Final Contract Year (CY) 2018 Marketing Guidance for California Medicare-Medicaid Plans

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Table of Contents

Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the Contract Year (CY) 2018 Medicare Marketing Guidelines (MMG), posted at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html, apply to Medicare-Medicaid plans (MMPs) participating in the California capitated financial alignment model demonstration, except as noted or modified in this guidance document.[1]

This guidance document provides information only about those sections of the MMG that are not applicable or that are different for MMPs in California; therefore, this guidance document should be considered an addendum to the CY 2018 MMG. This MMP guidance is applicable to all marketing done for CY 2018 benefits. The table below summarizes those sections of the CY 2018 MMG that are clarified, modified, or replaced for California MMPs in this guidance.

Table 1: Summary of Clarifications, Modifications, or Replacements of MMG Guidance

Medicare Marketing Guidelines (MMG) Section	**Change in this Guidance Document**
Section 20 – Materials Not Subject to Marketing Review	Provides one exception to the list of materials not subject to marketing review and submission processes in this section of the MMG.
Section 30.5 – Requirements Pertaining to Non-English Speaking Populations	Clarifies the requirements of this section for MMPs.
Section 30.6 – Required Materials with an Enrollment Form	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter	Replaces current guidance in the MMG with guidance for MMPs.
Section 30.8 –Enrollment Verification Requirements	Clarifies the requirements of this section for MMPs.
Section 30.10 – Star Ratings Information from CMS	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.10.1 – Referencing Star Ratings in Marketing Materials	Clarifies that the requirements of this section are not applicable to MMPs.

[1] Note that any requirements for Special Needs Plans (SNPs), Private Fee-for-Service (PFFS) plans, Preferred Provider Organizations (PPOs), and Section 1876 Cost-Based Plans (cost plans) in the MMG do not apply unless specifically noted in this guidance.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 30.10.2 – Plans with an Overall 5-Star Rating	Clarifies that the requirements of this section are not applicable to MMPs.
Section 40.6 – Hours of Operation Requirements for Marketing Materials	Adds requirements for MMPs to current MMG requirements of this section.
Section 40.8 – Marketing of Multiple Lines of Business	Clarifies that organizations offering both MMP and non-MMP products in a service area may not market the non-MMP products in MMP marketing materials.
Section 40.8.3 – Marketing Materials from Third Parties that Provide Non-Benefit/Non-Health Services	Clarifies that the requirements of this section do not apply to materials produced by the State and the State's enrollment broker.
Section 40.10 – Standardization of Plan Name Type	Clarifies the requirements of this section for MMPs.
Section 60.1 – Summary of Benefits (SB)	Replaces current guidance in this section with guidance for MMPs.
Section 60.2 – ID Card Requirements	Clarifies the requirements of this section for MMPs.
Section 60.4 – Formulary and Formulary Change Notice Requirements	Clarifies the requirements of this section for MMPs. Extends the requirements for formulary change notifications to Medicaid-covered drugs. Adds an option for MMPs to send a distinct and separate notice alerting enrollees how to access or receive the formulary.
Section 60.6 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)	Replaces current guidance in this section with guidance for MMPs.
Section 60.7 – Other Mid-Year Changes Requiring Enrollee Notification	Extends the requirements of this section to mid-year changes in Medicaid benefits.
Section 70.1 – Electronic Communication Policy	Adds requirements for MMPs to current MMG requirements of this section.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
70.2 – Marketing Through Unsolicited Contacts	Clarifies that, in addition to the requirements of this section, the State's enrollment broker information should be included on marketing materials under certain circumstances. Reiterates MMG guidance on unsolicited contact. Clarifies that marketing via conventional mail and other print media and marketing of MMPs to current enrollees is not considered unsolicited direct contact and is therefore permissible.
Section 70.3 – Prospective Enrollee Educational Events	Adds requirements for MMPs to current MMG requirements of this section.
Section 70.4.2 – Personal/Individual Marketing Appointments	Modifies the requirements of this section for MMPs.
Section 70.5 – Marketing in the Health Care Setting	Extends the flexibility for facilities to provide an explanatory brochure about contracted MMPs to long-term care facilities and chronic and psychiatric care hospitals.
Section 70.5.2 – Provider Affiliation Information	Clarifies that this section of the MMG is also applicable to MMPs.
Section 70.5.4 – Comparative and Descriptive Plan Information Provided by a Non-Benefit/Non-Health Service-Providing Third Party	Clarifies that the requirements of this section vis-à-vis State agencies also apply to the State's enrollment broker.
Section 80.1 – Customer Service Call Center Requirements	Replaces current guidance in this section regarding permissible use of alternate call center technologies on weekends and holidays with guidance for MMPs.
Section 80.2 – Informational Scripts	Clarifies requirements in this section for MMPs.
Section 80.3 – Enrollment Scripts/Calls	Clarifies that MMPs should review the Streamlined Enrollment Script Checklist when developing enrollment scripts.
Section 80.4.1 – Telephonic Contact	Clarifies the requirements of this section for MMPs.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 90 – The Marketing Review Process	Clarifies that references in this section (and subsections) to CMS in its role in marketing reviews also apply to the State.
Section 90.2.1 – Submission of Non-English and Alternate Format Materials	Clarifies that MMPs have state-specific MMP errata codes.
Section 90.2.3 – Submission of Multi-Plan Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 90.3 – HPMS Material Statuses Section 90.5 – Timeframes for Marketing Review	Clarifies the requirements of these sections with respect to the lack of "deeming" for jointly reviewed materials.
Section 90.6 – File & Use Process	Clarifies the File & Use certification process for MMPs.
Section 100.2 – Required Content	Adds requirements for MMPs to current MMG requirements of this section.
Section 100.2.2 – Required Documents for All Plans/Part D Sponsors	Modifies the requirements of this section for MMPs.
Section 100.3 – Electronic Enrollment	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.4 – Online Formulary, Utilization Management (UM), and Notice Requirements	Extends the formulary change notice requirements of this section to non-Part D drug formulary changes.
Section 110.2 – Marketing of Rewards and Incentives Programs	Clarifies that the requirements of this section, as well as those in CMS guidance regarding rewards and incentives programs, apply to MMPs.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 120 – Marketing and Sales Oversight and Responsibilities	Clarifies that starting for CY 2018 enrollments, MMPs will be permitted to compensate independent agent/brokers for certain opt-in enrollments. Clarifies that the requirements of this section apply to MMPs with respect to independent agents and brokers. Clarifies that MMP staff conducting marketing activity of any kind, as defined in Appendix 1 of the MMG, must be licensed in the State (and, when required, appointed) as an insurance broker/agent.
Section 120.6 – Activities That Do Not Require the Use of State-Licensed Marketing Representatives	Clarifies that the requirements of this section are applicable to MMPs.
Section 150 – Use of Medicare Mark for Part D Sponsors	Clarifies the requirements of this section for MMPs.
Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received	Replaces current disclaimer in this section with a disclaimer for MMPs.
Appendix 5 – Disclaimers	Modifies and clarifies disclaimer requirements for MMPs.

