CMS Manual System

Pub. 100-16 Medicare Managed Care

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

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I. SUMMARY OF CHANGES:

Table of Contents - New sections 20.4, 30.1, and 30.4 are added. Also, sections 30 through 30.3.5 are renamed because material was moved from other sections into these sections and/or the section is renamed. Sections 40 through 40.1.2 are renamed.

Section 10 – Introduction - Guidance on plan name requirements is moved from old section 30.1 to this section. Note regarding Internet marketing is moved from old section 30.1 to this section. Reference to Endnote 1 at the end of first sentence is deleted because the note is deleted.

Section 20 - Marketing Review Process - Requirement regarding approved materials is moved from section 30.1 to this section. New language specifies that CMS does not edit marketing materials for grammatical or spelling errors when conducting a marketing review. Guidance on marketing materials in non-English language or Braille is moved from old section 30.1 to this section.

Section 20.2 - Employer Group Marketing Review Process - Language is added to clarify that the waiver of review of employer group marketing materials applies to all employer group marketing materials, including materials used to disclose the information required at 42 CFR 422.111.

Section 20.4 – Time Frames for Marketing Review - This new section describes the 45-day and 10-day marketing review time frames. This information was previously contained in section 20.

Section 30 – Guidelines for Advertising and Pre-Enrollment Materials - An introduction is added for this section. Guidance on marketing to members of former plans is moved from old section 30.1 to this section. In addition, the section title is changed from “Guidelines for Advertising Materials.”

Section 30.1 – Guidelines for Advertising Materials - This new section is added to establish new requirements for advertising materials that significantly reduce the number and type of disclaimers/disclosures required for ads. Requirements are also reduced for what must be included in ads if study results are included. **NOTE**: If an organization chooses to remove any no-longer required disclaimers/disclosures from its advertisements, and makes no other changes to the advertisements, then the ad need not be sent in to CMS for prior approval. However, once changes are made, the M+C organization must send a copy of the version being used to the M+C organization’s Regional Office for its files.

Section 30.2 - Guidelines for Pre-Enrollment Materials - This material was previously contained in section 30.1 and is reorganized. New requirements for Preferred Provider

Organizations (PPO) are added. A new requirement regarding availability of alternative formats is added. Some requirements are moved to other sections of Chapter 3.

Section 30.3 – Pre-Enrollment Minimum Information Requirements - The material was previously contained in section 30.2.

Section 30.3.1 - Lock-In Requirements/Selecting a Primary Care Physician - How to Access Care in an HMO - The material was previously contained in Section 30.2.1.

Section 30.3.2 - Emergency Care (Cross References to QISMC 2.3.17) - The material was previously contained in section 30.2.2.

Section 30.3.3 - Urgent Care - The material was previously contained in section 30.2.3.

Section 30.3.4 - Appeal Rights - The material was previously contained in section 30.2.4.

Section 30.3.5 - Benefits and Plan Premium Information - The material was previously contained in section 30.2.5.

Section 30.4 – "Must Use/Can't Use/Can Use" Chart - The material was previously contained in section 30.3. Requirements on when certain disclaimers are required is revised. References regarding whether the guidelines applied to "all media" or specific media are removed. Language is added to clarify that under the "lock-in" statement Medicare cost plans must explain that members may use plan and non-plan providers. Language is added to explain the benefit/cost sharing differentials between use of plan and non-plan providers. Language is added to clarify that the chart does not indicate when a particular topic must be included in marketing materials. Instead the chart provides guidance on language use when the topic is included on a particular marketing piece. Can and Can't Use terms for PSOs that had previously been in section 30.1 are added to this section.

Section 40 - Guidelines for Post-Enrollment Materials - "Post-enrollment materials" are defined. Guidance on use of member lists is moved from old section 30.1 to this section.

Section 40.1 – General Guidance for Post-Enrollment Materials - Many of the disclaimer requirements in old section 30.1 applied to post-enrollment materials are moved to this section. Language is added to clarify which disclaimers apply to post-enrollment materials. New requirement regarding disclosure in the Evidence of Coverage (EOC) of availability of the EOC in alternative formats is added. **NOTE:** This new requirement is voluntary for 2004 EOCs, but required for 2005 EOCs.

Section 40.1.1 – Use of Model Post-Enrollment Materials - Section title is changed from "Use of Model Beneficiary Notification Materials." Definition is removed because it is contained within Section 40.

Section 40.1.2 – Use of Standardized Post-Enrollment Materials - Grammatical changes are made and a reference to the standard SB in section 40.4 is provided.

Section 40.1.3 - Model Annual Notice of Change ANOC) - Language added to update requirements to state that if there are no Medicare changes <u>or</u> plan changes taking effect on January 1 of the upcoming year, the organization does not need to send an ANOC or

SB to employer group enrollees. This guideline was provided by memorandum to all M+C organizations on September 27, 2002.

Section 40.4.2 - Guidelines for Outreach Program - The requirement that organizations must clarify in outreach materials, including member letters, that the Medicare Savings Programs are part of either the “State Medicaid Program” or “State Medical Assistance Programs” is added.

Section 40.5.1 - Summary of Benefits for Medicare+Choice Organizations - Requirements for Section 3 of the SB to change maximum number of pages from four to six is updated. Also language is removed allowing PPOs to have six additional pages for out-of-network benefits. The change from four to six pages will apply to all Medicare cost plans and M+C organizations, which includes PPOs.

Section 50.2 – Specific Guidance about Provider Promotional Activities - Language is added to clarify that the requirements throughout Chapter 3 apply to provider marketing. A suggestion is made to organizations to include language in their provider contracts requiring providers to follow CMS marketing guidelines when they market for the plan.

Section 60.1.2 – Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations - Disclaimer requirements for VAIS on marketing materials is streamlined.

Endnotes - Endnote 3 is deleted.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 31, 2003

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)

(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 3 / Table of Contents
R	Chapter 3 / 10 / Introduction
R	Chapter 3 / 20 / Marketing Review Process
R	Chapter 3 / 20.2 / Employer Group Marketing Review Process
N	Chapter 3 / 20.4 / Time Frames for Marketing Review
R	Chapter 3 / 30 / Guidelines for Advertising and Pre-Enrollment Materials
N	Chapter 3 / 30.1 / Guidelines for Advertising Materials
R	Chapter 3 / 30.2 / Guidelines for Pre-Enrollment Materials
R	Chapter 3 / 30.3 / Sales Package Minimum Information Requirements

