

Final Contract Year (CY) 2019 Marketing Guidance for California Medicare-Medicaid Plans

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Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the Contract Year (CY) 2019 Medicare Communications and Marketing Guidelines (MCMG), 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 MCMG that are not applicable or that are different for MMPs in California; therefore, this guidance document should be considered an addendum to the CY 2019 MCMG. This MMP guidance is applicable to all marketing done for CY 2019 benefits.

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 110 of this guidance. The requirements applicable to independent agents/brokers throughout the MCMG are, therefore, applicable to California MMPs in the scenarios described in section 110 of this guidance.

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/>.

Formulary and Formulary Change Notice Requirements

California MMPs should refer to the November 1, 2018 HPMS guidance memorandum, "Part D Communication Materials," for guidance on formulary and formulary change notice requirements. As noted in that memorandum, additional updates to reflect changes related to 42 CFR § 423.120(b)(5), regarding notice of mid-year formulary changes and changes to the definition of an approved month's supply, will be incorporated into the Medicare Prescription Drug Benefit Manual in a future release. In addition, we note that California MMPs are required to adhere to all new regulatory provisions and requirements.

The requirements of the November 1, 2018 HPMS guidance memorandum apply with the following modifications:

- 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 or not the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan.

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 MCMG do not apply unless specifically noted in this guidance.

- Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on California MMP websites.

Additional Guidance for California MMPs

The following is an additional California MMP-specific modification to the MCMG for CY 2019 beyond those that modify the MCMG:

- 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 20 - Communications and Marketing Definitions

MMPs are subject to marketing and beneficiary communications applicable to Medicare Advantage plans in 42 CFR Parts 422 and 423, as well as those applicable to Medicaid managed care organizations in 42 CFR Part 438. CMS has developed a joint review process for MMP beneficiary materials under each Financial Alignment Initiative capitated model demonstration that combines State and CMS review requirements and parameters. Given these differences, CMS will continue to consider all CY 2019 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F.² As a result, this section of the MCMG and its subsections do not apply to MMPs. We provide additional detail about materials subject to HPMS submission in the guidance related to section 90.1.1 of the MCMG in this document. In addition, for any other references to communications throughout the MCMG, the previous definition of marketing materials will apply.

Section 30.2 - 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 30.2 of the MCMG.

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 30.2 of the MCMG.

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.

² "Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program," which may be found in the Federal Register published April 16, 2018 (see <https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare>).

Section 30.3 - Non-English Speaking Population

The standard articulated in this section for translation of marketing materials into non-English languages 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 to or more stringent than the Medicare standard for translation for all California MMP service areas. Please refer to

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-011.pdf> for the Medi-Cal translation standards updated on June 30, 2017. 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.

CMS and the State have designated materials that have been vital and, therefore, must be translated into the non-English languages specified in this section.³ This information is located in section 100.4 of this document.

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.

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

Section 30.4 - Hours of Operation Requirements for 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's 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 County Organized Health System (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 30.6 - Electronic Communication Policy

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

³ CMS makes 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 <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html>. CMS makes available a Spanish and Chinese 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 40.2 - Marketing Through Unsolicited Contacts

Section 40.2 of the MCMG 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, therefore, is permissible.

In addition to the requirements of section 40.2 of the MCMG, 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 <https://www.healthcareoptions.dhcs.ca.gov/>.

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

Section 40.3 - Marketing Through Telephonic Contact

The requirements of section 40.3 of the MCMG apply with the following clarifications:

- Consistent with section 40.3 of the MCMG, calls made by MMPs to current members (including those enrolled in other product lines) are not considered unsolicited direct contact and, therefore, are 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 the Health Insurance Counseling and Advocacy Program (HICAP) for information and assistance.

Section 40.6 - Marketing Star Ratings

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 MCMG. Therefore, this section does not apply to MMPs.

Section 40.6.1 - Marketing Plans/Part D Sponsors 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 MCMG. Therefore, this section does not apply to MMPs.

Section 40.8 - Marketing of Rewards and Incentives Programs

MMPs may market rewards and incentives to current enrollees, as provided in section 40.8 of the MCMG. Any rewards and incentives programs must be consistent with section 100 of Chapter 4 of the Medicare Managed Care Manual.

Section 50.1 - 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 50.3 - 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 60.1 - Provider-Initiated Activities

We clarify that the guidance in this section about referring patients to other sources of information such as the "State Medicaid office" also applies to materials produced by and/or distributed by the State's enrollment broker.