Use of Independent Agents and Brokers

We clarify that California MMPs may compensate independent agents/brokers for certain opt-in enrollments as detailed in section 120 of this guidance. The requirements applicable to independent agents/brokers throughout the MMG are therefore applicable to California MMPs in the scenarios described in section 120 of this guidance.

Model Materials

We refer MMPs to the following available model materials. We note that materials MMPs create should take into account the reading level requirements established in the three-way contract. Available model materials reflect acceptable reading levels. Current Part D models are acceptable for use as currently provided, and MMPs must add required disclaimers Appendix 5 of this guidance and Appendix 5 of the MMG, as appropriate. Adding required MMP disclaimers to Part D models does not render the documents non-model when submitted for review or accepted as File & Use materials.

We refer MMPs to the following available model materials:

- MMP-specific model materials tailored to MMPs in California, including model enrollment disenrollment forms for those California MMPs in the two COHS counties, where the MMPs will facilitate plan enrollments; the Summary of Benefits (SB); Annual Notice of Change (ANOC); Evidence of Coverage (EOC) (Member Handbook); comprehensive integrated formulary (List of Covered Drugs); combined Provider and Pharmacy Directory; single Member ID Card; integrated denial notices; and welcome letters for opt-in and passively enrolled individuals and other plan-delegated enrollment notices: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

- Required Part D models, including the Part D Explanation of Benefits, Excluded Provider Letter, Prescription Transfer Letter, and Transition Letter: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html.

- Part D appeals and grievances notices and models (including those in Chapter 18 of the Prescription Drug Benefit Manual): https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html and https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html.

- Part C appeals and grievances notices and models (including those in Chapter 13 of the Medicare Managed Care Manual): http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Guidance.html and http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html.

- MMP-specific ANOC/EOC (Member Handbook) errata model: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. This errata model, based on the Medicare Advantage errata, may be helpful to MMPs in creating their own errata notices.

Provider and Pharmacy Directory Requirements

Guidance related to Provider and Pharmacy Directories is no longer included in the MMG and is, instead, available in Chapter 4 of the Medicare Managed Care Manual, the January 17, 2017 HPMS memorandum entitled, “Provider Directory Policy Updates,” Chapter 5 of the Prescription Drug Benefit Manual, and the August 16, 2016 HPMS memorandum entitled “Pharmacy Directories and Disclaimers.” This guidance on general, update, dissemination and timing, online directories, disclaimers, and submissions applies to MMPs with the following modifications:

- MMPs are required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. However, as provided in section 110.2.1 of Chapter 4 of the Medicare Managed Care Manual, MMPs may print separate directories for PCPs and specialists provided both directories are made available to enrollees at the time of enrollment**.**

- The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits.

- MMPs must use the model Provider and Pharmacy Directory document provided by CMS and the State. The model will be consistent with directory requirements in the three-way contract. A non-model directory is not permitted.

- For multi-county service areas, the combined Provider and Pharmacy Directory may be provided for all providers by county, provided the directory includes a disclaimer that the directory only includes providers in that particular county (or counties), that a complete directory is available on the plan's website, and that the enrollee may contact the plan's customer service call center to request assistance with locating providers in other counties or to request a complete hard copy Provider and Pharmacy Directory.

- Any request to provide a Provider and Pharmacy Directory at any geographic level smaller than a county must be approved by an MMP's Contract Management Team.

- The MMP Provider and Pharmacy Directory is considered a marketing material and must be submitted in the HPMS marketing module. MMPs may obtain more information about the specific review parameters and timeframes for the Provider and Pharmacy Directory under the California capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. In addition, we note that, the guidance in section 110.2.6 of Chapter 4 of the Medicare Managed Care Manual regarding submission of updates and/or addenda pages does not apply to California MMPs. California MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the California MMP Provider and Pharmacy Directory marketing code.

Compliance with Section 1557 of the Affordable Care Act of 2010

MMPs are subject to the disclosure requirements under Section 1557 of the Affordable Care Act. For more information, MMPs should refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557/.

Following are the California MMP-specific modifications to the MMG for CY 2018.

Section 20 – Materials Not Subject to Marketing Review

The requirements of section 20 of the MMG apply to California MMPs with the following modification:

- The MMP Provider and Pharmacy Directory is considered a marketing material and must be submitted in the HPMS marketing module. MMPs may obtain more information about the specific review parameters and timeframes for the Provider and Pharmacy Directory under the California capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module.

