



2013 Medicare Marketing Guidelines Training



*National Training
Webinar
June 20, 2012*

Welcome/Introductions



Stacey Plizga
Moderator, PRI

The Infinite Conferencing Screen

Closed Captioning Window appears here and is active when the Webinar begins.

- A. SSN and Medicare Claim Number (HICN)
- B. CMS contractor ID number
- C. Customer Service Number and Plan Website.
- D. Choice A and C
- E. Choice B and C

Click **Ask a Question** to ask a business question or for technical support

Supporting Material | Ask a Question | Answered Questions

Click **Supporting Material** button to download course documents

Click **Answered Questions** to see responses from the presenters

41

Polling

Module 2: Knowledge Check #2 Multiple Choice:
Which of the following elements must be on the Health Plan ID card?

- A. SSN and the Healthcare Insurance Claim Number (HICN)
- B. CMS contract number and PBP number
- C. Customer Service Number and Plan Website.
- D. Choice A and C
- E. Choice B and C

Submit

Poll will open. Select the correct choice and click the **Submit** button.

Module 2: Knowledge Check #2 Multiple Choice:
Which of the following elements must be on the Health Plan ID card?

Poll Results (1 answers)

A. SSN and the Healthcare Insurance Claim Number (HICN)	0%
B. CMS contract number and PBP number	0%
C. Customer Service Number and Plan Website.	0%
D. Choice A and C	0%
E. Choice B and C	100%

Close

Poll displays the results. When polling has stopped, this screen will close for you.

Help and Post Webinar Survey

Important Links

- Technical Support

MMGwebinar@CMSDrugHealthPlanEvents.org

- Survey available until 5PM EDT Friday, June 22nd
- <https://www.surveymonkey.com/s/CMS2013MMG>

Your Guides to a Successful Training Experience

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Agenda

- **Course Objectives**
- **Module 1:**
Guiding Principles
- **Module 2:**
Key Focus Areas Within the 2013 Medicare Marketing Guidelines
- **Module 3:**
2013 Medicare Marketing Guidelines Policy Clarifications
- **Module 4:**
HPMS Changes
- **Final Thoughts and Questions**



Course Objectives

By the end of this course, you will be able to:

1. Identify the 2013 Medicare Marketing Guidelines Guiding Principles
2. Recognize Key Focus Areas within the 2013 Medicare Marketing Guidelines
3. Comprehend Policy Clarifications within the 2013 Medicare Marketing Guidelines
4. Apply the Correct Procedures to use HPMS



Module 1: Guiding Principles



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Module 1: A New Approach and Overhaul of Current Guidelines

2013 Medicare Marketing Guidelines (MMG) has a new approach around the following areas:

- Focus on Marketing Requirements in Subpart V
- Eliminate redundancy
- Consolidate requirements
- Less prescriptive as in past MMGs
- End Results:
 - Around 70 pages removed from the 2013 MMG

Module 1: Guiding Principles

- The 2013 MMG went through extensive revisions to make it less prescriptive.
- The Guiding Principles were developed to provide a common sense approach to interpreting marketing requirements.
- The Guiding Principles should be used to structure marketing programs and plans.
- The Guiding Principles are found in Section 10 of the 2013 MMG.

Module 1: Three Guiding Principles

2013 Medicare Marketing Guidelines Guiding Principles

- Plan sponsors are responsible for ensuring compliance with CMS' current marketing regulations and guidance, including monitoring and overseeing the activities of their subcontractors, downstream entities, and/or delegated entities.
- Plan sponsors are responsible for full disclosure when providing information about plan benefits, policies, and procedures.
- Plan sponsors are responsible for documenting compliance with all applicable MMG requirements.

Module 1: First Guiding Principle

- Plan sponsors are responsible for ensuring compliance with CMS' current marketing regulations and guidance, including monitoring and overseeing the activities of their subcontractors, downstream entities, and/or delegated entities.

