Final CY 2014 Marketing Guidance for California Medicare-Medicaid Plans

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Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the CY 2014 Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual) and posted at: http://www.cms.gov/ManagedCareMarketing, apply to Medicare-Medicaid plans (MMPs) participating in the California Capitated Financial Alignment Demonstration, except as noted or modified in this guidance document.[1]

This guidance document provides information only about those sections of the Medicare Marketing Guidelines that are not applicable or that would be different for MMPs in California; therefore, this guidance document should be considered an addendum to the CY 2014 Medicare Marketing Guidelines (MMGs). This MMP guidance will be applicable to all marketing done for CY 2014 benefits. The table below summarizes those sections of the CY 2014 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 (MMGs) Section	Change in this Guidance Document
Section 10 – Introduction	Clarifies guidance on marketing start dates for CY 2014 and CY 2015.
Section 30.5 – Requirements Pertaining to Non-English Speaking Populations	Clarifies the requirements of this section for MMPs.
Section 30.5.1 – Multi-Language Insert	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 Members at Time of Enrollment and Thereafter	Replaces current guidance in MMGs with new guidance for MMPs.
Section 30.10 – Star Ratings Information from CMS	Clarifies that the requirements of this section are not applicable to MMPs.

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

Medicare Marketing Guidelines (MMGs) Section	Change in this Guidance Document
Section 30.10.1 – Referencing Star Ratings in Marketing Materials	Clarifies that the requirements of this section are not applicable to MMPs.
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	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 – Marketing of Multiple Lines of Business	Replaces current guidance in this section with new guidance for MMPs.
Section 40.8.3 – Marketing Materials from Third Parties that Provide Non-Benefit/Non-Health Services	Clarifies that these 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 50.1 – Federal Contracting Disclaimer	Replaces current disclaimer in this section with a new Federal-State disclaimer for MMPs.
Section 50.2 – Disclaimers When Benefits are Mentioned	Replaces current disclaimers in this section with new disclaimers for MMPs.
Section 50.3 – Disclaimers When Plan Premiums are Mentioned	Clarifies that the requirements of this section are not applicable to MMPs.
Section 50.4 – Disclaimer on Availability of Non-English Translations	Replaces current disclaimer in this section with a new disclaimer for MMPs.
Section 50.5 – SNP Materials	Clarifies that MMPs must include a disclaimer regarding the NCQA approval of their model of care and replaces current disclaimer in this section with a new disclaimer for MMPs.
Section 50.6 – Dual Eligible SNP Materials	Replaces current disclaimer in this section with a new disclaimer for MMP materials that include Part D benefit information.
Section 50.12 – Disclaimer for Plans Accepting Online Enrollment Requests	Clarifies that the requirements of this section are not applicable to MMPs.

Medicare Marketing Guidelines (MMGs) Section	Change in this Guidance Document
Section 50.13 – Disclaimer When Using Third Party Materials	Replaces current disclaimer in this section with a new disclaimer for MMPs.
Section 50.14 – Disclaimer When Referencing Star Ratings Information	Clarifies that the requirements of this section are not applicable to MMPs.
Section 60.1 – Summary of Benefits	Replaces current guidance in this section with new guidance for MMPs.
Section 60.2 – ID Card Requirements	Clarifies the requirements of this section for MMPs.
Section 60.4 – Directories	Clarifies the requirements of this section for MMPs and provides additional flexibility regarding the requirements for providing MMP directories to enrollees at the time of enrollment and thereafter.
Section 60.5 – 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.
Section 60.7 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)	Replaces current guidance in this section with new guidance for MMPs.
Section 60.8 – Other Mid-Year Changes Requiring Enrollee Notification	Extends the requirements of this section to mid-year changes in Medicaid benefits.
Section 70.5 – Marketing Through Unsolicited Contacts	Clarifies the requirements of this section for MMPs.
Section 70.7 – Outbound Enrollment and Verification Requirements	Clarifies the requirements of this section for MMPs.
Section 70.9.2 – Personal/Individual Marketing Appointments	Modifies the requirements of this section for MMPs.
Section 70.11 – Marketing in the Health Care Setting	Extends the requirements of this section to MMPs in long-term care facilities, and chronic and psychiatric care hospitals.
Section 70.11.5 – 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.

