years and in my opinion they have given me the best care possible.") If the member does not preface the superlative statement with the "in my opinion" phrase, the member must substantiate the statement with an acceptable qualifying information source.

Note 8 has been deleted.

[9] In accordance with *Chapter 3*, this information should be provided in at least 12-point font size.

[10] The M+C organizations may choose to disseminate an errata sheet or addendum during the year to update members with respect to changes in provider's addresses and phone numbers. However, in accordance with 42 CFR 422.111(c), M+C organizations must make a good faith effort to disclose any changes to the provider information upon request and, under 422.111(e), must make a good faith effort to provide written notice at least 30 calendar days before the termination effective date. M+C organizations should consult the M+C regulations for further information.

[11] In accordance with *Chapter 3*, the applicable TDD/TTY number must also be provided, including the hours of operation.

[12] The CMS' monthly capitation rate to an M+C organization for a plan member is higher for an enrollee who is a Medicaid recipient because, statistically, the Organization incurs higher medical costs due to higher utilization than that of a non-Medicaid recipient. However, *because CMS created the QI-1 category of Medicaid recipients after it established the standard monthly payment upon which it bases all capitation payments,* CMS *policy is to* not pay the Medicaid adjustment factor for *this group*.

[13] *Since health plans/M+C organizations are primarily responsible for conducting outreach, Chapter 3 has been written targeting that audience.* However, if the *health plan/M+C organization* contracts with another entity for any part of this outreach, the contracting entity must abide by *Chapter 3* as well.

[14] The CMS considers the following to be examples of substantive changes to an outreach program that would make the proposal and/or attached member materials an "initial" proposal: changes to the steps involved in the outreach process, changes to the language in the outreach letters, revisions to the telephone scripts, changes to the network of subcontractors participating in the outreach efforts, etc. CMS considers the following to be examples of changes allowable without designating the proposal as "initial": contact telephone numbers, letterhead, mailing dates and targeted member numbers, updates to income and resource criteria and benefit levels as updated by the State.

[15] *Outreach proposals should go to the PCT Lead, Ann Knievel, CMS San Francisco Regional Office, 75 Hawthorne Street, Suite 401, San Francisco, CA 94105; phone: 415-744-3625; fax:415-744-3761; Aknievel@cms.hhs.gov.*

[16] Section 1851(e)(3) of the Act and 42 CFR 422.10(b).

[17] An *application form* may be either:

1. A specifically designed enrollment application form which is attached to health plan/M+C organization marketing materials; or

2. A standard health plan/M+C organization enrollment application form with instructions that the form must be mailed back to the health plan M+C organization.

The key feature of the *application form* is that it must be completed by the beneficiary in the absence of health plan/M+C organization marketing influences and returned to the health plan/M+C organization by mail. (Self-addressed, postage paid, return envelopes may be provided by the health plan/M+C organization.).

[18] This "no" statement also applies to "zero" premium plans that might want to award a nominal value gift as a reward for longevity of enrollment.