Applies to anyone that a plan has delegated some responsibility to implement, including:

Agents and
Brokers

Third-Party
Marketing
Organizations

Providers

Pharmacy
Benefit
Managers

Module 1: First Guiding Principle, *Continued*

- Applies to anything that the plans and/or their designees conduct, including, but not limited to the following:



Marketing
events



Marketing
materials



Marketing
material
distribution



Collecting and
disseminating
information

Module 1: Second Guiding Principle

- Plan sponsors are responsible for full disclosure when collecting and disseminating information to beneficiaries about plan benefits, policies, and procedures.



Beneficiaries must have enough Information



Must have complete information to make informed choices



Use sound judgment

Module 1: Third Guiding Principle

- Plan sponsors are responsible for documenting compliance with all applicable MMG requirements.



Have systems and processes in place with all aspects of the marketing program



Provide oversight of systems and processes



Have clearly defined processes and procedures

Module 1: Knowledge Check #1

Situational Case:

A field marketing organization (FMO) trains and tests the agents for a given plan. They document their procedures and ensure they are within the MMG. During an audit, the Plan does not have the FMO's documentation. Who is responsible for producing the documentation?

- A. The FMO, since they are doing the work and documenting the procedures. This follows the guiding principle of documenting procedures.
- B. The Plan, since they have delegated the responsibility to the FMO. This follows the guiding principle of compliance with CMS's current marketing regulations and guidance, including monitoring and overseeing the activities of their delegated entities.

Module 2: Key Focus Areas within the 2013 Medicare Marketing Guidelines



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*Health Insurance Specialist,
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Module 2: 30.12 - Plan Ratings Information from CMS

- Plan Ratings information document must be distributed with any enrollment form or Summary of Benefits and be available on plan websites - *New!*
- Plan sponsors may only reference the contract's individual measures in conjunction with its overall performance rating in marketing materials - *New!*
- Plans may add their logo to the document.



Module 2: 30.12 - Plan Ratings Information from CMS, *Continued*

- Annually, plans will be required to use updated Plan Ratings information within 15 days of the release - *New!*
- New plans are not required to provide Plan Ratings information until the next contract year.



Module 2: 30.12.1 - Plan Ratings

Information from CMS

New!

- Plan sponsors' marketing may not reference or include poor performance status information as a means to circumvent enrollment and disenrollment election period rules.
- Plan sponsors with an overall Five-Star rating have the option to include CMS' gold star icon on marketing materials.
 - Materials cannot be misleading



Module 2: 30.7.1 - Multi-Language Insert

- The Multi-Language Insert is a document that contains the following statement translated into multiple languages - *New!*
 - “We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1-xxx-xxx-xxxx]. Someone who speaks [language] can help you. This is a free service.”

مرحبا العالم! Hallo Welt!
Hej Värld! Hello World!
Ciao Mondo
ハローワールド!
¡Olá mundo! 世界您好!
Salut le Monde!



Module 2: 30.7.1 - Multi-Language Insert, *Continued*

- Plans must include the Multi-Language Insert with the Summary of Benefits (SB) and the ANOC/EOC.
 - Plan sponsors have the option to incorporate the Insert as part of these materials or to provide as a separate document.
- The Multi-Language Insert cannot be modified except to include additional languages. If additional language are included, the statement must be translated.

Module 2: 60.2.1 - Health Plan ID Card Requirements

- Health plans must have member identification cards - *New!*
 - Applies to MA and Cost plans
 - CMS will issue Health Plan ID (HPID) numbers to all plan sponsors

CMS contract number and
PBP number on the
member ID card



Module 2: 60.2.1 - Health Plan ID Card Requirements, *Continued*

- The member identification card must comply with the most recent version of the Workgroup for Electronic Data Interchange (WEDI) *Health Identification Card Implementation Guide*.
- **New !** - Health plan ID cards must include:
 - The plan sponsor/plan website address
 - The plan sponsor's customer service number
 - The phrase "Medicare limiting charges apply" (on MA PPO or PFFS cards only)
 - The CMS contract and PBP number

Module 2: 70.1 - Nominal Gifts

Nominal Gifts versus Promotional Activities

- Generally, nominal gifts are used to attract the attention of potential enrollees.
- Generally, promotional activities are those designed to attract the attention of prospective members and/or encourage retention of current members.
- Both must adhere to nominal value - individual item/service worth \$15 or less.