Medicare Marketing Guidelines (MMGs) Section	Change in this Guidance Document
Section 80.1 – Customer Service Call Center Requirements	Modifies the requirements in this section regarding permissible use of alternative call center technologies on weekends and holidays.
Section 80.2 – Requirements for Informational Scripts	Clarifies requirements in this section for MMPs.
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 90.2.3 – Submission of Multiplan Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 90.3 – Material Status; Section 90.5 – Time Frames 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 Program	Clarifies the File & Use certification process for MMPs.
Section 90.6.1 – Restriction on the Manual Review of File & Use Eligible Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.2 – Required Content	Adds new requirements for MMPs to current MMG requirements of this section.
Section 100.2.1 – Required Documents for All Plan Sponsors	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.2.2 – Required Documents for Part D Sponsors	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.3 – Electronic Enrollment	Clarifies the requirements of this section for MMPs.
Section 100.5 – 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 120 – Marketing and Sales Oversight and Responsibilities	Clarifies that the requirements of this section (and subsections) are not applicable to MMPs with respect to independent agents and brokers, which will not be permitted under the demonstration.
Section 150 – Use of Medicare Mark for Part	Clarifies the requirements of this section for MMPs.

Medicare Marketing Guidelines (MMGs) Section	Change in this Guidance Document
D Sponsors	
Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received	Replaces current disclaimer in this section with a new disclaimer for MMPs.

In addition, we clarify that all requirements applicable to independent agents/brokers throughout the Medicare Marketing Guidelines will be inapplicable to MMPs in California, because the use of independent agents/brokers will not be permitted and all MMP enrollment transactions must be processed by the State enrollment broker or the California MMPs in the two County Organized Health Systems (COHS) counties.

We refer MMPs to the following available model materials. We note that materials created by MMPs should take into account the reading level requirements established in the three-way contract. Available MMP-specific model materials reflect acceptable reading levels. Current Part D models will be acceptable for use as currently provided.

- MMP-specific model materials: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. This will include model enrollment and disenrollment forms for those California MMPs in the two County Organized Health Systems (COHS) counties, where the MMPs will facilitate plan enrollments MMP-specific model materials tailored to MMPs in California will be added to this website on a flow basis as they are finalized and will also be disseminated via the Health Plan Management System (HPMS).

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

- Part D appeals and grievances models in Chapter 18 of the Prescription Drug Benefit Manual: http://cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.html.

- Part C appeals and grievances models in Chapter 13 of the Medicare Managed Care Manual: http://cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html.

- ANOC/EOC (Member Handbook) errata model: http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html

We expect to issue additional operational guidance – including final marketing codes for MMPs to use in submitting marketing materials in HPMS – as well as California-specific MMP marketing model templates after the release of this policy guidance.

Following are the California MMP-specific modifications to the Medicare Marketing Guidelines.

Section 10 – Introduction

MMP Marketing activity for CY 2014 may begin no earlier than February 1, 2014, or once the MMP has entered into a three-way contract with CMS and the State, has passed the CMS/State readiness review, and is connected to CMS enrollment and payment systems such that the MMP is able to receive payment and enrollments, whichever is later. Marketing for CY 2015 may begin no earlier than October 1, 2014.