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Chapter 3 / 30.3.1 / Lock-In Requirements/Selecting a Primary Care Physician - How to Access Care in an HMO
N	Chapter 3 / 30.3.2 / Emergency Care (Cross References to QISMC 2.3.17)
N	Chapter 3 / 30.3.3 / Urgent Care
N	Chapter 3 / 30.3.4 / Appeal Rights
N	Chapter 3 / 30.3.5 / Benefits and Plan Premium Information
N	Chapter 3 / 30.4 / "Must Use/Can't Use/Can Use" Chart
R	Chapter 3 / 40 / Guidelines for Post-Enrollment Materials
R	Chapter 3 / 40.1 / General Guidance for Post-Enrollment Materials
R	Chapter 3 / 40.1.1 / Use of Model Post-Enrollment Materials
R	Chapter 3 / 40.1.2 / Use of Standardized Post-Enrollment Materials
R	Chapter 3 / 40.1.3 / Model Annual Notice of Change
R	Chapter 3 / 40.4.2 / Guidelines for Outreach Program
R	Chapter 3 / 40.5.1 / Summary of Benefits for Medicare+Choice Organizations
R	Chapter 3 / 50.2 / Specific Guidance about Provider Promotional Activities
R	Chapter 3 / 60.1.2 / Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations
R	Chapter 3 / Endnotes

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Medicare Managed Care Manual

Chapter 3 - Marketing

Last Updated - Rev. 35, 10-31-03

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10 - Introduction

(Rev. 35, 10-31-03)

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

This chapter is organized as follows:

Section 20 -- Guidance on the marketing review process;

Section 30 -- Guidelines for advertising and other pre-enrollment materials;

Section 40 -- Guidelines for post-enrollment (beneficiary notification) materials;

Section 50 -- Guidelines on promotional activities, including health fairs and sales presentations; and

Section 60 -- Guidelines for other marketing activities, such as marketing value added items and services and multiple lines of business.

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.

NOTE: *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, pre-enrollment, and post-enrollment activity) the health plan/M+C organization pursues via the Internet. The specific requirements that apply depend on the type of material. For example, the advertising guidelines in §30.1 would apply to postings on the Internet that fall within the definition of advertising.*

The following are requirements regarding the establishment of a name for a M+C plan:

1. *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, 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, the CMS will allow the "grandfathering" of M+C plan names established before the final rule took effect (i.e., before June 29, 2000).*

2. *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."*

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20 - Marketing Review Process

(Rev. 35, 10-31-03)

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.

Marketing materials, once approved, remain approved until either the material is altered by the organization or conditions change such that the material is no longer accurate. The CMS may, at any time, require an organization to change any previously approved marketing materials if found to be inaccurate, even if the original submission was accurate at the time.

The CMS reviews marketing materials according to 42 CFR 422.80(c)(4), to ensure that the marketing materials "are not materially inaccurate or misleading or otherwise make material misrepresentations." This means that CMS does not disapprove marketing materials based on typographical or grammatical errors. It is the organization's decision to maintain professional excellence by producing marketing materials that do not contain typographical or grammatical errors.

Review of Marketing Materials in non-English Language or Braille

For marketing with materials that contain non-English or Braille information (in whole or in part), 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 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 in other regions provided that organizations submit attestation letters to each region vouching that the non-English or Braille version contains the same information as the English language version.

Marketing Material Identification Systems

*The following requirement applies to all marketing pieces **except** television and radio ads, outdoor advertisements, and banner/banner-like ads.*

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.

20.2 - Employer Group Marketing Review Process

(Rev. 35, 10-31-03)

Under the authority granted in §617 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, CMS has waived all M+C organizations from having to follow the requirements under 42 CFR 422.80(a) for employer group members. This means that M+C organizations need not have CMS pre-approve marketing materials prepared by M+C organizations designed for members of employer groups. The waiver does not include waiving the *disclosure* requirements at 42 CFR 422.111, which outline what information must be provided to members annually and at the time of enrollment. *While M+C organizations do not need to have employer group materials pre-approved under this waiver, they still must disclose the information at 42 CFR 422.111(b) to all members (e.g., plan benefits, prior authorization rules, grievance and appeals procedures, etc.)*.

The CMS will assume that M+C organizations have chosen to use this waiver unless we hear otherwise from the M+C organization. All M+C organizations will be required to send informational copies of employer group-specific marketing materials to the Regional Office/lead region within 14 days of their release/use. (Regional Offices will not be reviewing these materials; instead, they will keep them on file in the event any inquiries are received about them.)

The M+C organization assumes responsibility for the accuracy of the employer group marketing materials, including making any corrections to those materials when necessary. The M+C organization is expected to continue to follow the guidelines within this chapter when preparing its marketing materials. In the unusual circumstance of an

organization knowingly releasing/distributing incorrect or false marketing materials, sanctions, and or/fines may be imposed on that organization.

20.4 – Time Frames for Marketing Review

(Rev. 35, 10-31-03)

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 *health plan*/M+C organization unless such materials have been submitted to the CMS at least 45 days prior to distribution and the 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 the CMS. Guidelines for CMS review are further described at 42 CFR 422.80(c) for M+C organizations and 417.428(a) for cost plans.

While not required to do so by law, the CMS will make every effort to review materials prepared by cost plans within 10 days if they have followed CMS' cost plan model language without modification. However, while the CMS will try 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 the CMS since, by law, 45 days must pass before the material may be deemed approved.

Exception to the 45-day marketing review rule:

- **M+C Organization Exception:** When an M+C organization follows CMS model language without modification, the 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.

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 *M+C* organization's Evidence of Coverage (EOC) cannot be approved until *the* organization's Adjusted Community Rate (ACR) is approved. If an *M+C* organization submits *an* EOC *that follows the CMS model without modification* for review early in the year (prior to ACR approval), the Regional Office 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 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.

30 - Guidelines for Advertising *and Pre-Enrollment* Materials

(Rev. 35, 10-31-03)

The guidelines in this section apply to all advertising and pre-enrollment materials. The section is divided into four subsections:

30.1 -- Provides guidelines on advertising materials;

30.2 -- Provides guidelines on pre-enrollment materials;

30.3 -- Provides minimum information requirements for sales packages; and

30.4 -- provides the "Must Use/Can't Use" chart.

Guidelines for post-enrollment materials (beneficiary notification materials -- member handbooks, member letters, etc.) are addressed in §40.

Please note that health plans/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 marketing does not begin until after the date the beneficiary has received the plan termination letter. Some disclosures are required on pre-enrollment materials – refer to §30.2.A, Item #8.

30.1 - Guidelines for Advertising Materials

(Rev. 35, 10-31-03)

Advertising materials can be defined as materials that are primarily intended to attract or appeal to a potential enrollee. They are intended to be viewed quickly by a potential enrollee and are short in length/duration. Specifically, these advertisements are:

- *Television ads;*
- *Radio ads;*
- *Banner/banner-like ads;*
- *Outdoor advertising;*
- *Direct mail;*
- *Print ads (newspaper, magazine, flyers, etc.); and*
- *Internet advertising.*

This section outlines requirements for these types of advertisements.