Module 2: 70.2 - Promotional Activities

Plan sponsors must track and document items given to current members. Plan sponsors are not required to track pre-enrollment promotional items on a per person basis; however, they may not willfully structure pre-enrollment activities with the intent to give people more than \$50 per year.

Module 2: 70.3 - Rewards and Incentives

- Rewards and incentives may only be offered to current members for any Medicare covered preventive services that have a zero dollar cost-share. Examples include preventive screenings, immunizations, Welcome to Medicare visit.
- \$50 cap no longer applicable - *New!*



Module 2: 70.3 - Rewards and Incentives, *Continued*

Reward and incentive items must:

Be offered in connection with the whole service*

Be offered to all eligible members without discrimination

Have a monetary cap not to exceed \$15 per reward item (based on the retail value of the item)

Be tracked and documented during the contract year

Comply with all relevant fraud and abuse laws:

- Anti-kickback statute
- Civil monetary penalty prohibiting inducements to beneficiaries

*Example, a plan sponsor may offer a reward for participating in the smoking cessation program but not offer multiple awards for attending each smoking cessation class.

Module 2: 70.3 - Rewards and Incentives, *Continued*

Additionally, reward items cannot:

Be items that are considered a health benefit (e.g., a free checkup)

Be items that consist of lowering or waiving co-pays

Be offered in the form of cash or other monetary rebates

Be used to target potential enrollees (e.g., used in pre-enrollment advertising, marketing, or promotion of the plan)

Be structured to steer enrollees to particular providers, practitioners, or suppliers

Be tied directly or indirectly to the provision of any other covered item or service

Module 2: 70.3 - Rewards and Incentives, *Continued*

- Please refer to the resources below for the most current listing of Medicare covered preventive services with a zero dollar cost-share.



Coverage Email Updates Page (Sorted by Year):

- <https://www.cms.gov/CoverageGenInfo/EmailUpdates/list.asp#TopOfPage>



Main Coverage Center Page:

- <https://www.cms.gov/center/coverage.asp>



Sign-up for the Coverage Listserv:

- https://www.cms.gov/InfoExchange/03_listserv.asp#TopOfPage



Program Transmittals Page:

- <http://www.cms.gov/Transmittals/>

Module 2: 70.8 - Outbound Enrollment and Verification Requirements

- All plan sponsors must verify enrollments facilitated by independent and employed agents/brokers.
- Plans must ensure that enrolling beneficiaries understand the plan rules.