Section 30.5 – Requirements Pertaining to Non-English Speaking Populations

The standard articulated in this section for translation of marketing materials into non-English language will be superseded to the extent that California's standard for translation of marketing materials is more stringent. The Medi-Cal California translation standard is typically equivalent or more stringent than the Medicare standard for translation for all California MMP service areas. Please refer to http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-008.pdf for the Medi-Cal translation standards updated on July 15, 2014. Guidance regarding the translation requirements for all plans, including California MMPs, is released via HPMS annually each fall. The required languages for translation for each MMP are also updated annually, as needed, in the HPMS Marketing Module. We expect the California standards for translation of required materials will continue to be the most stringent standard.

Required materials for translation are enrollment forms, Summary of Benefits (SB), ANOC/EOC (Member Handbook), formulary (List of Covered Drugs), the Provider and Pharmacy Directory, the distinct and separate notice alerting enrollees how to access or receive the Provider and Pharmacy Directory described in section 30.7 of this guidance and Chapter 4 of the Medicare Managed Care Manual, integrated appeals notices, and the Part D transition letter.[2]

MMPs must have a process for ensuring that enrollees can make a standing request to receive the materials identified in this section, in alternate formats and in all non-English languages identified in this section and in the HPMS Marketing Module, at the time of request and on an ongoing basis thereafter.

Final populated translations of all marketing materials must be submitted in HPMS (see section 90.2 of the MMG for more information about the material submission process).

For additional information regarding notice and tagline requirements, please refer to Appendix A and B to Part 92 of Section 1557 of the Patient Protection and Affordable Care Act.

[2] CMS will make available Spanish translations of the California MMP SB, formulary (List of Covered Drugs), Provider and Pharmacy Directory, and ANOC/EOC (Member Handbook). These are posted at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. CMS makes available a Spanish translation of the Part D transition letter to all Medicare health plans at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html.

Section 30.6 – Required Materials with an Enrollment Form

Because the Medicare-Medicaid Coordination Office (MMCO) is in the process of developing a Star Ratings system for MMP performance, California MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, California MMPs will not be required to include the Star Ratings Information document when a beneficiary is provided with any enrollment instructions/forms. We further clarify that the responsibility for sending enrollment and disenrollment notices to enrollees in the non-COHS counties will be delegated to California's enrollment broker, with the exception of any notices delegated to MMPs, as described in Appendix 5 of the MMP Enrollment and Disenrollment Guidance (see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html).

Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter

This section is replaced with the following revised guidance:

> **Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter**
>
> 42 CFR 422.111(c)(1), 423.128(c)(1), 422.2264(a), 423.2264(a)
>
> The following materials must be provided to enrollees at the time of enrollment and annually thereafter:
>
> - ANOC/EOC (Member Handbook), or a standalone EOC (Member Handbook), as applicable and described in the replacement guidance for section 60.6 of the MMG contained in this document.
>
> - A comprehensive integrated formulary (List of Covered Drugs) that includes Medicare and Medicaid outpatient prescription drugs and over-the-counter pharmacy drugs or products provided under the MMP, or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs)
>
> - A combined Provider and Pharmacy Directory that includes all providers of Medicare, Medicaid, and additional benefits, or a distinct and separate notice alerting enrollees how to access or receive the directory (required at the time of enrollment and annually thereafter).
>
> - A single Member ID Card for accessing all covered services under the plan (required at the time of enrollment and as needed or required by the MMP post-enrollment).
>
> - For individuals enrolled through passive enrollment, a demonstration plan-specific SB containing a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including copays, applicable conditions and limitations, and any other conditions associated with

receipt or use of benefits. Because the EOC (Member Handbook) may not be provided until just prior to the effective date of a passive enrollment, the SB must be provided to individuals enrolled through passive enrollment prior to receipt of the EOC (Member Handbook) to ensure that they have sufficient information about plan benefits to make an informed decision prior to the passive enrollment effective date. Refer to the revised guidance for section 60.6 of the MMG contained in this document for more information about when an MMP must send an SB to current enrollees post-enrollment.

MMPs must send enrollees who opt in to the demonstration the following materials for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever occurs later. We clarify that this group of enrollees who opt in includes individuals who are eligible for passive enrollment but select a different MMP or initiate an earlier enrollment date than their passive enrollment effective date. For late-month enrollment transactions (those for which CMS confirmation of enrollment is received less than ten (10) calendar days before the end of the month prior to the effective date), MMPs must send enrollees these materials for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment. MMPs should refer to the date of the Daily Transaction Reply Report (DTRR) that has the notification to identify the start of the ten (10) calendar-day timeframe.

- A welcome letter, which must contain 4Rx information, consistent with a model developed jointly by CMS and the State

- A comprehensive integrated formulary (List of Covered Drugs), or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs)

- A combined Provider and Pharmacy Directory, or a distinct and separate notice alerting enrollees how to access or receive the directory, consistent with Chapter 4 of the Medicare Managed Care Manual

- A single Member ID Card

- An EOC (Member Handbook)

MMPs must send enrollees who are passively enrolled the following materials for receipt no later than 20 calendar days prior to the effective date of enrollment:

- A welcome letter, which must contain 4Rx information, consistent with a model developed jointly by CMS and the State

- A comprehensive integrated formulary (List of Covered Drugs), or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs)

- A combined Provider and Pharmacy Directory, or a distinct and separate notice alerting enrollees how to access or receive the directory, consistent with Chapter 4 of the Medicare Managed Care Manual

- An SB

In addition, MMPs must provide enrollees who are passively enrolled an EOC (Member Handbook) and a single Member ID Card for receipt by the end of the month preceding the month the enrollment will take effect (e.g., the Member ID Card and EOC (Member Handbook) must be received by a beneficiary by March 31 for an April 1 effective enrollment date).

After the time of initial enrollment for both enrollees who are passively enrolled and enrollees who opt in to the demonstration, the ANOC and EOC (Member Handbook) must also be provided annually consistent with the replacement guidance for section 60.6 of the MMG contained in this document.