Section 60.4.1 - Special Guidance for Institutional Special Needs Plans (I-SNPs) Serving Long-Term Care Facility Residents

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 60.5 - Provider Affiliation Announcements

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

Section 70.1.2 - Documents to be Posted on Website

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 MCMG. Therefore, MMPs are not required to post a CMS star ratings document on their websites.

Section 70.1.3 - 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's 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 80.2 - Customer Service Call Center Hours of Operations

We clarify that 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. Customer service call center hours and days must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication. 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/or 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 in section 80.1 of the MCMG, 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 (1) business day later. All other guidance in section 80.2 of the MCMG applies to MMPs.

Section 80.3 - Informational Scripts

We clarify that informational calls to plan call centers that become enrollment calls at the proactive request of the beneficiary must be transferred to the State's 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's enrollment broker.

MMPs should refer to section 80.7 of this guidance, as well as section 80.7 of the MCMG, 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 section 20 of this guidance.

Section 80.4 - Telesales and Enrollment Scripts

Telesales and enrollment scripts are considered marketing and must be submitted to CMS as outlined in section 90 of this guidance. In addition, we clarify that MMPs should review the Streamlined Enrollment Script Checklist when developing enrollment scripts.

Section 80.7 - Activities That Do Not Require the Use of State-Licensed Marketing Representatives

Consistent with section 80.7 of the MCMG, 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 section 20 of this guidance.

Section 90 - Tracking, Submission, and Review Process

Any references in this section of the MCMG, 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 90.1 - Material Identification

The second paragraph of this section of the MCMG is modified as follows for MMPs:

The material ID is made up of two parts: (1) MMP contract number, (i.e., H number) followed by an underscore and (2) any series of alphanumeric characters chosen at the discretion of the MMP. Use of the material ID on marketing materials must be immediately followed by the status of either approved or accepted (e.g., H1234_drugx38 Approved). Please note that MMPs should include an approved status only after the material is approved and not when submitting the material for review.

The remainder of section 90.1 of the MCMG applies to MMPs, including the requirement that non-English and alternate format materials based on previously created materials may have the same material ID as the material on which they are based.

Section 90.1.1 - Materials Subject to Submission

CMS has developed a joint review process for MMP beneficiary materials under each Financial Alignment Initiative capitated model demonstration that combines State and CMS review requirements and parameters. Given these differences, CMS will continue to consider all CY

2019 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F.⁴

Section 90.4 - Submission of Websites and Webpages for Review

We clarify that the guidance in section 90.4 of the MCMG applies to California MMPs, with the following modification:

- All website content must be submitted in HPMS as a File & Use submission under the Internet Website marketing material code for CA.

Section 90.5 - Submission of Multi-Plan Materials

This section does not apply to MMPs.

Section 90.6 - Status of HPMS Material

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. In addition, we note that the “non-marketing” status is not available for joint review process (JRP) marketing codes in HPMS for CY 2019. All other guidance in this section of the MCMG applies.

Section 90.8 - File & Use Process

We clarify that the File & Use certification process for MMPs is included in the three-way contract. All other guidance in section 90.8 of the MCMG applies.

Section 100 - Required Materials

We clarify that CMS will continue to consider all CY 2019 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F.⁴ As a result, all marketing materials must be submitted in HPMS. All other portions of this section apply to MMPs.

Section 100.4 - List of Required Materials

This section is replaced with the following revised guidance:

Section 100.4 - List of Required Materials 42 CFR Parts 417, 422, 423, 438

⁴ “Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program,” which may be found in the Federal Register published April 16, 2018 (see <https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare>).

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 in Appendix 2 of this guidance and Appendix 2 of the MCMG, 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; welcome letters for opt-in and passively enrolled individuals; and other plan-delegated enrollment notices: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.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>.

Required Materials and Instructions for MMPs

Below is a list of required materials for California MMPs. In addition, we provide high-level information for each material. Guidance (as noted) should be reviewed as applicable. Additionally, MMPs should consult the HPMS Marketing Code Look-up functionality for specific codes and instructions for uploading required materials.