Module 2: 70.8 - Outbound Enrollment and Verification Requirements, *Continued*

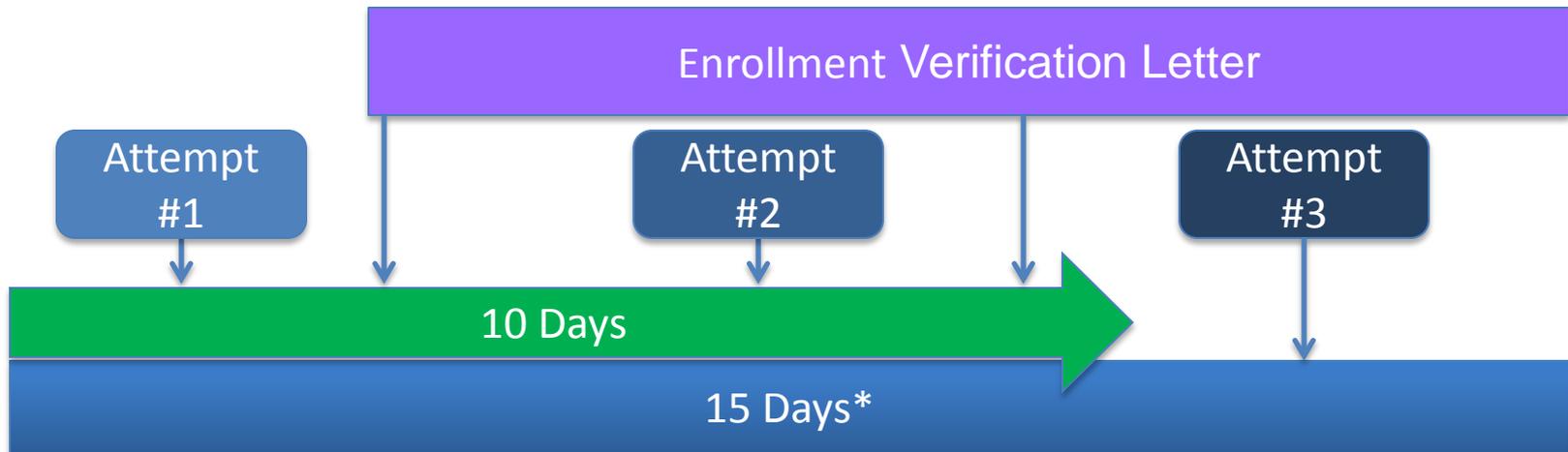
- Plan sponsors must make a minimum of three documented attempts to contact the applicant by telephone within fifteen (15) calendar days of receipt of the application; the first two attempts must be made within the first 10 days.
- If the enrollment application is incomplete, plan sponsors should concurrently conduct the OEV process while obtaining the missing information needed to complete the application.



* Incomplete enrollment applications should be completed concurrently with the OEV process as applicable.

Module 2: 70.8 - Outbound Enrollment and Verification Requirements, *Continued*

- Plan sponsors that do not successfully reach the beneficiary on the first or second attempt must send the applicant an enrollment verification letter in addition to making the third documented outbound verification call attempt within the 15 day timeframe.



* Incomplete enrollment applications should be completed concurrently with the OEV process as applicable.

Module 2: 90.2.2 - Submission of Websites for Review

- Websites are available for public use during the CMS review period.
- If any portion of the website is disapproved, the plan sponsor must remove the disapproved portion immediately - *New!*



Module 2: 100 - Plan Sponsor Websites and Social/Electronic Media

- Guidance has been consolidated for website requirements - *New!*
 - Appendix 1 removed and placed in section 100



Module 2: 100 - Plan Sponsor Websites and Social/Electronic Media

- Plan sponsors are allowed to use social/electronic media (e.g., Facebook, Twitter, Scan Code, or QR Code).



- These tools are considered marketing materials and are subject to these guidelines.



Module 2: 120.2 - Plan Reporting of Terminated Agents

- When plan sponsors discover incidents of unlicensed agents or brokers submitting applications they must:
 - Terminate the agent/broker,
 - Report them to the authority in the State where the application was submitted, and
 - Notify any beneficiaries enrolled by the unqualified agent to advise of the agent's status.
- Beneficiaries may request to make a plan change.

Module 2: 120.4.7 - Agent/Broker Compensation

- Plan sponsors must notify CMS annually whether they intend to use independent agents/brokers for the upcoming plan year and the amounts they will pay them.
- Plan sponsors must pay independent agents/brokers an amount that is at or below the adjusted fair market value cut-off amounts (released each spring by CMS) – *New!*

Module 2: Knowledge Check #1

Situational Case:

A plan sponsor offers 5 Medicare plans. Of those, 3 are Five-Star plans. In an advertisement in the local newspaper, the plan sponsor highlights its Five-Star rating and lists all five plans underneath the highlight. Upon review by CMS, the Account Manager is notified. What do you think was CMS' concern?