Additional informational materials about benefits or plan operations may be included in these required mailings to new and current enrollees – both at the time of enrollment and annually thereafter – consistent with the requirements of section 60.3 of the MMG.

The following tables summarize the requirements of this section.

Table 2: Required Materials for New Members

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Passive enrollment	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • SB	20 calendar days prior to the effective date of enrollment[3]

[3] Note that for plans electing to conduct early Health Risk Assessments (HRAs) – that is, HRAs prior to the effective date of enrollment – the timing for receipt of these materials is no later than 30 days prior to the effective date of enrollment. Plans electing to conduct early HRAs will receive separate guidance on timelines and other requirements.

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Passive enrollment	• Member ID Card • EOC (Member Handbook)	No later than the day prior to the effective date of enrollment
Opt-in enrollment (with enrollment confirmation received more than 10 calendar days before the end of the month)	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook)	No later than the last day of the month prior to the effective date
Opt-in enrollment (with enrollment confirmation received less than 10 calendar days before the end of the month)	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook)	No later than 10 calendar days from receipt of the CMS confirmation of enrollment

Table 3: Required Materials for Renewing Members

Required Materials for Renewing Members	Timing of Beneficiary Receipt
• ANOC/EOC (Member Handbook) • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) OR • ANOC • SB • Formulary (or a distinct and separate notice alerting enrollees how to access or receive the formulary)	September 30 The ANOC, SB, and List of Covered Drugs (Formulary) must be posted on plan websites by September 30. The EOC (Member Handbook) must only be posted by September 30 if it is sent with the ANOC.
If only the ANOC, SB, and formulary are sent for receipt by September 30: • EOC (Member Handbook)	December 31 The EOC (Member Handbook) must be posted on plan websites by December 31. The ANOC, SB, and formulary (List of Covered Drugs) must still be posted by September 30.
Member ID Card	As needed
Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory)	September 30. The plan website's directory must be kept up-to-date consistent with Chapter 4 of the Medicare Managed Care Manual. The Provider and Pharmacy Directory must be posted on plan websites by September 30.

Section 30.8 – Enrollment Verification Requirements

The outbound enrollment and verification (OEV) requirements described in this section apply only with respect to voluntary opt-in enrollments in which a COHS plan's employed agent provides plan-specific information to the individual, thus influencing the individual's plan choice and/or assisting in a subsequent enrollment request, consistent with section 30.8 of the MMG. We consider an MA to MMP plan change, even if within the same parent organization, to be a plan switch that triggers the OEV requirements.

Section 30.10 – Star Ratings Information from CMS

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this section does not apply to MMPs.

Section 30.10.1 – Referencing Star Ratings in Marketing Materials

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this section does not apply to MMPs.

Section 30.10.2 – Plans with an Overall 5-Star Rating

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this section does not apply to MMPs.

Section 40.6 – Hours of Operation Requirements for Marketing Materials

In addition to the requirements of this section, MMPs in the six counties with the enrollment broker must also provide the phone and TTY/TDD numbers and days and hours of operation information for the State enrollment broker in marketing materials that are provided prior to the time of enrollment and where a customer service number is provided for current and prospective enrollees to call. In the COHS counties, the MMP must provide the phone and TTY/TDD numbers and days and hours of operation information for the MMP customer service line for current and prospective enrollees.

Section 40.8 – Marketing of Multiple Lines of Business

We clarify that organizations offering both MMPs and non-MMP Medicare health plan options in a service area may only market MMP offerings in their MMP materials.

Section 40.8.3 – Marketing Materials from Third Parties that Provide Non-Benefit/Non-Health Services

In addition to the guidance in this section, CMS and the State clarify that materials produced by the State and distributed by California's enrollment broker do not constitute non-benefit/non-health service-providing third-party marketing materials. Therefore, such materials do not need to be submitted to the plan for review prior to their use. As indicated in section 20 of the MMG, the MMG does not apply to communications by State governments, and materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials.

Section 40.10 – Standardization of Plan Name Type

As is the case for other Medicare health plans, MMPs are required to include the plan type in each plan's name using standard terminology consistent with the guidance provided in this section. CMS created the standardized plan type label "Medicare-Medicaid Plan" to refer generically to all plans participating in a capitated financial alignment model demonstration.

MMPs must use the “Medicare-Medicaid Plan” plan type terminology following their plan name at least once on the front page or beginning of each marketing piece, excluding envelopes, consistent with the requirements of section 40.10 of the MMG.

MMPs may also use State-specific plan type terminology in their marketing materials (e.g., a plan can state that Medicare-Medicaid Plans are also known as Cal MediConnect Plans in California), provided they comply with the guidance regarding use of the CMS standardized plan type in section 40.10 of the MMG.

We also clarify that MMPs in California that offer Medicare Advantage products, including SNPs, in the same service area as their MMPs, may use the same plan marketing name for both those products. However, in order to reduce beneficiary confusion, MMPs must include “Cal MediConnect Plan” in the plan marketing name.

Section 60.1 – Summary of Benefits (SB)

This section is replaced with the following revised guidance. We also note that Appendix 4 of the MMG does not apply to MMPs.

> **Section 60.1 – Summary of Benefits (SB)**
>
> 42 CFR 422.111(b)(2), 423.128(b)(2)
>
> MMPs must use the Summary of Benefits (SB) model document provided by CMS and the State. A non-model SB is not permitted. The SB must contain a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including applicable copays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.
>
> The SB must be sent in Spanish to enrollees if the member’s primary language is known to be Spanish based on the State language preference indicator in enrollment files.

Section 60.2 – ID Card Requirements

MMPs are required to meet the Member ID card content requirements in sections 60.2, 60.2.1, and 60.2.2 of the MMG. We clarify, however, that MMPs must issue a single Member ID Card meeting these requirements for all services offered under the plan. Separate pharmacy and health benefits Member ID cards are not permitted. MMPs must use the model Member ID Card document provided by CMS and the State. A non-model Member ID Card is not permitted.