Annual Notice of Changes (ANOC)	
<i>To Whom Required:</i>	Must be provided to current enrollees of the plan, including those with October 1, November 1, and December 1 effective dates.
<i>Timing:</i>	<ul style="list-style-type: none"> • MMPs must send for enrollee receipt no later than September 30 of each year. (Note: The ANOC must be posted on MMP website by October 15.) • Enrollees with October 1, November 1, and December 1 enrollment effective dates must receive the ANOC for the upcoming year by one (1) month after the effective date of enrollment but not later than December 15.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> • Code 15109. • Must be submitted prior to mailing ANOCs.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • CA MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • Actual Mail Dates (AMDs) and number of recipients (not the number of ANOCs mailed) must be entered into HPMS within 15 days of mailing. This includes mail dates for alternate materials. MMPs that mail in waves should enter the AMD for each wave. MMPs may enter up to ten waves of mailings. For instructions on meeting this requirement, refer to the <i>Update AMD/Beneficiary Link/Function</i> section of the Marketing Review Users Guide in HPMS. • Note: For a single mailing to multiple recipients, as allowed under section 100.1 of the MCMG, MMPs should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed. • Plans may include the following with the ANOC: <ul style="list-style-type: none"> ○ Summary of Benefits (SB) ○ Provider and Pharmacy Directory ○ EOC (Member Handbook) ○ Formulary (List of Covered Drugs) ○ Form allowing enrollees to “opt in” to receiving their upcoming ANOC and EOC (Member Handbook) via email ○ No additional plan communications unless otherwise directed
<i>Translation Required (5% Threshold):</i>	Yes.

ANOC and EOC (Member Handbook) Errata	
<i>To Whom Required:</i>	Must be provided when plan errors are found in the ANOC or EOC (Member Handbook) and sent to current enrollees.
<i>Timing:</i>	Must send to enrollees immediately following CMS approval.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> • Code 15106 for ANOC errata. • Code 15171 for EOC (Member Handbook) errata. • ANOC errata must be submitted by October 15. • EOC (Member Handbook) errata must be submitted by November 15.
<i>Format Specification:</i>	Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<p>MMPs must use an errata notice to notify enrollees of plan errors in their original documents. We clarify that errata notices should only be used to notify enrollees of plan errors in plan materials.</p> <p>Note: 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 the “Mid-Year Change Notification” guidance in this section. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to plan error. Instead, plans should use the HPMS marketing module replacement function for these changes.</p>
<i>Translation Required (5% Threshold):</i>	Yes.

Coverage/Organization Determination, Discharge, Appeals and Grievance Notices	
<i>To Whom Required:</i>	<ul style="list-style-type: none"> • Must be provided to enrollees who have requested an appeal or have had an appeal requested on their behalf. • Grievances may be responded to electronically, orally, or in writing.
<i>Timing:</i>	Provided to enrollees (generally by mail) on an ad hoc basis, based on required timeframes in three-way contract.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	Various codes for other CMS required notices. Refer to HPMS Marketing Code Look-up functionality for CA MMP codes.
<i>Format Specification:</i>	Other CMS models; modifications permitted.
<i>Guidance and Other Needed Information:</i>	Three-way contract, Chapter 13 of the Medicare Managed Care Manual, and Chapter 18 of the Medicare Prescription Drug Benefit Manual.
<i>Translation Required (5% Threshold):</i>	Yes.

Evidence of Coverage (EOC) / Member Handbook	
<i>To Whom Required:</i>	Must be provided to all enrollees of plan.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must send to current enrollees of plan for receipt by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • 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 an EOC (Member Handbook) document for the upcoming contract year. We clarify that, for these members, the ANOC may be included in the EOC (Member Handbook) or provided separately, 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 a distinct and separate notice alerting enrollees how to access or receive the directory) for the upcoming year, must be received by one (1) month after the effective date of enrollment, but not later than December 15.
<i>Method of Delivery:</i>	<ul style="list-style-type: none"> • New enrollees - must send hard copy (required). • Existing (not new) enrollees - may send notice informing them how to access the EOC (Member Handbook) electronically instead of mailing hard copies of the document (consistent with section 100.2.1 of the MCMG).
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> • Code 15108. • Submitted prior to October 15 of each year.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • CA MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	No additional information.
<i>Translation Required (5% Threshold):</i>	Yes.

Excluded Provider Letter	
<i>To Whom Required:</i>	Provided to enrollees when a sponsor has excluded a prescriber or pharmacy participating in the Medicare program based on an Office of Inspector General (OIG) exclusion.
<i>Timing:</i>	Provided to enrollees on an ad hoc basis.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	Code 15137.
<i>Format Specification</i>	Model provided; modifications permitted.
<i>Guidance and Other Needed Information:</i>	https://oig.hhs.gov/fraud/exclusions.asp
<i>Translation Required (5% Threshold):</i>	Yes.