- A. The appropriate disclaimers were missing.
- B. There is no mention of the Five-Star SEP.
- C. Beneficiaries do not know which plans are the Five-Star plans.

Module 2: Knowledge Check #2

Multiple Choice:

Which of the following elements must be on the Health Plan ID card?

- A. SSN and the Healthcare Insurance Claim Number (HICN)
- B. CMS contract number and PBP number
- C. Customer Service Number and Plan Website
- D. Choice A and C
- E. Choice B and C

Module 2: Knowledge Check #3

True or False:

Plans can offer rewards and incentives for any of their covered services?

- A. True
- B. False

Module 2: Knowledge Check #4

True or False:

If the Summary of Benefits and the ANOC/EOC documents are sent separately to beneficiaries, then the Multi-Language Insert must be sent with each document.

- A. True
- B. False

Module 2: Knowledge Check #5

Multiple Choice:

The Standardized Plan Ratings information document must be included with which of the following media distributions?

- A. Enrollment form distribution
- B. Summary of Benefits distribution
- C. Plan Websites
- D. All of the above

Module 2: Knowledge Check #6

Multiple Choice:

How many outbound enrollment verification calls should be made IN THE FIRST 10 DAYS?

- A. 3
- B. 4
- C. 2
- D. 5



Module 3: 2013 Medicare Marketing Guidelines Policy Clarifications



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Module 3: Section 20 - Materials Not Subject to Review

New!

- Ad-Hoc Enrollee Communication Materials
- OMB Forms
- VAIS Materials
- Mid-year Change Enrollee Notifications



Module 3: 30.8 - Required Materials with an Enrollment Form

- When a beneficiary is provided with enrollment instructions/form, s/he must also receive:
 - Plan Ratings information (as specified in 30.12)
 - Summary of Benefits
 - Multi-Language Insert (see Section 30.7.1)