Section 60.4 – Formulary and Formulary Change Notice Requirements

The requirements of section 60.4, 60.4.1, 60.4.2, 60.4.3, 60.4.4, 60.4.5, and 60.4.6 of the MMG apply to MMPs with the following modifications:

- MMPs must make available a comprehensive integrated formulary (List of Covered Drugs) that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the plan;

- MMPs are only permitted to make available a comprehensive, not abridged, formulary (List of Covered Drugs);

- MMPs must use the model formulary (List of Covered Drugs) document provided by CMS and the State (a non-model formulary (List of Covered Drugs) is not permitted); and

- Formulary change notices must be sent for any negative formulary change (as described in section 30.3.3, "Midyear Formulary Changes," and section 30.3.4, "Provision of Notice Regarding Formulary Changes," of Chapter 6 of the Prescription Drug Benefit Manual), regardless of whether the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan. Consistent with the guidance in the MMG, this notice must be provided to affected enrollees at least 60 calendar days prior to the change.

We note that the new option available to all Part D sponsors in section 60.4 of the MMG to send either a hard copy formulary (List of Covered Drugs) or a distinct and separate notice (in hard copy) describing where enrollees can find the formulary (List of Covered Drugs) online and how enrollees can request a hard copy formulary also applies to California MMPs starting with Contract Year 2018. MMPs should refer to section 60.4 of the MMG for additional detail about these requirements.

Section 60.6 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

This section is replaced with the following revised guidance:

> **Section 60.6 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) (Member Handbook)**
>
> 42 CFR 417.427, 422.111(a)(3), 422.111(d)(2), 423.128(a)(3)
>
> MMPs are required to send an ANOC summarizing all major changes to the plan's covered benefits from one contract year to the next prior to the beginning of the second contract year of the demonstration and annually thereafter. MMPs may send the ANOC and EOC (Member Handbook) as a combined document or separately, as provided below.
>
> MMPs must send the ANOC for member receipt by September 30 each year. The EOC (Member Handbook) may be sent as a standalone document as follows:
>
> - MMPs must send new enrollees (whether they opt in to the demonstration or are passively enrolled) an EOC (Member Handbook) for member receipt by the end of the month preceding the month the enrollment will take effect (e.g., the document must be received by a beneficiary by June 30 for a July 1 effective enrollment date). For late-month enrollment transactions (those for which CMS confirmation of enrollment is received less than ten (10) calendar days before the end of the month prior to the effective date), MMPs must send these materials for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment.

- After the time of initial enrollment, MMPs must annually send an EOC (Member Handbook) for member receipt by December 31. MMPs choosing this option (rather than a combined ANOC/EOC (Member Handbook) by September 30) must also send an SB with the ANOC.

New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current contract year, as well as a combined ANOC/EOC (Member Handbook) document for the upcoming contract year. We clarify that, for these members, the combined ANOC/EOC (Member Handbook) for the upcoming year, as well as the formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary), and the Provider and Pharmacy Directory (or distinct and separate notice about how to access the directory online or obtain a hard copy) for the upcoming year, must be received by one month after the effective date of enrollment, but not later than December 15th.

Additional informational materials beyond the materials required to be sent with the ANOC/EOC (Member Handbook) or ANOC and EOC (Member Handbook) may be included with the ANOC, EOC (Member Handbook), or ANOC/EOC (Member Handbook) mailings consistent with the requirements of section 60.3 of the MMG.

We remind MMPs that they must upload in HPMS either (1) a standalone ANOC and a standalone EOC (Member Handbook), or (2) a combined ANOC/EOC (Member Handbook). MMPs should only use the combined ANOC/EOC (Member Handbook) material code if they are sending enrollees a combined document. Otherwise, MMPs should use both the standalone EOC and the standalone ANOC codes. Submitting materials under both standalone and combined ANOC/EOC (Member Handbook) codes will impact CMS' ANOC and EOC (Member Handbook) timeliness and accuracy monitoring efforts and may subject MMPs to compliance action.

To ensure timely mailing of their annual ANOC/EOC (Member Handbook), MMPs must indicate the actual mail date (AMD) and the number of enrollees who were mailed the documents in HPMS within fifteen (15) calendar days of mailing. This includes mail dates for alternate materials. We remind MMPs that they should enter AMD information in HPMS for mailings to current members only. Plans should not enter AMD information for October 1, November 1, or December 1 effective dates, or for January 1 effective dates for new members. MMPs that mail in waves should enter the AMD for each wave. MMPs may enter up to ten waves of mailings. MMPs that use a standalone ANOC and a standalone EOC (Member Handbook) must enter AMD information for one to ten mailing waves, as applicable, separately for both materials. MMPs that use a combined ANOC/EOC (Member Handbook) should enter AMD information for one to ten mailing waves, as applicable, only for the combined ANOC/EOC. For instructions on meeting this requirement, refer to the *Update AMD/Beneficiary Link/Function* section of the Marketing Review Users Guide in HPMS.

Note: For a single mailing to multiple recipients, as allowed under section 30.7.1 of the MMG, MMPs should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed.

MMPs must use an errata notice to notify enrollees of certain errors in their original mailings. We clarify that errata notices should only be used to notify enrollees of plan errors in plan materials. Any mid-year changes, including but not limited to mid-year

legislative benefit additions or removals and changes in enrollment policies, should be communicated to current enrollees consistent with section 60.7 of this guidance and section 60.7 of the MMG. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to plan error.

Section 60.7 – Other Mid-Year Changes Requiring Enrollee Notification

The notification requirements for mid-year Medicare benefit changes described in this section are also applicable to mid-year Medi-Cal or required demonstration additional benefit changes affecting MMPs.