Explanation of Benefits (EOB) – Part D	
<i>To Whom Required:</i>	Must be provided anytime an enrollee utilizes their prescription drug benefit.
<i>Timing:</i>	Sent at the end of the month following the month when the benefit was utilized.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	Code 15136.
<i>Format Specification:</i>	Part D EOB model; modifications permitted.
<i>Guidance and Other Needed Information:</i>	Three-way contract and Medicare Prescription Drug Benefit Manual, Chapters 5 and 6, and HPMS code usage instructions.
<i>Translation Required (5% Threshold):</i>	Yes.

Formulary (List of Covered Drugs)	
<i>To Whom Required:</i>	Must be provided to all enrollees of plan.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must be sent to current enrollees of plan for receipt by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.
<i>Method of Delivery:</i>	Hard copy or via Electronic Notice of Documents (consistent with section 100.2.1 of the MCMG); or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	Code 15103.
<i>Format Specification:</i>	Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • 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. • OTC items and/or supplemental benefits that are in excess of Medicaid requirements may not be included in this document. • MMPs are only permitted to make available a comprehensive, not abridged, formulary (List of Covered Drugs).
<i>Translation Required (5% Threshold):</i>	Yes.

Integrated Denial Notice	
<i>To Whom Required:</i>	Any enrollee with an adverse benefit determination.
<i>Timing:</i>	Provided to enrollees (generally by mail) on an ad hoc basis, at least ten (10) days in advance of any adverse benefit determination.
<i>Method of Delivery:</i>	Hard copy or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	Code 15121.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • CA MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	Three-way contract.
<i>Translation Required (5% Threshold):</i>	Yes.

Member ID Card	
<i>To Whom Required:</i>	Must be provided to all plan enrollees.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • Must also be provided to all enrollees if information on existing card changes.
<i>Method of Delivery:</i>	Must be provided in hard copy. In addition to the hard copy, plans may also provide a digital version (e.g., app).
<i>HPMS Timing and Submission:</i>	Code 15111.
<i>Format Specification:</i>	Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	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.
<i>Translation Required (5% Threshold):</i>	No.

Mid-Year Change Notification to Enrollees	
<i>To Whom Required:</i>	Must be provided to all applicable enrollees when there is a mid-year change in benefits, plan rules, formulary, provider network, or pharmacy network.
<i>Timing:</i>	Ad hoc, based on specific requirements for each issue.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	Various codes. Refer to HPMS Marketing Code Look-up functionality for CA MMP codes.
<i>Format Specification:</i>	Model not available; must include required content.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until model notice is received from CMS. • MMPs may elect to share Non-Renewal and Service Area Reduction (NR/SAR) information only with first tier, downstream, and related entities (FDRs) or anyone that the MAO does business with (i.e., contracted providers). • Additional NR/SAR notice information can be found in the annual “Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models” HPMS memo. • If a non-model document is created, the document must contain all the elements in the model.
<i>Translation Required (5% Threshold):</i>	Yes.

Outbound Enrollment Verification	
<i>To Whom Required:</i>	Must be provided for all agent/broker assisted enrollments.
<i>Timing:</i>	Must be conducted within 15 calendar days following the receipt of the enrollment request.
<i>Method of Delivery:</i>	Hard copy, telephonic, email.
<i>HPMS Timing and Submission:</i>	Code 15156.
<i>Format Specification:</i>	Model not available; must include required content.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • Communication must address enrollment into Part C or Part D Plan and provide customer service number for beneficiary questions regarding costs, benefits, rules, or any other question about the Part C/Part D Plan. • May be completed via phone call (including during welcome call) or via email, if email is requested by an enrollee. • Must send a written communication if the Plan/Part D sponsor fails to speak with the individual within 15 calendar days of enrollment requests. • Agent/brokers are not permitted to be part of the enrollment verification call. • Enrollment verification processes must stop if Plan/Part D sponsor is notified that beneficiary is ineligible to enroll in plan or if beneficiary has canceled the enrollment. • Method and timing of the enrollment verification must be documented (date, time, and method of contact).
<i>Translation Required (5% Threshold):</i>	Yes.

Part D Transition Letter	
<i>To Whom Required:</i>	Must be provided when a beneficiary receives a transition fill for a non-formulary drug.
<i>Timing:</i>	Must be sent within three (3) days of adjudication of temporary transition fill.
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	Code 15140.
<i>Format Specification:</i>	Model provided; modifications permitted.
<i>Guidance and Other Needed Information:</i>	Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4.10.
<i>Translation Required (5% Threshold):</i>	Yes.