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. For CY 2013, the Medi-Cal translation standard is equivalent or more stringent for all California MMPs. Please refer to http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2002/MMCDAPL02003.pdf for the Medi-Cal translation standards. The applicable translation standards for each plan can be accessed in the Health Plan Management System (HPMS) Marketing Module's Material Language Look-up functionality.[2] In service areas that meet the translation standard, the following materials must be translated into all required non-English languages: enrollment forms, Summary of Benefits, ANOC/EOC (Member Handbook), formulary (List of Covered Drugs), provider/pharmacy directory (Provider and Pharmacy Network Directory), and the Part D transition letter).[3]

Section 30.5.1 – Multi-Language Insert

We clarify that MMPs will need to include a Multi-Language Insert with their demonstration-specific Summary of Benefits (SB), Annual Notice of Change (ANOC)/Evidence of Coverage (Member Handbook) documents, and enrollment forms (applicable only to MMPs in the COHS counties), as is the case for other plan sponsor types with their Medicare Advantage and Part D SBs and ANOC/EOC documents. California MMPs must use the Multi-Language Insert in Appendix 4 of the Medicare Marketing Guidelines and add the required language in four additional languages – Armenian, Cambodian, Farsi, and Hmong. MMPs will be responsible for the additional translations of the required language into Armenian, Cambodian, Farsi, and Hmong.

We also clarify that alternate format materials must be made available upon request.

[2] Refer to April 10, 2013 HPMS memorandum, "Translation Requirements for CY 2013 Medicare-Medicaid Plans (MMPs)" at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CY2013MMPTranslationHPMSMemoFinal041013.pdf for more information.

[3] CMS will make available Spanish translations of the California MMP formulary, provider/pharmacy directory, and ANOC/EOC (Member Handbook). CMS makes available a Spanish translation of the Part D transition letter to all Medicare health plans at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html.

30.6 – Required Materials with an Enrollment Form

Because MMPs will be too new to measure under the CMS plan (star) rating system, they 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 will be delegated to California's enrollment broker for all demonstration service areas except the COHS counties.

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

This section is replaced with the following revised guidance:

> **Section 30.7 – Required Materials for New and Renewing Members at Time of Enrollment and Thereafter**
>
> 42 CFR 422.111, 423.128, 422.2264, 423.2264
>
> The following materials must be provided to enrollees at the time of enrollment and annually thereafter:
>
> - Annual Notice of Change/Evidence of Coverage (EOC) (Member Handbook), or simply an Evidence of Coverage (Member Handbook), as applicable and described in the replacement guidance below for section 60.7 of the Medicare Marketing Guidelines.
>
> - 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.
>
> - A combined provider and pharmacy directory (Provider and Pharmacy Network Directory) that includes all providers of Medicare, Medicaid, and additional benefits (required at the time of enrollment; see section 60.4 for additional information about provision of a directory post-enrollment).
>
> - A single identification (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 Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including co-pays, 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 60.7 contained in this document for more information about when an MMP must send an SB to current enrollees post-enrollment.

MMPs must provide enrollees who self-select into the demonstration the following materials 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. 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 no later than ten (10) calendar days from receipt of CMS confirmation of enrollment. MMPs should refer to the date of the Transaction Reply Report (TRR) that has the notification to identify the start of the ten (10) calendar day timeframe.

- A comprehensive integrated formulary
- A combined pharmacy/provider directory, or information about how to access or receive the pharmacy/provider directory, consistent with section 60.4 of this guidance.
- A single ID card

MMPs must provide enrollees who are passively enrolled the following materials no later than 30 calendar days prior to the effective date of enrollment:

- A welcome letter consistent with a model developed jointly by CMS and the State
- A comprehensive integrated formulary
- A combined pharmacy/provider directory, or information about how to access or receive the pharmacy/provider directory, consistent with section 60.4 of this guidance.
- An SB

Additional materials may not be included in this mailing, unless the MMP chooses to mail the EOC (Member Handbook) and ID card early along with the materials in this mailing.

In addition, MMPs must provide enrollees who are passively enrolled a single ID card for receipt by the end of the month preceding the month the enrollment will take effect (e.g., the ID card must be received by a beneficiary by December 31 for a January 1 effective enrollment date).

For both enrollees who are passively enrolled and enrollees who self-select into the demonstration, the Annual Notice of Change and EOC (Member Handbook) must be provided at the time of enrollment and annually thereafter consistent with the replacement guidance below for section 60.7 of the Medicare Marketing Guidelines.

