DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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**CENTER FOR MEDICARE**

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TO: Medicare Advantage Organizations
Medicare Advantage-Prescription Drug Organizations
Cost-Based Contractors
Prescription Drug Plan Sponsors

FROM: Danielle Moon, J.D., M.P.A.
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RE: Clarification of Medicare Marketing Guidelines Requirements and Outbound Enrollment Verification Policy

On June 4, 2010, CMS sent an HPMS memorandum announcing the issuance of the revised Medicare Marketing Guidelines (MMG) as Chapters 3 and 2 of the Medicare Managed Care Manual and the Prescription Drug Benefit Manual, respectively. Since the release of the revised Medicare Marketing Guidelines, many plan sponsors have requested additional clarification about some of this new guidance. The purpose of this memorandum is to provide clarifying guidance (see Attachments 1 and 2) regarding the following sections of the MMG:

- Section 30.7 Requirements for Plan Sponsors with Non-English Speaking Populations or Populations with Special Needs, specifically with regard to ID cards;
- Section 40.1 Marketing Material Identification Number, specifically with regard to envelopes;
- Section70.6 Outbound Enrollment and Verification Calls to All New Enrollees
- Section 90.2.1 Mandatory Use of Marketing Material Review Checklists for All Documents;
- Section 90.8 Template Materials; and
- Section 90.21 Materials Not Subject to Review

The clarifications in this memorandum apply to all plan sponsors, with the exception of employer or union-sponsored plans and PACE organizations. These clarifications are effective immediately upon release of this guidance memorandum. Plan sponsors should contact their CMS Regional Office Account Manager or Marketing Reviewer with any questions about these requirements.

Attachment 1 – Clarifying Guidance for Sections 30.7, 40.1, 70.6, 90.2.1 and 90.8 of the Medicare Marketing Guidelines

Attachment 2 – Replacement for Section 70.6 (Outbound Enrollment and Verification Calls to All New Enrollees) of the Medicare Marketing Guidelines

**ATTACHMENT 1: Clarifying Guidance for Sections 30.7, 40.1, 70.6, 90.2.1 and 90.8 of the Medicare Marketing Guidelines (MMG)**

**Section 30.7 (Requirements for Plan Sponsors with Non-English Speaking Populations or Populations with Special Needs)**

Section 30.7 of the MMG stipulates that plan sponsors must make marketing materials in sections 30.9, 30.10, and 30.11 of the MMG available in any language that is the primary language of more than ten percent of a plan sponsor's PBP service area. Section 30.10 includes the membership ID card as a material that plan sponsors are required to provide to enrollees at the time of enrollment and as needed or required by the plan sponsor post-enrollment and therefore is among the materials that required translation, per section 30.7 of the MMG. We clarify that member ID cards are excluded from the translation requirements in section 30.7 of the MMG. However, if a plan sponsor has already issued and/or provided membership ID cards in an alternate language, then the plan sponsor may continue to do so at its discretion. Plan sponsors should note that all other materials listed in sections 30.9, 30.10, and 30.11 of the MMG, including plan ratings information, are subject to translation requirements. Translation of plan ratings information will not be considered an alteration of the document.

**Section 40.1 (Marketing Material Identification Number)**

We clarify that CMS will not require plan sponsors to include the marketing material identification number on envelopes. However, with respect to submission and review of envelopes, plan sponsors will be required to submit, under the File & Use process, a Word document with one of the four CMS approved mailing statements, rather than actual envelopes. We note that the requirements regarding plan sponsor mailing statements in section 50.2 of the MMG – including the requirement that envelopes with additional information beyond one of the four mailing statements must be submitted for a 45-day review – still apply. Envelopes must be submitted using marketing code 9003. Plan sponsors should ensure that envelopes follow the font size requirement in section 40.2 of the MMG and that any mailing statements provided be consistent with section 50.2 of the MMG so information is prominently displayed and beneficiaries can easily identify the content of the mailer.

We also clarify that envelopes only need to be re-submitted when there is a change in content. Envelopes do not need to be re-submitted based only on a change in envelope size. Specifically, if a plan uses the same mailing statement on 3 different mailing packages (e.g., 8 x 12 envelope, letter size envelope, and box) the envelope with each mailing statement only needs to be submitted once, provided the required mailing statement remains unchanged and additional information is not included.

**Section 70.6 (Outbound Enrollment and Verification Calls to New Enrollees)**

In our June 4, 2010 memorandum, we indicated that final guidance regarding outbound enrollment verification (OEV) processes and timelines would be issued as a part of the final enrollment/disenrollment guidance (Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Prescription Drug Benefit Manual). Many plan sponsors have submitted

comments regarding these draft requirements. After considering these comments, we are issuing this additional guidance on OEV processes and timelines as part of the CY 2011 MMG.