Section 70.1 – Electronic Communication Policy

In addition to the requirements of this section, MMPs must include a disclaimer regarding messaging rates in electronic communications.

Section 70.2 – Marketing Through Unsolicited Contacts

Section 70.2 of the MMG provides examples of unsolicited direct contact with current and prospective enrollees. We reiterate that marketing via conventional mail and other print media (e.g., advertisements, direct mail) is not considered unsolicited contact and is therefore permissible. We also clarify, both here and in section 80.4.1 of this guidance, that marketing of MMPs to current enrollees (including those enrolled in other product lines such as its Med-Cal managed care product) is not considered unsolicited direct contact and is therefore permissible.

In addition to the requirements of section 70.2, MMPs conducting permitted unsolicited marketing activities such as conventional mail and other print media are required to include the following disclaimer on all materials used for that purpose:

> "For information on <Plan name> and other Cal MediConnect options for your health care, call the Department of Health Care Services at 1-800-430-4263 (TTY: 1-800-735-2922), or visit http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Home/default.aspx."

For purposes of this section, enrollment materials sent to passively enrolled individuals are not considered marketing through unsolicited contact.

Section 70.3 – Prospective Enrollee Educational Events

In addition to the guidance in this section, we note that, as provided under the three-way contract, the state may request that California MMPs provide current schedules of all educational events conducted for current or prospective enrollees.

Section 70.4.2 – Personal/Individual Marketing Appointments

The provisions of this section apply to MMPs, with the following modifications:

- MMP-employed sales agents are not permitted to conduct unsolicited personal/individual appointments.

- An individual appointment must only be set up at the request of the member or his/her authorized representative. An MMP can offer an individual appointment to a member who has contacted the MMP to request assistance or information. However, MMPs are prohibited from making unsolicited offers of individual appointments.

- An MMP must make reasonable efforts to conduct an appointment in the member's preferred location. An MMP cannot require that an individual appointment occur in a member's home.

In addition to the requirements outlined in this section, if enrollment applications are distributed during the course of a personal/individual marketing appointment or phone conversation, any and all associated cover pages must remain attached to the application. If plan customer service staff assist potential enrollees in filling out enrollment applications, the staff must direct the potential enrollee to first read any and all associated cover pages attached to the application. If contact is made via phone, staff must offer to read all pages aloud to the enrollee. Plan customer service staff who assist in completing an application must document their name on the application. Applications will then be forwarded to Health Care Options (HCO) to complete the enrollment process.

Section 70.5 – Marketing in the Health Care Setting

The flexibility provided in the last paragraph of this section for long-term care facility staff to provide residents meeting the eligibility criteria for an Institutional Special Needs Plan (I-SNP) with an explanatory brochure for each I-SNP with which the facility contracts is also applicable to MMPs. This flexibility is also applicable to staff in chronic and psychiatric hospitals for MMP-eligible individuals, post-stabilization.

Section 70.5.2 –Provider Affiliation Information

We clarify that the requirements of this section regarding announcements of new or ongoing provider affiliations will also apply to MMPs.

Section 70.5.4 – Comparative and Descriptive Plan Information Provided by a Non-Benefit/Non-Health Service-Providing Third Party

We clarify that the guidance in this section referring to materials provided by a "State agency" also applies to materials produced by and/or distributed by the State's enrollment broker.

Section 80.1 – Customer Service Call Center Requirements

This section is replaced with the following revised guidance:

> **Section 80.1 – Customer Service Call Center Requirements**
>
> 42 CFR 422.111(h)(1), 423.128(d)(1)
>
> MMPs must operate a toll-free call center for both current and prospective enrollees seven (7) days a week, at least from 8:00 a.m. to 8:00 p.m. PT, except as provided below. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. MMPs may use alternative technologies on

Saturdays, Sundays, and State and all Federal holidays except New Year's Day, in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide the required information listed below, and/or allow a beneficiary to leave a message in a voice mail box. A customer service representative must then return the call in a timely manner, no more than one business day later.

The use of a call center and the provision of information through a call center are mandatory for all MMPs.

Call centers must meet the following operating standards:

- Provide information in response to inquiries outlined in sections 80.2 – 80.4 of the MMG. If callers are transferred to a third party for provision of the information listed in sections 80.2 and 80.4 of the MMG, all other requirements in this section apply to the services as performed by the third party.

- Follow an explicitly defined process for handling customer complaints.

- Provide interpreter services to all non-English speaking, limited English-proficient, and hearing impaired beneficiaries.

- Inform callers that interpreter services are "free." Interpreters should be available within eight (8) minutes of reaching the CSR.

- Provide TTY service to all hearing impaired beneficiaries. CSRs through the TTY service should be available within seven (7) minutes of the time of answer.

- Limit average hold time to two (2) minutes. The average hold time is defined as the time spent on hold by the caller following the IVR system, touch-tone response system, or recorded greeting and before reaching a live person.

- Answer eighty (80) percent of incoming calls within thirty (30) seconds.

- Limit the disconnect rate of all incoming calls to five (5) percent. A disconnected call is defined as a call that is unexpectedly dropped by the MMP.

Hold time messages (messages played when an enrollee or prospective enrollees is on hold when calling the plans) that promote the MMP or include benefit information must be submitted in HPMS for review as marketing materials (see section 90.2 of the MMG for more information about the material submission process). MMPs are prohibited from using hold time messages to sell other products.

For Pharmacy Technical Help or Coverage Determinations and Appeals Call Center requirements, refer to Appendix 3 in the MMG.

Section 80.2 – Informational Scripts

We clarify that informational calls to plan call centers that become enrollment calls at the proactive request of the beneficiary may be transferred to the State enrollment broker or utilize

the streamlined enrollment process, except in the case of MMPs in the COHS counties. Plan customer service staff may not remain on the line once the call has been transferred to the State enrollment broker.