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 • Pharmacy/provider directory (or information about how to access or receive the directory) • SB	30 calendar days prior to the effective date of enrollment
	• ID card • EOC (Member Handbook)	No later than the day prior to the effective date of enrollment
Self-selected enrollment (with enrollment confirmation received more than 10 calendar days before the end of the month)	• Formulary • Pharmacy/provider directory (or information about how to access or receive the directory) • ID card • EOC (Member Handbook)	No later than the last day of the month prior to the effective date.
Self-selected enrollment (with enrollment confirmation received less than 10 calendar days before the end of the month)	• Formulary • Pharmacy/provider directory (or information about how to access or receive the directory) • 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 OR • ANOC • SB • Formulary	September 30
If only the ANOC, SB, and formulary are sent by September 30: • EOC (Member Handbook)	December 31
• ID card	As needed
• Pharmacy/provider directory (or information about how to access or receive the directory)	At least every three years, with change pages for major network changes as needed. The plan website's directory must be kept up-to-date consistent with section 100.4.

Section 30.10 – Star Ratings Information from CMS

Because MMPs will be too new to measure under the CMS plan (star) rating system, this section does not apply to MMPs.

Section 30.10.1 – Referencing Star Ratings in Marketing Materials

Because MMPs will be too new to measure under the CMS plan (star) rating system, this section does not apply to MMPs.

Section 30.10.2 – Plans with an Overall 5-Star Rating

Because MMPs will be too new to measure under the CMS plan (star) rating system, 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 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 hours of

operation information for MMP customer service for current and prospective enrollees. The State will provide additional information to MMPs regarding the enrollment broker.

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 sponsor for review prior to their use. As indicated in the CMS "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 2, 2012 CMS Medicare Marketing Guidelines do not apply to communication 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 will be required to include the plan type in each plan's name using standard terminology consistent with the guidance provided in this section. CMS has created the standardized plan type label "Medicare-Medicaid Plan" to refer generically to all plans participating in a Capitated Financial Alignment Demonstration. MMPs must use the "Medicare-Medicaid Plan" terminology consistent with the requirements of section 40.13 of the Medicare Marketing Guidelines.

CMS is unable to create State-specific plan type labels in HPMS for each State's demonstration plans; therefore all MMPs will be referred to by the standardized plan name type "Medicare-Medicaid Plan" in CMS' external communications – e.g., the Medicare & You handbook and the Medicare Plan Finder tool on www.medicare.gov. MMPs may also use any 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, under which the MMP must use the "(Medicare-Medicaid Plan)" standardized plan type label following the plan name at least once on the front page or beginning of each marketing piece. The State will provide additional information on branding for the demonstration.

In addition, we 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 50.1 – Federal Contracting Disclaimer

This section is replaced with the following revised guidance:

Section 50.1 – Federal and State Contracting Disclaimer

42 CFR 422.2264, 423.2264

All marketing materials must include the statement that the MMP contracts with both the Federal and the State government. 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: Banner and banner-like ads, envelopes, outdoor advertising, radio, television and Internet banner ads do not need to include the Federal and State contracting disclaimer.

Section 50.2 – Disclaimers When Benefits are Mentioned

This section is replaced with the following revised guidance:

Section 50.2 – Disclaimers When Benefits Are Mentioned

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

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

> Only for summary documents like the Summary of Benefits: "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, List of Covered Drugs, pharmacy and provider networks [and/or copayments] may change on January 1 of each year."

Section 50.3 – Disclaimers When Plan Premiums are Mentioned

This section 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.

Section 50.4 – Disclaimer on Availability of Non-English Translations

This section is replaced with the following revised guidance:

Section 50.4 – Disclaimer on Availability of Non-English Translations

42 CFR 422.2264, 423.2264

Plan sponsors that meet either: (1) Medicare's five (5) percent threshold for language translation (Refer to section 30.7); or (2) the relevant Medicaid translation standard must place the following alternate language disclaimer on all materials as required in section 30.7.