Specifically, our OEV process and timeline requirements for CY 2011 enrollments are as follows:

- Plan sponsors must make at least three (3) documented attempts to contact the applicant by telephone within fifteen (15) calendar days – not ten (10) calendar days, as provided in previous draft enrollment/disenrollment guidance for CY 2011 – of receiving the enrollment request. If plan sponsors are unable to successfully complete the telephone verification on the first attempt, then they must send the applicant an enrollment verification letter. Plan sponsors must not delay processing the enrollment request (including activation of benefits and submission of enrollment request data to CMS) while completing the OEV process.

- Any enrollment verification letter that is sent is in addition to any required enrollment notice, such as enrollment acknowledgment and confirmation letters. After the model enrollment verification letter has been sent, the plan sponsor must make and document at least two additional telephone attempts to successfully complete the verification. Plan sponsors must document enrollment verification activities.

- The outbound enrollment verification script and letter must inform beneficiaries that they must notify the plan sponsor of their intent to cancel the processing of their enrollment within seven (7) calendar days of the date of the letter or call, or by the latest day of the month in which the enrollment request was received, whichever is later.

- We will update model enrollment verification and telephone scripts for CY 2011 and issue them separately.

Attachment 2 contains replacement language for section 70.6 of the MMG. Until we update the Guidelines in 2011 for CY 2012, plan sponsors should refer to this revised language rather than the current language in section 70.6 of the CY 2011 MMG released on June 4, 2010.

**Section 90.2.1 (Mandatory Use of Marketing Material Review Checklists for All Documents)**

After careful evaluation, CMS has determined that the purpose of checklists is satisfied through other existing means such as the attestation, which is required upon submission of every marketing material, and the MMG. Therefore, effective with the issuance of this memorandum, checklists – including all checklists previously released for CY 2011 – will no longer be utilized. The language in the attestation has been updated and revised in the HPMS.

**Section 90.8 (Template Materials) and Section 90.21 (Materials Not Subject to Review)**

The MMG require plan sponsors to submit populated versions for all approved template materials. As we have begun to implement this revised policy, a number of operational concerns have emerged, such as concerns with uploading populated versions of *every* variable element and

the impact on plan sponsor compliance with the 90/10 rule for File & Use materials (see section 90.6.3 of the MMG).

Section 20 of the MMG defines templates as any marketing materials that include placeholders to be populated by variable elements. Section 90.6.2 of the MMG states that template materials do not qualify for File & Use. We clarify, for applicable codes, that if a model material is used without modification and File & Use is indicated as being available for the category and code, the material is still eligible for File & Use, and may be eligible to be designated as a template material. Plan sponsors that choose to modify model materials must continue to submit the material for review. We note that model materials used without modification will not count against plans in the 90/10 report regardless of their template status.

Upon further evaluation, we are also revising our policy to exclude specific variable placeholders from the population requirement. Specifically, the following variable placeholders do NOT need to be resubmitted after population:

- Dates;
- Events;
- Addresses, phone or fax numbers;
- Hours of operation;
- Organization or company names;
- Plan name;
- Logos;
- Agent/Agency
- Persons' names and pronoun variations; and
- Member specific variables (i.e., case numbers, drug specific references and coverage determination decisions)

Materials with any other variable placeholders, including those for plan specific benefits, premium, and cost-sharing information must be submitted through the template process and finalized by uploading the "Final Expedited Review/Populated Template" in HPMS.

When submitting a material with variable placeholders in the HPMS, plan sponsors should indicate that the material is a template when initially submitting the piece by checking the "Template Material" field, and entering a "Template Material ID" as required. Plan sponsors should submit templates using current material codes and categories that define a piece. We clarify that templates must be populated within 30 days of the approved date, 30 days of the File & Use distribution date, or 30 days of the approved bid for materials filed prior to bid approval. Plan sponsors are responsible for submitting final versions of templates in the HPMS Marketing Module using the associated "Final Expedited Review" code, and will be required to enter the "Template Material ID" of the original "MASTER" template material in the "Template Material ID" field. Note that "Final Expedited Review" materials will receive a status of "Populated Template" in the HPMS, and do not required prospective reviews. Note that CMS has created additional final expedited review codes for each material category for this purpose.

Model template materials submitted without modification may be submitted as File & Use (assuming File & Use is available for that code). When submitting a model document without modification as a template, plan sponsors must select "Template Materials" and should not change the File & Use status in order for the material to be submitted appropriately. Section 90.10 of the MMG outlines CMS' expectations for submitting templates and indicates that changes to placeholder information do not need to be submitted as a new material, but that plan sponsors must submit final populated versions of templates.