MMPs should refer to section 120.6 of this guidance, as well as section 120.6 of the MMG, for clarification of the types of activities conducted by a plan customer service representative that do not require the use of State-licensed marketing representatives. MMPs must use a State-licensed (and, when required, appointed) marketing agent for any activity that meets the definition of marketing in Appendix 1 of the MMG.

Section 80.3 – Enrollment Scripts/Calls

In addition to the guidance in this section, we clarify that MMPs should review the Streamlined Enrollment Script Checklist when developing enrollment scripts.

Section 80.4.1 – Telephonic Contact

The requirements of section 80.4.1 of the MMG apply with the following clarifications:

- Consistent with section 80.4.1 of the MMG, calls made by MMPs to current members (including those enrolled in other product lines) are not considered unsolicited direct contact and are therefore permissible. Organizations that offer non-MMP and MMP products may call their current non-MMP enrollees (for example, those in Medi-Cal managed care products), including individuals who have previously opted out of passive enrollment into an MMP, to promote their MMP offerings.

- Plans may use reasonable efforts to contact current non-MMP enrollees who are eligible for MMP enrollment to provide information about their MMP products. Callers with questions about other Medicare program options should be warm transferred to 1-800-MEDICARE or to Health Insurance Counseling and Advocacy Program (HICAP) for information and assistance.

Section 90 – The Marketing Review Process

Any references in this section, and in all subsections thereunder, to CMS in its role in reviewing marketing materials are also references to the State for purposes of MMP marketing material review.

Section 90.2.1 – Submission of Non-English and Alternate Format Materials

The requirements of this section apply without modification. We note, however, that MMPs should use state-specific MMP errata codes. For more information about errata codes, MMPs should consult the Marketing Code Look-up functionality in the HPMS marketing module.

Section 90.2.3 – Submission of Multi-Plan Materials

This section does not apply to MMPs.

Section 90.3 – HPMS Material Statuses

We clarify that, for purposes of MMP materials, there is no "deeming" of materials requiring either a dual review by CMS and the State or a one-sided State review, and materials remain in a "pending" status until the State and CMS reviewer dispositions match. Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MMPs may obtain more information about the specific review parameters and timeframes for marketing materials under the California capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. All other guidance in this section of the MMG and its subsections applies.

Section 90.5 – Timeframes for Marketing Review

We clarify that, for purposes of MMP materials, there is no "deeming" of materials requiring either a dual review by CMS and the State or a one-sided State review, and materials remain in a "pending" status until the State and CMS reviewer dispositions match. Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MMPs may obtain more information about the specific review parameters and timeframes for marketing materials under the California capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. All other guidance in this section of the MMG and its subsections applies.

Section 90.6 – File & Use Process

We clarify that the File & Use certification for MMPs is included in the three-way contract. All other guidance in section 90.6 of the MMG and all its subsections applies.

Section 100.2 – Required Content

In addition to the requirements outlined in this section, MMPs (except those in COHS counties) must also include a direct link to the State enrollment broker website on their website. MMPs must also include information on the potential for contract termination (i.e., a statement that the MMP may terminate or non-renew its contract, or reduce its service area, and the effect any of those actions may have on MMP enrollees, as required under 42 CFR 422.111(f)(4)), and information that materials are published in alternate formats (e.g., large print, braille, audio).

Section 100.2.2 – Required Documents for All Plans/Part D Sponsors

The requirements of this section apply with the following modifications:

- MMPs will not be required to post the LIS Premium Summary Chart as this document will not be applicable to MMPs.

- Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, MMPs are not required to post a CMS star ratings document on their websites.

Section 100.3 – Electronic Enrollment

We clarify that the Medicare Plan Finder Online Enrollment Center is not enabled for MMPs. Plan enrollment requests via plan secure internet websites are permissible for MMPs as specified in this section of the MMG. The State will provide additional guidance on electronic enrollment of enrollees by MMPs.

Section 100.4 – Online Formulary, Utilization Management (UM), and Notice Requirements

Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on MMP websites as required in this section. All other guidance in this section applies without modification.

Section 110.2 – Marketing of Rewards and Incentives Programs

MMPs may market rewards and incentives to current enrollees as provided in section 110.2 of the MMG. Any rewards and incentives programs must be consistent with section 100 of Chapter 4 of the Medicare Managed Care Manual.

Section 120 – Marketing and Sales Oversight and Responsibilities

All MMP enrollments will continue to be processed by the State's enrollment broker (or plan for County Organized Health System, or COHS, plans). However, we clarify that starting for CY 2018 enrollments, California MMPs will be permitted to compensate independent agent/brokers in two scenarios, further detailed in the table below, in which individuals opt in to MMPs that are offered by the same parent organization as their previous coverage (for example, a Dual Eligible Special Needs Plan, or D-SNP), and that enrollment into the previous coverage was facilitated by an independent agent/broker. This situation can occur in the middle of the initial compensation year or in a subsequent year in which the agent/broker is receiving a renewal compensation for retention in that Medicare Advantage (MA) plan.

Essentially, this policy allows the MMP to continue compensating an independent agent/broker based on the circumstances in which the same independent agent/broker would have received compensation had the member stayed in the parent organization's MA product instead of opting into the MMP. This prevents independent agent/brokers from experiencing a financial penalty if a member stays with the same parent organization but eventually elects to join the parent organization's MMP.