The following definitions apply to some of the ads addressed in this section:

- ***Outdoor Advertising (ODA):*** *The 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.). The ODA is designed to catch the attention of a person and influence them to call for detailed information on the product being advertised.*

- ***Banner 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.*

- ***Banner-like Advertisements:*** *A "banner-like" advertisement can be ODA and is usually in some media other than television, is intended to be very brief, to 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.*

The following guidelines apply to advertisements:

A. Language Requirements

1. ***Disclaimers/Disclosures:***

    a. *For banner ads, banner-like ads and ODA, health plans/M+C organizations are not required to include* ***any*** *disclaimers or disclosures (e.g., lock-in and premium information) on the ads.*

    b. *For all other advertising materials not listed in"a" above, health plans/M+C organizations must include the statement that the organization contracts with the Federal government. Refer to the Must Use/Can't Use/Can Use chart in §30.4 for statements the organization may use.*

       If the material references benefits/cost sharing, and is being used under the streamlined review process addressed in §20.3, then the material must also include the disclaimer that the benefits/cost sharing is "pending Federal approval." With one exception for certain materials (see c. below), no other disclaimers or disclosures (e.g., lock-in and premium information) are required for these advertising materials.

    c. *In addition to the disclaimers required in b. above, flyers and invitations to sales presentations that are used to invite beneficiaries to attend a group session with the intent of enrolling those individuals attending must also include the following two statements:*

        - *"A sales representative will be present with information and applications"; and*

- *“For accommodation of persons with special needs at sales meetings, call [insert phone number].”*

2. ***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.*

3. ***TTY Numbers:*** *With the exceptions listed below, TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. Health plans/M+C organizations can use either their own or State relay services, as long as the number included is accessible from TTY equipment.*

   Exceptions:

   - *TTY numbers need not be included on ODA and banner/banner-like ads or in radio ads that include a telephone number; and*
   - *With respect to television ads, the TTY number need not be the same font size/style as other phone numbers since it may result in confusion and cause some prospective enrollees to call the wrong phone number. Instead, health plans/M+C organizations are allowed to use various techniques to sharpen the differences between TTY and other phone numbers on a television ad (such as using a smaller font size for the TTY number than for the other phone numbers).*

4. ***Reference to Studies or Statistical Data:*** *Health plans/M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, cost, etc. as long as specific study details are given. At a minimum, study details that need to be included are the source and dates. (**NOTE**: When submitting the material to CMS for review, the organization must provide the study sample size and number of plans surveyed for review purposes). The 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 of the organizations included in the study. 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.*

5. ***Physicians and Other Health Care Providers:***

   a. *If the number of physicians and other health care providers is used in an ad, the ad must include only those physicians and providers available to Medicare beneficiaries. (Medicare cost plans may annotate in materials that members may obtain services from any Medicare provider.)*

b. *For print ads and direct mail materials:*

   1. *If a total number of physicians and providers is used in the ad, it must separately delineate the number of primary care providers and specialists included; and*

   2. *If the M+C organization uses the name and/or picture of providers and/or facilities to market itself, the provider information may only be used within the context of informing beneficiaries of providers that are associated with the M+C organization's delivery system.*

6. ***Preferred Provider Organizations (including PPO Demonstrations) Only:***

   The following requirements only apply to Internet ads, brochures, and direct mail pieces. They do not apply to television and radio ads, ODA, and banner/banner-like ads.

   - ***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 available from non-preferred providers.*

   - ***Cost Savings Described in Marketing Materials:*** *If a PPO states in marketing materials that prospective enrollees may save money if they join the plan, it must acknowledge the added cost of accessing services out-of-network and/or that using services in-network can cost less than using services out-of-network.*

B. Formatting Requirements

1. ***Font Size Rule:*** *With the exception listed below, for all written advertising materials* footnotes and any text appearing in the advertisement 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 organization. The text size is left to the discretion of the organization and can be smaller than size 12-point font, but the commercial message and footnotes must be the same size font.

   Exception:

   - *Information contained in brochures and direct mail pieces must be no smaller than Times New Roman 12-point or equivalent font. More detail on this requirement is contained in §30.2.*

   - *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 normally used by the newspaper for its Public Notices section.*

30.2 - Guidelines for Pre-Enrollment Materials

(Rev. 35, 10-31-03)

"Pre-enrollment" materials are materials that health plans/M+C organizations use to promote the plan and to increase plan membership. These materials provide more detail on the plan (e.g., plan rules, plan benefits, etc.) than what is provided in an advertisement. Pre-enrollment materials include both sales and enrollment materials, including the following types of materials:

- *Product descriptions used in the sales/enrollment process -- enrollment booklets, sales kits, etc.; and*
- *Sales scripts, sales presentations, etc.*

NOTE: *There are other enrollment-related documents that are usually included in sales packages -- such as enrollment applications and the Statement of Understanding. Requirements and models for these documents are addressed in Chapter 2.*

NOTE: *While the SB could be viewed as both a pre- and post-enrollment material, we have placed instructions regarding these documents in the post-enrollment section since, at a minimum, it must be sent to current enrollees. Instructions on the SB can be found at* *§40.5*.

The following guidelines apply to pre-enrollment materials:

A. Language Requirements

1. **Lock-In Statement:** The concept of "lock-in" must be clearly explained in all *pre-enrollment* materials. For marketing pieces *that* 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 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 Private Fee-For-Service Plan (PFFS) *or PPO*.

   For Medicare cost plans, all pre-enrollment materials must clearly explain that members may use plan and non-plan providers, and also explain the benefit/cost sharing differentials between use of plan and non-plan providers.

2. ***Networks and Sub-networks:*** All *pre-enrollment* 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.

4. ***Identification of All Plans in Materials:*** Where M+C organizations may file separate/distinct Adjusted Community Rate (ACR) Proposals and the Plan Benefit Package (PBP*s*) cover 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 *health plans/*M+C organizations may *identify or mention more than one plan in a single marketing piece* at their discretion.

5. ***Contracting Statement:*** *All pre-enrollment materials (and some other materials, as mentioned in §§30.1 and 40) must include a statement that the health plan/M+C organization contracts with the Federal government. Refer to the Must Use/Can't Use/Can Use chart in §30.4 for statements the organization may use.*

6. ***TTY Numbers:*** *The TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TTY number must also include the hours of operation, if they are for customer or health plan services. Health plans/M+C organizations can use either their own or state relay services, as long as the number is accessible from TTY equipment.*

7. ***Availability of Alternative Formats:*** *To ensure that beneficiaries have access to beneficiary education materials in alternative formats (e.g., Braille, foreign languages, audio tapes, large print), Health plans/M+C organizations must provide a disclosure on pre-enrollment materials indicating the document is available in alternative formats.*

8. ***Marketing plans to beneficiaries of non-renewing Medicare plans:*** *As stated in §30, health plans/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 marketing does not begin until after the date the beneficiary has received the plan termination letter. In addition to the targeted message, any pre-enrollment marketing pieces must contain a statement indicating that the health plan/M+C plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area.*

9. ***Preferred Provider Organizations (including PPO Demonstrations) Only:***

    - ***Cost Savings Described in Marketing Materials:*** *If a PPO states in marketing materials that prospective enrollees may save money if they join the plan, it must also acknowledge the added cost of accessing services out-of-network, and/or that using services in-network can cost less than using services out-of-network.*
    - ***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 pre-enrollment material that member responsibility may be greater out of network since the coinsurance is based on the Medicare allowed amount and not on the potentially lower contracted amount.*
    - ***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 available from non-preferred providers.