Finally, we clarify that ad-hoc enrollee communications will be exempt from our template guidance, as these materials can only be submitted File & Use, as described in section 90.2.2 of the MMG. This clarification modifies section 90.21 of the MMG by requiring that customer service correspondence pertaining to unique questions or issues that affect an individual or small subset of the plan's enrollment" —that is, ad-hoc enrollee communications, defined in section 20 of the MMG – must be filed in HPMS under marketing code 7013 ("Ad-Hoc Enrollee Communications") under the File & Use process.

**ATTACHMENT 2 – Replacement Language for Section 70.6 (Outbound Enrollment and Verification Calls to All New Enrollees) of the Medicare Marketing Guidelines**
***(Language changes reflected by bold and italicized font below)***

## 70.6 Outbound Education and Verification Calls to All New Enrollees

*(Rev. Issued 08-X-10, Effective/Implementation 08-X-10)*

42 CFR 422.2272(b), 42 CFR 423.2272(b)

All plan sponsors are required to conduct outbound education and verification calls for enrollments effectuated by agents and brokers – including both independent and employed agents and brokers – to ensure beneficiaries requesting enrollment understand the plan rules. It is important for the plan sponsor's sales staff to obtain from the applicant the best phone number to be used for verification and to provide a description of the enrollment verification process to the applicant during the application process.

Outbound calls mean that calls are made to the applicant after the sale has occurred. Calls cannot be made at the point of sale. The plan sponsor must ensure that the verification calls made to applicants are not made directly by sales agents and also that the sales agents are not physically present with the applicant at the time of the verification call. Plan sponsors may not use automated calling technologies to effectuate these outbound calls; our expectation is the calls will be interactive. The plan sponsor must conduct these calls for all new enrollments effectuated by agents and brokers (including both independent and employed agents and brokers). Excluded from this requirement include enrollments into employer or union sponsored plans, enrollments into PACE plans, auto-enrollments, facilitated enrollments, and reassignments effectuated by CMS, enrollments submitted by State Pharmaceutical Assistance Programs (SPAPs), and enrollments from one plan to another plan offered by the same MA organization or PDP sponsor, regardless of the role of agents and brokers. Please note that if a member with LIS makes an enrollment request that supersedes or changes a CMS-generated enrollment, and that election is effectuated by an agent or broker, the outbound verification requirements apply.

***Plan-to-plan switches within an MA or Part D parent organization (both contract-to-contract and within contract) require outbound enrollment verification if the enrollment request involves a change in plan type or plan product (e.g., HMO to PPO, SNP HMO to non-SNP HMO). Plan-to-plan switches within an MA or Part D parent organization involving the same plan type or product type (e.g., PFFS to PFFS, DE SNP to DE SNP, PDP to PDP) are not subject to OEV requirements.***

Plan sponsors may continue to use existing scripts provided that they convey the information included in the most up-to-date model script. New or revised scripts must be submitted to CMS through the normal process for approval.

We expect plan sponsors to make a minimum of three documented attempts to contact the applicant by telephone within fifteen (15) calendar days of receiving the enrollment request. If the plan sponsor is unable to successfully complete the outbound verification on the first attempt, we expect the sponsor to send the applicant an enrollment verification letter.

***Plan sponsors must not delay processing the enrollment request (including, but not limited to, activation of benefits and submission of enrollment request data to CMS) while completing the OEV process.***

Any enrollment verification letter that is sent is in addition to any other required enrollment notice, such as enrollment acknowledgement and confirmation letters. After the model enrollment verification letter has been sent, the plan sponsor is expected to make and document at least two additional telephone attempts to successfully complete the outbound enrollment verification. The minimum three attempts to conduct the verification by telephone and, if applicable, the mailing of the enrollment verification letter, are expected to be completed no later than ***fifteen (15) calendar days*** of the plan sponsor's receipt of the enrollment request. Plan sponsors must document outbound enrollment verification activities. We expect that both the script and the enrollment verification letter will inform beneficiaries that they must notify the plan sponsor of their intent to cancel the processing of their enrollment within seven (7) calendar days from the date of the letter or call or the last day of the month in which the enrollment request was received, whichever is later

***The outbound verification requirements apply to sales agents and other plan representatives only when they are acting in the role of sales agents and as such, are steering beneficiaries to one or a subset of all available plans. In other words, if a licensed agent is acting strictly as a customer service representative – that is, carrying out customer service duties such as providing factual information, or taking demographic information in order to complete an enrollment request at the initiative of an enrollee who has already decided to enroll in a plan – the outbound enrollment verification requirements do not apply. However, if there is steering and/or marketing by the CSR/agent and an enrollment request results, such an enrollment request is subject to the OEV requirements***.