Table 4: Permissible Options for Compensating Independent Agents/Brokers when a Member Transitions from a Compensation-eligible MA Product by Opting into a California MMP

Original Enrollment	New Enrollment	Relationship between New and Old Enrollments	Method of Enrollment into the New Plan	Current Compensation Situation	Compensation Situation after MMP Enrollment
MA plan	MMP	Same parent organization	Member-initiated opt-in enrollment through the state's enrollment broker (or plan, for COHS plans)	MA plan is currently paying initial compensation for MA plan enrollment	MMP may elect to pay agent/broker a pro-rated initial compensation payment, as applicable depending on the timing of the enrollment, and may make renewal compensation payments for subsequent compensation cycle years
MA plan	MMP	Same parent organization	Member-initiated opt-in enrollment through the state's enrollment broker (or plan, for COHS plans)	MA plan is currently paying renewal compensation for MA plan enrollment	MMP may elect to pay agent/broker a pro-rated share of the renewal compensation payment, depending on the timing of the enrollment, and may make renewal compensation payments for subsequent compensation cycle years

Consistent with the guidance in section 120.4 et. seq. of the MMG, in the initial compensation scenario in the table above, the MA plan would be required to pro-rate the compensation paid to the agent for the months the enrollee was no longer enrolled in the MA plan.

In addition, we clarify that all other requirements applicable to independent agents/brokers throughout the MMG, including section 120 of the MMG, will be applicable to California MMPs with this policy change for CY 2018. We remind plans that all MMP enrollments will continue to be processed by the State's enrollment broker (or plan, for COHS plans).

We clarify that CMS does not regulate compensation of employed agents.

We also clarify that MMP staff conducting marketing activity of any kind – as defined in Appendix 1 of the MMG – must be licensed in the State (and, when required, appointed) as an insurance broker/agent.

Section 120.6 – Activities That Do Not Require the Use of State-Licensed Marketing Representatives

Consistent with section 120.6 of the MMG, we clarify that in order to provide more than factual information, MMP outbound callers must be State-licensed (and, when required, appointed) marketing agents. MMPs must use State-licensed (and, when required, appointed) marketing agents for any activity that meets the definition of marketing in Appendix 1 of the MMG.

Section 150 – Use of Medicare Mark for Part D Sponsors

We clarify that MMPs have been required to sign a licensing agreement to use the official Medicare Mark as part of the three-way contract rather than through the HPMS contracting module. All other guidance in section 150 of the MMG and all its subsections applies.

Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received

The disclaimer described in this section should be modified as follows:

> "Neither Medicare nor Medi-Cal has reviewed or endorsed this information."

Appendix 5 – Disclaimers

The disclaimers in Appendix 5 of the MMG apply to MMPs except as modified or clarified below.

Federal Contracting Disclaimer

This disclaimer is replaced with the following revised MMP-specific disclaimer:

> **Federal and State Contracting Disclaimer**
>
> 42 CFR 422.2264(c), 423.2264(c)
>
> All marketing materials must include the statement that the MMP contracts with both the Federal and the State government. MMPs should include the contracting statement either in the text or at the end/bottom of the piece. The following statement must be used:

"<Plan's legal or marketing name> is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees."

NOTE: In addition to the exceptions noted in section 50 of the MMG, radio, television, and internet banner ads do not need to include the Federal and State contracting disclaimer.

Benefits Are Mentioned

These disclaimers are replaced with the following revised MMP-specific disclaimers:

Benefits Are Mentioned

42 CFR 422.111(a) and (b), 422.2264, 423.128(a) and (b), 423.2264

The following disclaimers must be used when benefit information is included in marketing materials:

Only for summary documents like the SB: "This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Member Handbook."

"Limitations [, copays,] and restrictions may apply. For more information, call <plan name> <Member Services> or read the <plan name> Member Handbook." "Benefits [and/or copays] may change on January 1 of each year."

"Benefits [and/or copays] may change on January 1 of each year."

Plan Premiums Are Mentioned

This disclaimer does not apply to MMPs, as MMPs are not permitted to assess plan premiums, and States will pay Medicare Part B premiums on behalf of Medicare-Medicaid enrollees in MMPs.

Availability of Non-English Translations

This disclaimer is replaced with the following revised MMP-specific disclaimer:

Availability of Non-English Translations

42 CFR 422.2264(e), 423.2264(e)

California MMPs must place the following non-English language disclaimer on the materials identified as required for translation into non-English languages in section 30.5 of this guidance:

"If you speak <language of disclaimer>, language assistance services, free of charge, are available to you. Call <Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation>. The call is free."

The non-English language disclaimer must be included in all non-English languages that meet the more stringent of either the Medicare or the Medi-Cal translation standard (refer to section 30.5 of this guidance).

Referencing NCQA Approval

We clarify that the prohibition on discussion of numeric Special Needs Plan (SNP) approval scores in marketing materials or press releases also applies to MMPs. MMPs may only include the following information related to their National Committee for Quality Assurance (NCQA) Model of Care approval:

"<Plan name> has a Model of Care approved by the National Committee for Quality Assurance (NCQA) and California until <last contract year of NCQA and State approval of Model of Care> based on a review of <plan name>'s Model of Care."

Mentioning Cost-Sharing Information on D-SNP Materials

The following disclaimer must be on any MMP materials that mention Part D benefits unless the plan charges $0 copays for <u>all</u> Part D drugs:

"Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details."

Plans Accepting Online Enrollment Requests

This disclaimer does not apply to MMPs, as the Online Enrollment Center on the Medicare Plan Finder website is not available to MMPs.

Third Party Materials

This disclaimer applies to MMPs with the following modification to the disclaimer language:

"We give you this material for your information only. It does not take the place of your doctor's advice. The Medicare and Medi-Cal programs did not review this information."

Referencing Star Ratings Information

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this disclaimer does not apply to MMPs.

Pharmacy/Provider Network and Formulary

This disclaimer is replaced with the following revised MMP-specific disclaimer:

Provider and Pharmacy Network and Formulary (List of Covered Drugs)

42 CFR 422.111(a) and (b), 423.128(a) and (b)

The following disclaimer must be included on materials whenever the formulary (List of Covered Drugs) or provider and pharmacy networks are mentioned:

“The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.”