B. Formatting Requirements

1. ***Font Size Rule for Member Materials:*** *Readability of written materials is crucial to informed choice for Medicare beneficiaries. All pre-enrollment 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 enrollment and disenrollment forms and notices. The CMS is cognizant of the fact that, when actually measured, 12-point font size 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.*

2. ***Font Size Rule for Footnotes and Subscripts:*** *The 12-point font size or larger rule described above also applies to any footnotes or subscript annotations in notices.*

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. 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.*

4. ***Reference to Studies or Statistical Data:*** *Health plans/M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, cost, etc. as long as specific study details are given. At a minimum, study details that need to be included are: Source, dates, sample size, and number of plans surveyed. Health plans/M+C organizations may not use study or statistical data to directly compare their plan to another. If health plans/M+C organizations use study data that includes information on several other health plans/M+C organizations, they will not be required to include data on all of the organizations included in the study. 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.*

5. ***Medicare Cost Plans Only***

    - *In all pre-enrollment marketing materials 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]

- *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 pre-enrollment marketing materials.*

C. Submission and Review Requirements

- ***Sales Scripts:*** *Sales scripts, both for in-home and telephone sales use, must be reviewed by the 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).*

D. Other Requirements

- ***Logos/Tag Lines:*** *The CMS recognizes the difference of purpose and intent between company logos/product tag lines and other advertising or marketing materials. The guidelines regarding 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 §30.4 of this Chapter for more information on restrictions associated with the use of superlatives.*

30.*3* - Sales Package Minimum Information Requirements

(Rev. 35, 10-31-03)

This section contains guidance regarding rules that health plans/M+C organizations are required to provide in writing to beneficiaries prior to enrollment.

30.*3*.1 - Lock-In Requirements/Selecting a Primary Care Physician - How to Access Care in an HMO

(Rev. 35, 10-31-03)

Health plans/M+C organizations must describe rules for receipt of primary care, specialty care, hospital care, and other medical services in their EOC. These rules may vary by health plan/M+C organization. Health plans/M+C organizations must disclose specific rules for referrals for follow-up specialty care in their EOC. Prior to enrollment, prospective members must be able to obtain information regarding the health plan network coverage and rules in sufficient detail to make an informed choice.

When a beneficiary enrolls in a plan/M+C organization, he/she agrees to use the network of physicians, hospitals, and providers that are affiliated with the plan for all health care services, except emergencies, urgently needed care, or out-of-area renal dialysis services.

Contractors with a POS benefit or Visitors Program benefit should list plan-specific requirements and level of coverage found in your EOC.

A plan member selects a primary care physician (PCP) to coordinate all of the member's care. A primary care physician is usually a family practitioner, general practitioner, or internist. The primary care physician knows the plan's network and can guide the member to plan specialists when needed. The member always has the option to change to a different primary care physician. Changes in PCP will be effective according to the plan guidelines that, in some instances, could be the first or the 15th day of the following month as opposed to immediately.

Neither the health plan/M+C organization nor Medicare will pay for medical services that the member receives outside of the network unless it was authorized, or it is an emergency, urgently needed care, or out-of-area dialysis service. The member may be responsible for paying the bill.

In the case of enrollees in §1876 Cost Contracts, enrollees must be informed that after enrollment is effective, in order for them to receive the full coverage offered, services other than emergency and urgently-needed services must be obtained through the HMO or CMP. In the case of cost enrollees, however, they may receive services that are not provided or arranged by their HMO or CMP, but they would be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare program. They also would be liable for any charges not covered by the Medicare program.[5]

30.*3*.2 - Emergency Care (Cross References to QISMC 2.3.17)

(Rev. 35, 10-31-03)

Members are not required to go to health plan-affiliated hospitals and practitioners when they experience an emergency. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are:

1. Furnished by a provider qualified to furnish emergency services; and
2. Needed to evaluate or stabilize an emergency medical condition.

For information on M+C organization responsibility for emergency care stabilization and post-stabilization requirements see [42 CFR 422.113(b)(3),(c)(2)(i) through (iii)].

Describe precisely where emergency coverage will be available under the health plan/M+C organization (e.g., the United States and its Territories, worldwide, etc.).

30.*3*.3 - Urgent Care

(Rev. 35, 10-31-03)

Urgently needed services means covered services provided when an enrollee is temporarily absent from the M+C plan's service area (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required:

1. As a result of an unforeseen illness, injury, or condition; and
2. It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan.

Urgently needed care provided by non-plan providers is covered when a member is in the service area or continuation area under the unusual circumstance that the organization's provider network is temporarily unavailable or inaccessible. Normally, if a member needs urgent care and is in the health plan's/M+C organization's service area or continuation area, the member is expected to obtain care from the health plan's/M+C organization's providers.

30.*3*.4 - Appeal Rights

(Rev. 35, 10-31-03)

Members have a right to appeal any decision the health plan/M+C organization makes regarding, but not limited to, a denial, termination, payment, or reduction of services. This includes denial of payment for a service after the service has been rendered (post-service) or denial of service prior to the service being rendered (pre-service).

30.*3*.5 - Benefits and Plan Premium Information

(Rev. 35, 10-31-03)

Premium information must include the statement: "You must continue to pay your Medicare Part B premium."

When specifying benefits, annual limits (e.g., $1,000 annual maximum for prescription drugs), annual benefit payout (e.g., $700 for eyeglasses every 2 years) and applicable copayments (e.g., $5 copayment for a doctor visit) must be specified. Major exclusions and limitations must be stated clearly. For example, restriction of pharmacy benefits to a specific formulary or a restricted set of pharmacies must be explained. Health plans/M+C organizations must state clearly all monetary limits, as well as any restrictive policies that might impact a beneficiary's access to drugs or services. When annual dollar amounts or limits are provided, the health plan/M+C organization must also mention the applicable

quarterly or monthly limits, and whether any unused portion of that benefit can be carried over from one calendar quarter to the next. Include a closing statement such as: "For full information on [plan/M+C organization name] (e.g., drugs, routine physical exam, eyeglasses, dental, etc.) benefits, call our Customer Service Department at [plan/M+C organization phone number]."