> "You can get this information for free in other languages. Call <toll-free number>. The call is free.

The alternate language disclaimer must be provided in both English and all non-English languages that meet the more stringent of either the Medicare or the Medicaid translation standard. The non-English disclaimer must be placed below the English version and in the same font size as the English version.

NOTE: ID cards are excluded from this requirement.

Section 50.5 – SNP Materials

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:

> "[Insert Plan Name] has a Model of Care approved by the National Committee for Quality Assurance (NCQA) and California until [insert last contract year of NCQA and State approval of model of care] based on a review of [insert Plan Name's] Model of Care."

Section 50.6 – Dual Eligible SNP Materials

This section is replaced with the following revised guidance:

Section 50.6 – MMP Materials Including Part D Benefit Information

42 CFR 422.2, 422.4(a)(1)(iv), 422.111(b)(2)(iii), 422.2264, 423.2264

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 receive. Please contact the plan for more details."

Section 50.12 – Disclaimer for Plans Accepting Online Enrollment Requests

This section does not apply to MMPs, as the Online Enrollment Center on the Medicare Plan Finder website will not be available to MMPs.

Section 50.13 – Disclaimer When Using Third Party Materials

This section 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."

Section 50.14 – Disclaimer When Referencing Star Ratings Information

Because MMPs will be too new to measure under the CMS star rating system, this section does not apply to MMPs.

Section 60.1 – Summary of Benefits

This section is replaced with the following revised guidance:

> **Section 60.1 – Summary of Benefits**
>
> 42 CFR 422.111(b)(2), 422.111(f), 423.128(b)(2)
>
> MMPs must use the Summary of Benefits (SB) model document provided to California MMPs by CMS and the State. 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 co-pays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.
>
> The Multi-Language Insert must be included with the SB, and 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 ID card content requirements in sections 60.2, 60.2.1, and 60.2.2. We clarify, however, that MMPs must issue a single ID card meeting these requirements for all services offered under the plan. Separate pharmacy and health benefits ID cards will not be permitted. MMPs must use the model ID card document provided to California MMPs by CMS and the State.

Section 60.4 – Directories

The pharmacy and provider directory requirements in sections 60.4, 60.4.1, 60.4.1.1, and 60.4.2 apply to MMPs with the following modifications:

- MMPs are required to make available a single, combined pharmacy/provider directory. Separate pharmacy and provider directories will not be permitted;

- At the time of enrollment and then as required thereafter, MMPs have the option to either mail a pharmacy/provider directory or to mail a document that provides enrollees with information about how to access the directory on the MMP website, as well as how to call the customer service call center to request assistance with locating providers and request that a pharmacy/provider directory be mailed to them. Any request to provide a pharmacy/provider directory at any geographic level smaller than a county must be approved the MMP's Contract Management Team.

- The combined pharmacy/provider 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 pharmacy/provider 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) and that the enrollee may contact the customer service call center to request assistance with locating providers in other counties or to request a complete pharmacy/provider directory; and

- MMPs must use the model pharmacy/provider directory document provided to California MMPs by CMS and the State.

Section 60.5 – Formulary and Formulary Change Notice Requirements

The requirements of section 60.5, 60.5.1, 60.5.2, 60.5.3, 60.5.4, 60.5.5, and 60.5.6 apply to MMPs with the following modifications:

- MMPs must provide a comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the plan;

- MMPs will only be permitted to provide comprehensive formularies, not abridged formularies;

- MMPs must use the model formulary document provided to California MMPs by CMS and the State; and

- Formulary change notices must be sent for any non-maintenance negative formulary change, regardless of whether the drug or item is a Part D or a non-Part D covered formulary drug or item. Consistent with the guidance in the Medicare Marketing Guidelines, this notice must be provided to affected enrollees at least 60 calendar days prior to the change.