Plan-Delegated Enrollment and Disenrollment Notices	
<i>To Whom Required:</i>	Must be provided as outlined in National Enrollment/Disenrollment Guidance for States & MMPs.
<i>Timing:</i>	Varies; must follow required timeframes as outlined in National Enrollment/Disenrollment Guidance for States & MMPs.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	Codes 15153 and 15154.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • CA MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • National Enrollment/Disenrollment Guidance for States & MMPs. • CA Enrollment Guidance Appendix 5. • MMPs must use the Marketing Code Lookup functionality in the HPMS Marketing Module, along with the enrollment/disenrollment guidance to determine the most appropriate code for their submissions.
<i>Translation Required (5% Threshold):</i>	Yes.

Pre-Enrollment Checklist	
<i>To Whom Required:</i>	Must be provided to potential enrollees with the Summary of Benefits (SB) when the SB is accompanying an enrollment form.
<i>Timing:</i>	Prior to enrollment.
<i>Method of Delivery:</i>	In the same format the SB was provided.
<i>HPMS Timing and Submission:</i>	Code 15170.
<i>Format Specification:</i>	Model required. Modifications to disclaimer language is not permitted; however, COHS plans may delete bullets that do not apply to their specific plan type.
<i>Guidance and Other Needed Information:</i>	Must accompany the SB. Refer to Appendix 3 in this document and in the MCMG.
<i>Translation Required (5% Threshold):</i>	Yes.

Prescription Transfer Letter	
<i>To Whom Required:</i>	When a Part D sponsor requests permission from an enrollee to fill a prescription at a different network pharmacy than the one currently being used by enrollee.
<i>Timing:</i>	Ad hoc.
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	Code 15138.
<i>Format Specification:</i>	Part D model provided; modifications permitted.
<i>Guidance and Other Needed Information:</i>	The model notice should only be used when the transfer of the prescription is not initiated by the beneficiary (or someone on his or her behalf).
<i>Translation Required (5% Threshold):</i>	Yes.

Provider and Pharmacy Directory	
<i>To Whom Required:</i>	Must be provided to all current enrollees of the plan.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must be sent to current enrollees of Plan for receipt by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be provided to current enrollees upon request, within three (3) business days of the request. • Must update directory information any time they become aware of changes. All updates to the online provider and pharmacy directories are expected to be completed within 30 days of receiving information. Updates to hard copy provider and pharmacy directories must be completed within 30 days; however, hard copy directories that include separate updates via addenda are considered up-to-date.
<i>Method of Delivery:</i>	Hard copy or via Electronic Notice of Documents (consistent with section 100.2.1 of the MCMG); or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
<i>HPMS Timing and Submission:</i>	Code 15104.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • CA MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.

Provider and Pharmacy Directory	
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • MMPs are required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. MMPs may print separate directories for primary care physicians (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. • For MMPs with 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. • 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. • As applicable, refer to the language and guidelines issued in the August 16, 2018, HPMS memorandum, "Pharmacy Directories and Disclaimers" for the pharmacy portion of the combined directory.
<i>Translation Required (5% Threshold):</i>	Yes.

Scope of Appointment (SOA)	
<i>To Whom Required:</i>	Must be documented for all marketing activities, in-person, telephonically, including walk-ins to Plan/Part D sponsor or agent offices.
<i>Timing:</i>	Prior to the appointment.
<i>Method of Delivery:</i>	Beneficiary signed hard copy, telephonic recording, or electronically signed.
<i>HPMS Timing and Submission:</i>	Code 15148.
<i>Format Specification:</i>	No model required; must include required content.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • The following requirements must be on the scope of appointment (SOA) form or on the recorded call: <ul style="list-style-type: none"> ○ Product types to be discussed ○ Date of appointment ○ Beneficiary and agent contact information ○ Statement stating no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur. • A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon.
<i>Translation Required (5% Threshold):</i>	Yes.

Summary of Benefits (SB)	
<i>To Whom Required:</i>	Enrollees who are passively enrolled. Optional with the ANOC and as requested for other enrollees.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be available by October 15 of each year, but can be released as early as October 1 of each year.
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	Code 15101. Submitted prior to October 15 of each year.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • CA MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • 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. • Appendix 5 of the MCMG, Summary of Benefit Instructions, does not apply.
<i>Translation Required (5% Threshold):</i>	Yes.