Also, a statement must be made that the (Health Plan/M+C organization's Name) contract with CMS is renewed annually, and that the availability of coverage beyond the end of the current contract year is not guaranteed.

Cost contractors must describe their premiums and cost-sharing for services received through the HMO or CMP, and any optional supplemental benefit packages they offer. They must also indicate that premiums, cost-sharing, and optional supplemental benefits may change each year, and that the HMO or CMP may decide not to renew its contract for a given calendar year.

30.*4* - "Must Use/Can't Use/Can Use" Chart

(Rev. 35, 10-31-03)

The "Must Use/Can't Use/Can Use" Chart provides guidance on language that *health plans/*M+C organizations must use, can't use, and can use in pre-enrollment *materials and in post-enrollment materials (as addressed in §40.1). With the exception of the "Contract with the Government" topic contained in the Chart, the "Must Use" column does **not** apply to advertisements (as defined in §30.1). Only the "Can't Use" and "Can Use" column applies to advertisements.*

The Chart does not indicate when a particular topic must be included in marketing materials. Instead, it provides guidance on language use when the topic is included on a particular marketing piece. If a topic is required to be included in a marketing material, the requirement for its inclusion can be found in §30.2 for pre-enrollment materials and §40.1 for post-enrollment materials.

Although use of suggested "Can Use" language is not required, its use will expedite the review process. Please note that the specific language and format used in all standardized marketing materials like the standardized Summary of Benefits is required. Please also note that the language provided in the "Must Use" column of the "Must Use/Can't Use/Can Use Chart" is required if the particular topic is being addressed in a pre- or post-enrollment marketing material.

Some phrases in this document may not apply to your 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 organization.

"Must Use/Can't Use/Can Use" Chart

(Rev. 35, 10-31-03)

The following chart provides guidance on language that M+C organizations must use, can't use, and can use in pre-enrollment *materials and in post-enrollment materials. With the exception of the "Contract with the Government" topic contained in the Chart, the "Must Use" column does **not** apply to advertisements (as defined in §30.1). Only the "Can't Use" and "Can Use" column applies to advertisements.*

This Chart does not indicate when a particular topic must be included in marketing materials. Instead, it provides guidance on language use when the topic is included on a particular marketing piece. If a topic is required to be included in a marketing material, the requirement for its inclusion can be found in §30.2 for pre-enrollment materials and §30.3 for post-enrollment materials.

The use of any language found in the "Can Use" column is discretionary.

Subject	**Must Use**	**Can't Use**	**Can Use**	**Reason**
Lock-In	- Enrolled members "must use (name of health plan/M+C organization) (contracting, affiliated, or name of health plan/ M+C organization participating) providers for routine care" - " Health plan/M+C organization available to all Medicare beneficiaries" *- For Medicare cost plans, all pre-enrollment materials must clearly explain that members may use plan and non-plan providers, and also explain the benefit/cost sharing differentials between use of plan and non-plan providers.* This information may be either in the text of the piece or in a disclaimer at the end/bottom of the piece	- The term "Participating Providers"		

Subject	Must Use	Can't Use	Can Use	Reason
Descriptions of the M+C organization's Quality [6]		- Superlatives (e.g., highest, best)[7] - Unsubstantiated comparisons with other M+C organizations - Direct negative statements about other M+C organizations including individual statements from members or former members	-Qualified superlatives (e.g., among the best, some of the highest) - Superlatives (e.g., ranked number 1, if they can be substantiated by ratings, studies or statistics (Source must be identified in the advertising piece.) See §30 for more information. - " Health plan/M+C organization delivers (adjective) quality of care" - Can use satisfaction survey results, e.g., "The (name of specific study) indicated we rated highest in member satisfaction." (Must disclose year and source.) See §30 for more information. - M+C organizations may use CAHPS survey data regarding their own organization but may not use it to make specific comparisons to other M+C organizations.	
Premium Costs	- If a health plan/M+C organization premium is mentioned, it must be accompanied by a statement that beneficiaries must continue to pay Part B premium or Medicare premium. - If an annual dollar amount/limit is mentioned, quarterly or monthly limits must also be mentioned as	- "No premium" - "No premium or deductible" - "Free"	The following may be used: - "No health plan/M+C organization premium" - " Health plan/M+C organization premium equals _____" - "$0 health plan/M+C organization premium"	

Subject	Must Use	Can't Use	Can Use	Reason
	well as any ability to carry over any remaining benefit from quarter to quarter.		organization premium" - At no extra cost to you" but only if referring to a specific benefit - "No health plan/M+C organization premium or deductibles" - "No premium or deductibles (you must continue to pay the Medicare Part B premium" - "No premium beyond your monthly Medicare payment" - "No premium other than what you currently pay for Medicare"	
Testimonials	- Content must comply with CMS marketing guidelines, including statements by members. - Speaker must identify specific health plan/M+C organization membership.	- Cannot have non-members say he/she belongs. (Can use actors, but they cannot say they belong to the health plan/M+C organization.) - " Health plans/M + C organizations cannot use negative testimonials about other plans from members or ex-members."		

Subject	Must Use	Can't Use	Can Use	Reason
Contract with the Government	*With the exception of outdoor advertisements and banner/banner-like ads, all other advertisements and all pre- and post-enrollment materials must include this disclaimer.* This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece. *- "A/An [insert plan type: HMO, PPO, POS plan, PSO, etc.] with a Medicare contract"* *- "An M+C organization with a Medicare contract"* *- "A Health Plan with a Medicare contract"* *- "A Federally Qualified HMO with a Medicare contract"* *- "A Federally Qualified Medicare contracting HMO"* *- "Medicare approved [insert plan type: HMO, PPO, POS plan, PSO etc.]"* *- "A Coordinated Care Plan with an Medicare+Choice contract"*	- "Recommended or endorsed by Medicare" - Cannot imply that health plan/M+C organization has a unique or custom arrangement with the government, e.g.: -- "Special contract with Medicare" --"Special health plan/M+C organization for Medicare beneficiaries"		
Physicians and Other Health Care Providers	- If the number of physicians and other health care providers is used, it must include only providers available to Medicare beneficiaries. - If a total number *of physicians and providers* is used it must separately delineate the number of	- Implication that providers are available exclusively through the particular HMO unless such a statement is true - "Participating providers" unless you use health	- "(Health plan/M+C organization's name) participating providers" - "Plan" providers - "Network" providers	Do not use the word "participating" when referring to health plan/M+C organization providers (unless you use health plan/M+C organization name), since it could be confused with a participation agreement with