Section 60.7 – Annual Notice of Change (ANOC) and Evidence of Coverage

This section is replaced with the following revised guidance:

> **Section 60.7 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) (Member Handbook)**
>
> 42 CFR 422.111(a)(3), 422.111(d)(2), 423.128(a)(3)
>
> MMPs are required to send an Annual Notice of Change (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. The MMP 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 self-select into 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 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.

Starting in CY 2014, 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.

Additional materials may not be included in the ANOC/EOC mailing.

To ensure that MMPs are mailing their annual ANOC/EOC (Member Handbook) in a timely manner, plan sponsors must indicate the actual mail date in HPMS within fifteen (15) calendar days of mailing. MMPs that mail in waves should enter the actual date for each wave. For instructions on meeting this requirement, refer to the *Update Material Link/Function* section of the Marketing Review Users Guide in HPMS.

MMPs must use the ANOC/EOC (Member Handbook) errata model to notify enrollees of any errors in their original mailings.

Section 60.8 – Mid-Year Changes Requiring Enrollee Notification

The notification requirements for mid-year Medicare benefit changes described in this section will also be applicable to mid-year Medicaid or required demonstration additional benefit changes.

Section 70.5 – Marketing Through Unsolicited Contacts

In addition to the requirements of section 70.6, MMPs conducting permitted unsolicited marketing activities such as 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: -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 70.7 – Outbound Enrollment and 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 70.7 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 70.9.2 – 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 that 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 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 that 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 70.11 – 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-SNPs) 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 70.12.5 – 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 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)

Except as otherwise provided, 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. For CY 2014, MMPs may use alternative technologies on Saturdays, Sundays, and State and Federal holidays. For example, an MMP may use an interactive voice response 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.

Call centers must meet the following operating standards:

- Provide information in response to inquiries outlined in sections 80.2-80.4.
- Follow an explicitly defined process for handling customer complaints.
- Provide interpreter service to all non-English speaking and limited English proficient beneficiaries.
- Inform callers that interpreter services are "free."
- Provide TTY service to all hearing impaired beneficiaries.
- 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 interactive voice response (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.

For Pharmacy Technical Help or Coverage Determinations and Appeals Call Center requirements refer to Appendix 4.

Section 80.3 – Requirements for Informational Scripts

We clarify that informational calls to plan call centers that become sales/enrollment calls at the proactive request of the beneficiary must be transferred to the State enrollment broker, except in the case of MMPs in the COHS counties.

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 90.2.3 – Submission of Multiplan Materials

This section does not apply to MMPs.

Section 90.3 – Material Status

We clarify that, for purposes of MMP materials, there will be no "deeming" of materials requiring a dual review by CMS and the State, and materials will remain in a "pending" status until the State and CMS reviewer dispositions match. All other guidance in this section and its subsections applies.

Section 90.5 – Time Frames for Marketing Review

We clarify that, for purposes of MMP materials, there will be no "deeming" of materials requiring either a dual review by CMS and the State, or a one-sided State review. Materials that require a CMS-only review will deem after the respective 10- or 45-day review period. All other guidance in this section and its subsections applies.

Section 90.6 – File & Use Program

We clarify that the File & Use program certification program for MMPs will be handled through the three-way contract. All other guidance in section 90.6 and all its subsections applies.

Section 90.6.1 – Restriction on the Manual Review of File & Use Eligible Materials

This section does not apply to MMPs.

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, and information that materials are published in alternate formats (e.g., large print, Braille, audio CD).

Section 100.2.1 – Required Documents for All Plan Sponsors

Because MMPs will be too new to measure under the CMS star rating system, MMPs will not be required to post a CMS star ratings document on their websites.

Section 100.2.2 – Required Documents for Part D Sponsors

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

Section 100.3 – Electronic Enrollment

We clarify that the Medicare Plan Finder Online Enrollment Center will not be enabled for MMPs. Plan enrollment requests via plan secure internet websites will be 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 100.5 – 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 MMPs' websites as required in this section.

Section 150 – Use of Medicare Mark for Part D Plans

We clarify that MMPs will be 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 section 150 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."