Welcome Letter	
<i>To Whom Required:</i>	Must be provided to all new enrollees of MMP.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	Code 15102.
<i>Format Specification:</i>	CA MMP model required for Contract Year.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • Must contain 4Rx information consistent with the model. • National Enrollment/Disenrollment Guidance for States & MMPs section 30.5.1.
<i>Translation Required (5% Threshold):</i>	Yes.

Required Materials for New MMP Enrollees

The following table summarizes the required materials, and timing of receipt, for new MMP enrollees.

Table 1. Required Materials for New Members

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Passive enrollment	<ul style="list-style-type: none"> • 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 ⁵
Passive enrollment	<ul style="list-style-type: none"> • Member ID Card • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to receive the EOC) 	No later than the day prior to the effective date of enrollment
Opt-in enrollment (with enrollment confirmation received more than ten (10) calendar days before the end of the month) ⁶	<ul style="list-style-type: none"> • 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) (or a distinct and separate notice alerting enrollees how to receive the EOC) 	No later than the last day of the month prior to the effective date

⁵ 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.

⁶ 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. 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.

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received less than ten (10) calendar days before the end of the month) ⁷	<ul style="list-style-type: none"> • 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

Section 110 - Agent/Broker Activities, Oversight, and Compensation Requirements

All MMP enrollments continue to be processed by the State’s enrollment broker (or plan for County Organized Health System, or COHS, plans). However, we clarify that California MMPs are permitted to compensate independent agent/brokers in two scenarios, further detailed in the following table, 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.

⁷ 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. 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.

Table 2. 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 110.6.5 et seq. of the MCMG, 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.

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 section 20 of this guidance – must be licensed in the State (and, when required, appointed) as an insurance broker/agent.

In addition, we clarify that, for CY 2019 enrollments, California MMPs approved by the California Department of Health Care Services will be permitted to use and compensate independent agents/brokers for MMP enrollments in accordance with requirements of the HPMS memorandum, “California MMPs: Update to Agent/Broker Compensation Policy for Contract Year 2019,” dated June 11, 2018, and all applicable Medicare guidance, including the MCMG.

We remind plans that all MMP enrollments continue to be processed by the State’s enrollment broker (or plan, for COHS plans).

Appendix 2 - Disclaimers

The disclaimer language in the table below replaces the language in Appendix 2 of the MCMG.

Table 3. State-specific MMP Disclaimers

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Federal Contracting	<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.	Required on materials as described in the “Applicable Documents and Notes” column in Appendix 2 of the MCMG.
Benefits – “This is not a complete list...”	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 <plan name> Member Handbook.	Required on the SB and all materials with 10 or more benefits except the EOC (Member Handbook).
Availability of Non-English Translations	ATTENTION: 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.	Required on materials as described in the “Applicable Documents and Notes” column in Appendix 2 of the MCMG.
Plan Online Enrollment Center	This disclaimer does not apply to MMPs.	N/A
Star Ratings	This disclaimer does not apply to MMPs.	N/A
Materials Developed by a Third Party	This disclaimer does not apply to MMPs.	N/A

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Non-plan and Non-health Information	Neither Medicare nor Medi-Cal has reviewed or endorsed this information.	Required on non-plan and non-health related information once prior authorization from the enrollee is granted to receive materials.

Appendix 3 - Pre-Enrollment Checklist

The requirements of Appendix 3 of the MCMG apply **only** to COHS MMPs in California. COHS MMPs should follow the guidance in Appendix 3 with the following modifications:

- Delete the following language, “In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.”
- Revise the following language from, “Benefits, premiums and/or copayments/co-insurance may change on January 1, [insert year]” to “Benefits and/or [*insert if applicable*: copays] may change on January 1, [insert year].”
- Add the following bullet, “This plan is a Medicare-Medicaid Plan (MMP). Your ability to enroll will be based on verification that you are entitled to both Medicare and Medicaid.” Plans must revise references to “Medicaid” to “Medi-Cal,” the State-specific name for the program.
- Modify the references to “Evidence of Coverage” to “Member Handbook (Evidence of Coverage).”
- Modify the references to “provider directory” and “pharmacy directory” to “Provider and Pharmacy Directory.”

In addition, as indicated in section 100.4 of this document, COHS MMPs should submit this document as a File & Use submission in HPMS under code 15170, (CA) COHS Plan Pre-Enrollment Checklist.

Appendix 7 - 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 Appendix 7 of the MCMG applies.