Subject	Must Use	Can't Use	Can Use	Reason
	primary care providers and specialists included. - If the M+C organization uses the name and/or picture of providers and/or facilities to market itself, the provider information may only be used within the context of informing beneficiaries of providers that are associated with the M+C organization's delivery system.	plan/M+C organization name - The M+C organization may not identify itself by the name of a participating provider or provider group, with the exception of a PSO.	- "Contracting" providers - "Affiliated" providers - Number of providers should be same total number of Medicare providers	Medicare. Health plan/M+C organizations should either use "contracting" or " health plan/M+C organization name" when referring to health plan/M+C organization providers. It must be clear to the beneficiary with whom the M+C contract with CMS is held.
Eligibility	- Must indicate that beneficiaries must be entitled to Part A and enrolled in B For M+C plans-- Must indicate that all Medicare beneficiaries with Parts A and B of Medicare may apply For §1876 cost contracting health plans: -- Must indicate that all Medicare beneficiaries may apply This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece.	"No health screening" unless specific mention is made of ESRD "Seniors" unless term appears with "and all other Medicare eligibles" " Health plan/M+C organization designed especially for seniors" "Senior health plan/M+C organization" unless part of health plan/M+C organization name "Individuals age 65 and over"	- "Anyone with Medicare may apply" - "Medicare entitled by age or disability" - "Individuals eligible for Medicare by age or disability" - "Individuals on or entitled to Medicare by age or disability" - "Medicare beneficiaries" - "Medicare enrollees" - "People with or on Medicare" - "No physicals required" - "No health screening" if a caveat is included for ESRD - "Grandfathered enrollees"	Since all Medicare beneficiaries may enroll in Medicare-contracting HMOs, you may not refer to your health plan/M+C organization as a "senior health plan/M+C organization" (unless you refer to it as part of the health plan/M+C organization name). The term "senior health plan/M+C organization" implies that disabled beneficiaries may not enroll. Medicare Part A is not a requirement for enrollment in Medicare-cost contracting HMOs. M+C organizations may only enroll individuals with both Parts A and B of Medicare, with the exception of "grandfathered" members.

Subject	Must Use	Can't Use	Can Use	Reason
Claims Forms / Paperwork		"No paperwork" "No claims or paperwork/complicated paperwork" No claims forms"	"Virtually no paperwork" "No paperwork when using health plan/M+C organization providers" "Hardly any paperwork"	Members may be required to submit bills or claims documentation when using out-of-plan providers.
Benefits: a) Comparison	- If premiums and benefits vary by geographic area, must clearly state this or must clearly state geographic area in which differing premiums and benefits are applicable. - If only benefits vary, clearly state geographic area in which benefits are applicable.	- Minimal co-pays may vary by county - Minimal co-pays may apply	- "Premiums and benefits may vary by county *[and plan]*" or "These benefits apply to the following counties"* - "Except for ________ county"* - M+C organizations may compare benefits to Medigap plans as long as information is provided accurately and in detail.	Premiums, benefits, and/or copayment amounts may vary by county within a given service area.
Benefits: b) Limitations		- "At no extra cost to you" or "free" if co-pays apply	- State exact dollar amount limit on any benefit - "Limitations and restrictions may apply" - "Minimal copayments will apply" - "Minimal copayments vary by county"* - State which benefits are subject to limitations	If benefits are specified within the piece, any applicable copayment should be stated or you may include the general statement as shown.

Subject	Must Use	Can't Use	Can Use	Reason
Benefits: c) Prescription Drugs	- If prescription drugs are mentioned and have limitations, must say: - Limited outpatient drug coverage; or, - Drug coverage benefits subject to limitations; or - Up to xxx annual/ quarterly/ monthly limit or xxx limit per year/quarter/month and other limits and restrictions may apply. - Copayment amounts and indicate for a xx number of days supply - If benefits are restricted to a formulary, this must be clearly stated. - In addition, must state: - That formulary contents are subject to change within a contract year without advance notice - Health plan/M+C organization should be contacted for additional details.	- "We cover prescription drugs" unless accompanied by reference to limitation - "Prescription drug coverage" unless accompanied by reference to limitation	- Fully disclose dollar amount of copayments and annual/quarterly/monthly limit - If limited, you must say so - Limited outpatient drug coverage with xx copayments for xx number of days supply and xxx annual/quarterly/monthly limit - "Prescriptions must be filled at contracting or health plan/M+C organization affiliated pharmacies."	Prescription drugs are an important benefit that must be adequately described. Any dollar limits must be clearly conveyed.

Subject	Must Use	Can't Use	Can Use	Reason
Benefits: d) Multi-Year Benefits	- Whenever multi-year benefits are discussed, M+C organizations are required to make appropriate disclosure that the benefit may not be available in subsequent years.		- "[benefit] may not be available in subsequent years" OR - "[name of M+C organization] contracts with Medicare each year, this benefit may not may not be available next year" *- "At the end of each year, [name of organization] may leave the Medicare program or change plan benefits. However, new plans or benefits may also become available."*	Potential applicants and members must be informed that multi-year benefits in current year benefit packages are not guaranteed in future contract years.
- Definitions - Emergency and Urgently Needed Care		- "Life threatening" - "True emergency"	- Emergency - definition as stated in current CMS policy. - Urgent - definition as stated in current CMS policy.	Emergency and urgent care criteria should be explained per Medicare guidelines rather than in the commercial context.
Drawings / Prizes		- "Eligible for free drawing and prizes"	- "Eligible for a free drawing and prizes with no obligation" - "Free drawing without obligation"	It is a prohibited marketing practice to use free gifts and prizes as an inducement to enroll. Any gratuity must be made available to all participants regardless of enrollment. The value of any gift must be less than the nominal amount of $15.

Subject	Must Use	Can't Use	Can Use	Reason
Sales presentations	- Indicate that a telecommunication device for the deaf (TTY) is available to get additional information or to set up a meeting with a sales representative. If mentioned in a response card where the beneficiary's phone number is requested: - "A sales representative may call."	- "A health plan representative will be available to answer questions."	*"A telecommunications device for the deaf (TTY) is available to get additional information or set up a meeting with a sales representative."*	
Medicare + Choice Provider Sponsored Organizations		*- State licensed M+C organizations may 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.*	- *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 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*	

[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.

40 - Guidelines for *Post-Enrollment* Materials

(Rev. 35, 10-31-03)

"Post-enrollment" materials are those materials used by health plans/M+C organizations to convey benefit or plan operational information to enrolled beneficiary health plan members. *Post-enrollment* 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, *rules* and procedures. *Post-enrollment marketing materials include, but are not limited to, the Annual Notice of Change, the Evidence of Coverage, the Provider Directory, and the Summary of Benefits.* These materials are also *called* beneficiary notification materials and subject to *additional* CMS requirements.

This section is organized in several sub-sections:

40.1 -- Provides guidelines on beneficiary notification materials;

40.2 -- Provides guidelines on provider directories;

40.3 -- Provides guidance on drug formularies;

40.4 -- Provides guidelines on outreach to dual eligible membership; and

40.5 -- Provides guidance on the SB.

Please note that health plans/M+C organizations may not use Medicare member lists for non-plan-specific purposes. If an 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.

NOTE: *The requirements outlined in the "Must Use/Can't Use/Can Use" Chart* contained in *§30.4* also apply to post-enrollment materials.

40.1 - General Guidance for *Post-Enrollment* Materials

(Rev. 35, 10-31-03)

In many cases, the requirements for pre-enrollment notices (in §30) are the same for post-enrollment materials. The following are guidelines for post-enrollment materials:

A. Language Requirements

1. ***Lock-In Statement:*** *The concept of "lock-in" must be clearly explained in the SB, the EOC, and Member Handbooks.*

   For Medicare cost plans, all pre-enrollment materials must clearly explain that members may use plan and non-plan providers, and also explain the benefit/cost sharing differentials between use of plan and non-plan providers.

2. ***Networks and Sub-networks:*** *The SB, the EOC, Provider Directories and Member Handbooks 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.*

4. ***Contracting Statement:*** *The SB, Member Handbooks, and the EOC must include a statement that the organization contracts with the Federal government. Refer to the Must Use/Can't Use/Can Use chart in §30.4 for statements the organization may use.*

5. ***TTY Numbers:*** *The TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TTY number must also include the hours of operation, if they are for customer or health plan services. Health plans/M+C organizations can use either their own or state relay services, as long as the number included is accessible from TTY equipment.*

6. ***Availability of Alternative Formats (EOC only):*** *To ensure that beneficiaries have access to beneficiary education materials in alternative formats (e.g., Braille, foreign languages, audio tapes, large print), health plans/M+C organizations must provide a disclosure on the EOC indicating the document is available in alternative formats.*

7. ***Reference to Studies or Statistical Data:*** *Health plans/M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, cost, etc. as long as specific study details are given. At a minimum, study details that need to be included are: Source, dates, sample size, and number of plans surveyed. Health plans/M+C organizations may not use study or statistical data to directly compare their plan to another. If health plans/M+C organizations use study data that includes information on several other health plans/M+C organizations, they will not be required to include data on all of the organizations included in the study. 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.*

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

9. ***Minimum Information Requirements (EOC Only):*** *The minimum information requirements outlined in §30.3 apply to the EOC.*

10. ***Preferred Provider Organizations (including PPO Demonstrations) Only:***

    - ***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 available from non-preferred providers. The EOC must specifically explain which benefits are offered at the non-preferred benefit level and any limitations that may apply.*

    - ***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.*

B. Formatting Requirements

1. ***Font Size Rule for Member Materials:*** *Readability of written materials is crucial to informed choices 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, letters confirming enrollment and disenrollment, notices of non-coverage and notices informing members of their right to an appeals process. The CMS is cognizant of the fact that, when actually measured, 12-point font size 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.*

   Exception:

   - *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.*

2. ***Font Size Rule for Footnotes and Subscripts:*** *The 12-point font size or larger rule also applies to any footnotes or subscript annotations in post-enrollment notices.*

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. 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.

C. Other Requirements

1. ***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 that choose this option 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.*

40.1.1 - Use of Model *Post-Enrollment* Materials

(Rev. 35, 10-31-03)

The passage of the Benefits Improvement and Protection Act of 2000 has changed the review process for model beneficiary notification materials. *For* specific guidance on these changes and the usage of model materials, see §20,"Marketing Review Process."

40.1.2 - Use of Standardized *Post-Enrollment* Materials

(Rev. 35, 10-31-03)

The CMS has implemented certain standardized beneficiary notification marketing materials for health plan participants in Medicare managed care. In particular, all M+C organizations are required to use a standardized Summary of Benefits (SB). Use of standardized materials by M+C organizations is mandatory. *Guidelines for the standard SB can be found in §40.4*.

Employer group health plans (EGHPs) *are exempt from using the* standardized SB. After discussions with various interested parties, including employer groups, consulting firms, beneficiary advocacy groups, and employer unions, *the* CMS has decided to exempt EGHPs from the requirement to use *the* CMS' standardized summary of benefits

40.1.3 - Model Annual Notice of Change (ANOC)

(Rev. 35, 10-31-03)

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 31 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.

***NOTE**: Regarding ANOCs and SBs for employer group members: With one exception, health plans/M+C organizations must send ANOCs and SBs to employer group members at the same time they send it to all other individual members. The exception is when there are no Medicare changes **or** plan changes taking effect on January 1 of the upcoming year. In this case, the organization does not need to send an ANOC (or an SB) to employer group enrollees. For example, if there were no January 1 changes in Medicare coverage to communicate to enrollees in a particular year, it is possible that an organization may not have any January 1 plan changes to communicate to their employer group enrollees if the employer group open enrollment season occurs at some other time during the year (e.g., July 1). Under these circumstances, the organization does not need*

to send an ANOC (or an SB) to employer group members in October (or December for Medicare cost plans). However, keep in mind that the organization would still need to notify employer group enrollees of any upcoming plan changes with an ANOC and SB at least 30 days in advance of those changes, as required at 42 CFR 422.111(d)(3) and 42 CFR 417.436(c).

MODEL ANNUAL NOTICE OF CHANGE

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

[Note: The organization may modify this introductory paragraph to tailor 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

40.4.2 - Guidelines for Outreach Program

(Rev. 35, 10-31-03)

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 QI-1 and QI-2 levels. [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. *Clarify in outreach materials, including member letters, that the Medicare Savings Programs are part of either the "State Medicaid Program" or "State Medical Assistance Programs".*

5. 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.

6. 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.

7. 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.

8. 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.

9. Include alternate sources of information in 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).

10. 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.

11. 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.

12. 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.

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 refrain from contacting the member for at least six months following the last outreach attempt.

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. 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.

40.5.1 – Summary of Benefits for Medicare+Choice Organizations

(Rev. 35, 10-31-03)

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. The 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 6 pages of promotional text and graphics and is not standardized with regard to format or content. The 6-page limit means that the information is limited to 6 single-sided pages or 3 double-sided pages. However, there is one exception to this limit:

- *When an M+C organization is translating the SB to a foreign language, it may add pages as necessary to ensure the translation conveys the same information as 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.

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 percent 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 after every statement in the OM column that describes the following benefits and after footnote (1), where applicable. 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.

   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.

4. 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.

50.2 - Specific Guidance About Provider Promotional Activities

(Rev. 35, 10-31-03)

Some health plans/M+C organizations use their providers to help them market their Medicare product. As used in this chapter, the term "provider" means all Medicare health plan/M+C organization contracting health care delivery network members; e.g., physicians, hospitals, etc. The purpose of this section is to specify what *marketing* practices in this area meet both CMS requirements and the needs of the health plans/M+C organizations with respect to entities considered providers by health plans/*M+C organizations*.

In general, providers should only market in their capacity as a member of the plan's network and only in coordination with the health plan/M+C organization (for example, providers/provider groups could co-sponsor an open house or a health fair with a health plan/M+C organization, or could cooperatively advertise on TV).

Marketing by a plan provider shall be deemed to be marketing by the health plan/M+C organization. Therefore, health plans/M+C organizations should stipulate in their contracts with providers that any coordinated marketing to be carried out by the provider must be done in accordance with all applicable CMS marketing guidelines. All marketing materials describing the health plan/M+C organization in any way must get prior approval, have the health plan/M+C organization's name or logo as well as the provider's/provider group's name or logo, adhere to the guidelines in this chapter, and have prior approval by CMS.

The CMS is concerned with provider marketing for the following reasons:

- Providers are usually not fully aware of all health plan/M+C organization benefits and costs; and
- A provider may confuse the beneficiary if the provider is perceived as acting as an agent of the health plan/M+C organization vs. acting as the beneficiary's provider.

Providers may face conflicting incentives when acting as a health plan/M+C organization representative since they know their patients' health status. Desires to either reduce out-of-pocket costs for their sickest patients, or to financially gain by enrolling their healthy

patients may result in recommendations that do not address all of the concerns or needs of a potential health plan/M+C organization enrollee.

There are some permissible delegated provider marketing activities, however. Listed below are some requirements for these, and the reasons they are permitted:

1. **Health Fairs** - At health fairs, provider groups and individual providers can give out health plan/M+C organization brochures including *enrollment applications.* Because they may not be fully aware of all benefits and costs of the various health plans/M+C organizations, providers or their representatives cannot compare benefits among health plans/M+C organizations in this setting. In addition, applications may not be taken at health fairs. (See the discussion of health fairs and health promotion events in *§50.1.3* above.)

2. **Provider Office Activities and Materials** - In their own offices, provider groups and individual providers can give out health plan/M+C organization brochures, and posters announcing health plan/M+C organization affiliation (all of which must be exclusive of applications). Providers, their representatives and qualified health plan/M+C organization (marketing) representatives are all prohibited from taking applications in the place where health care is delivered, such as provider offices or hospital wards. This is to prevent Medicare beneficiaries from experiencing inappropriate pressure to enroll at the time that health care is being delivered. Providers cannot offer inducements to persuade beneficiaries to join health plans/M+C organizations or to steer beneficiaries to a specific health plan/M+C organization.

   In addition, providers cannot offer anything of value to induce health plan/M+C organization enrollees to select them as their provider. When patients seek information or advice from their own physician regarding their Medicare options, physicians may engage in this discussion. Because physicians are usually not fully aware of all health plan/M+C organization or original Medicare benefits and costs, they are advised to additionally refer their patient to other sources of information, such as 1-800-MEDICARE, the State Health Insurance Assistance Program, and/or specific health plan/M+C organization marketing representatives. Additional information can also be found on CMS' Web site, http://www.medicare.gov/. Physicians are permitted to printout and share information with patients from CMS' Web site.

3. **Providers/Provider Group Affiliation Information**- Providers/provider groups can announce a new affiliation with a health plan/M+C organization to their patients. An announcement to patients of a new affiliation which names only one health plan/M+C organization may occur only once. Additional contacts from providers to their patients regarding affiliation must include all the Medicare health plans/M+C organizations with which the provider contracts. This includes, for example, annual affiliation announcements, announcements that certain affiliations have terminated, and the display of health plan/M+C organization brochures/posters. If these communications describe health plans/M+C organizations in any way (as opposed to just listing them), they must be prior approved by CMS (see below).

4. **Providers/Provider Group Comparative/Descriptive Information** - Providers/provider groups may provide printed information to their patients comparing the benefits of different health plans/M+C organizations with which they contract. Such materials must have the concurrence of all health plans/M+C organizations involved and must be prior approved by CMS. The health plans/M+C organizations may want to determine a lead health plan/M+C organization to coordinate submission of these materials. CMS continues to hold the health plans/M+C organizations responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting medical groups and other health care providers. The providers/provider groups may not health screen when sending out such information to their patients. The reason for this is that any material sent to beneficiaries that talks about health plans/M+C organizations is marketing and health screening is a prohibited marketing activity.
5. **Providers/Provider Group Web Sites** - Providers/provider groups may provide links to health plan/M+C organization enrollment applications and/or provide downloadable enrollment applications as long as the site provides the links/downloadable formats to enrollment applications for all health plans/M+C organizations with which the provider/provider group participates.

The "**Medicare and You**" **Handbook** or "**Medicare Compare Information**" (from CMS' Web site, http://www.medicare.gov), may be distributed by providers/provider groups without additional approvals. There may be other documents that provide comparative/descriptive material about health plans, are of a broad nature, and are written by CMS or have been prior approved by CMS. These materials may be distributed by *health plans/*M+C organizations and providers without further CMS approval. Please advise your health plan/M+C organization providers and provider groups of the provisions of these rules.

60.1.2 - Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations

(Rev. 35, 10-31-03)

Health plans/M+C organizations can market, either through oral presentations or written materials, Value-Added Items and Services (VAIS). Organizations can also mention VAIS in their newsletters. *With one exception*, VAIS may not appear in the PBP or the Standardized SB. *The exception is with the discount prescription drug program, which can be mentioned in section 3 of the SB as long as they include the required disclaimers*.. In addition, the SB must clearly state (in the location that the program is described) that the discount *prescription* drug program will be available for the entire contract year.

Any description of VAIS must be preceded by the following prominently displayed language:

> *The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes*

regarding these products and services may be subject to the [Name of plan] grievance process.

Organizations may include VAIS along with their ANOC and*/or* SB in one bound brochure as long as the value-added services are clearly distinct from the ANOC and*/or* SB (such as on a different color piece of paper), and the information on value-added services includes all the disclaimers required in this chapter.

Because VAIS does not meet the definition of a benefit under the M+C program, neither *"benefit"* nor associated administrative costs may appear in the ACR. Furthermore, because they are not contained within the contracted health benefits package, these services are not subject to the Medicare appeals process. VAIS may not be described in Medicare Compare or the "Medicare and You" handbook.

The CMS will not require prior approval of materials describing VAIS, since VAIS are not benefits as described within CMS regulations *and therefore are not technically within CMS purview*. The CMS will review these materials on monitoring visits to ensure compliance with these requirements. The CMS may initiate a monitoring visit if it becomes aware that materials have been distributed describing VAIS without the appropriate disclaimers or in violation of the requirements stated herein. CMS will also investigate complaints by beneficiaries regarding VAIS, just as it would other possible violations of CMS requirements.

Endnotes

(Rev. 35, 10-31-03)

[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] *This endnote has been deleted*.

[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.

[8] 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.