MEDICAL CENTER

NAME _____ AGE _____
ADDRESS _____ DATE _____

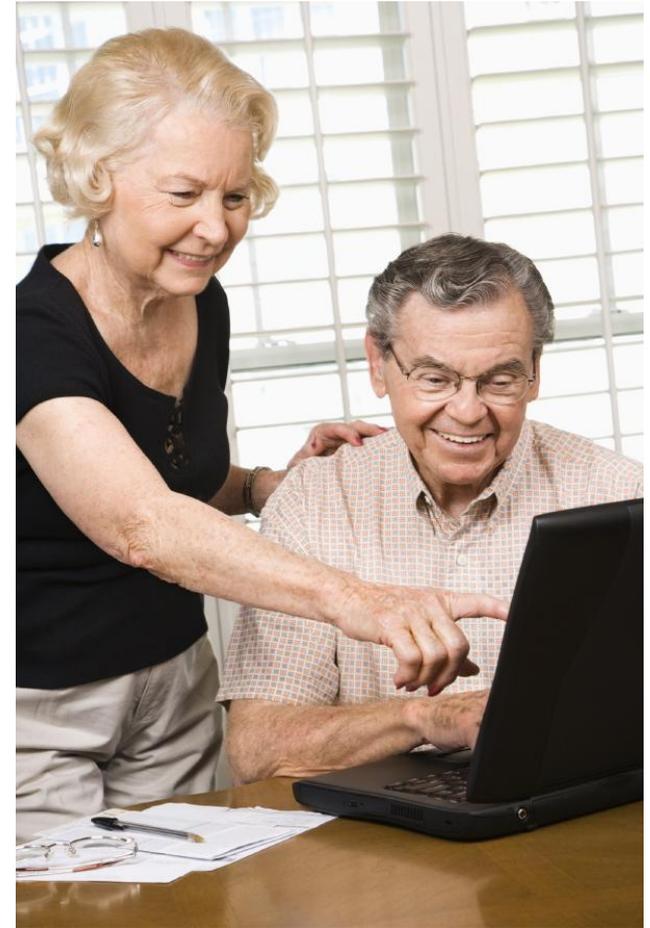
Rx

SIGNATURE

LABEL
REFILL 0 1 2 3 4 5 PRN NR

Module 3: 30.8 - Required Materials with an Enrollment Form, *Continued*

- Online enrollment
 - Prior to online enrollment, plan sponsors must make available the following materials online:
 - Plan Ratings information (as specified in 30.12)
 - Summary of Benefits
 - Multi-language Insert (see Section 30.7.1)



Module 3: 30.9 - Required Materials for New and Renewing Members at Time of Enrollment and Thereafter

- The following items must be sent to new and renewing enrollees:
 - Annual Notice Of Change/Evidence Of Coverage (ANOC/EOC)
 - Comprehensive formulary or abridged formulary
 - Pharmacy directory
 - Provider directory
 - Membership Identification Card



Module 3: 30.9.1- Mailing Materials to Addresses with Multiple Members

New! - Every member must receive the materials noted in 30.9 at the time of enrollment. Thereafter, plan sponsors have the option of mailing these materials to either every member or every address where up to four members reside.

- Must include all names on the envelope, or list one name on the envelope and include all others or a cover letter accompanying the mailing.
- ID cards are excluded.



Module 3: 40.1 - Marketing Material Identification

- Material ID is made up of two parts:
 - Plan sponsor's contract or MCE number (H,R,S, or Y) followed by an underscore
 - Any series of alpha numeric characters
- Date is no longer required - *New!*



Module 3: 40.1 - Marketing Material Identification, *Continued*

- All marketing materials must have the marketing material ID number with the following exceptions:
 - The member ID card (although PDP or MA-PD member ID cards must include the CMS contract number and PBP number on them)
 - Envelopes
 - Radio ads
 - Outdoor advertisements
 - Banner or banner-like ads
 - Social media comments and posts

Module 3: 40.12 - Providing Materials in Different Media Types

- Plan sponsors may provide materials using different media types (e.g., electronic or portable media like email, CD, or DVD).
 - Must receive consent prior to providing materials in this format (i.e., individuals must opt-in).



Module 3: 40.8 - Hours of Operation Requirements for Marketing Materials

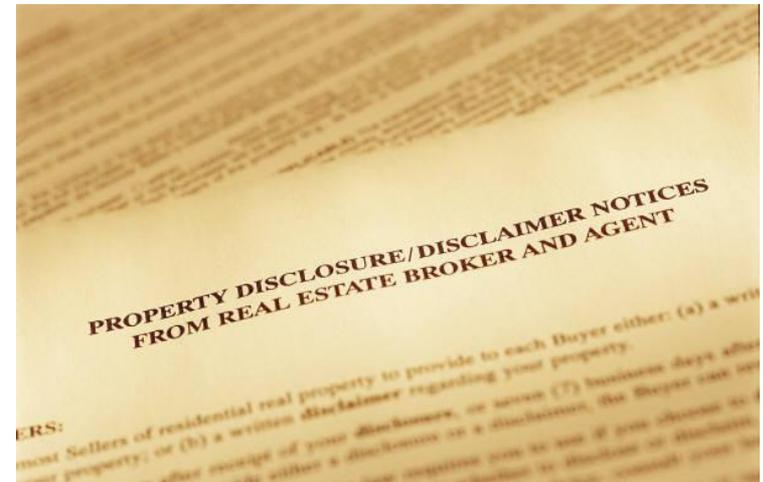
- Hours of operation must be listed on all materials where a customer service number is provided for current and prospective enrollees to call.
- Hours of Operation must be listed once, not every time -

New!



Module 3: 50 - Disclaimers

- New!** - Marketing materials are grouped into two distinct categories:
- Materials directed to potential enrollees
 - Communications to existing members

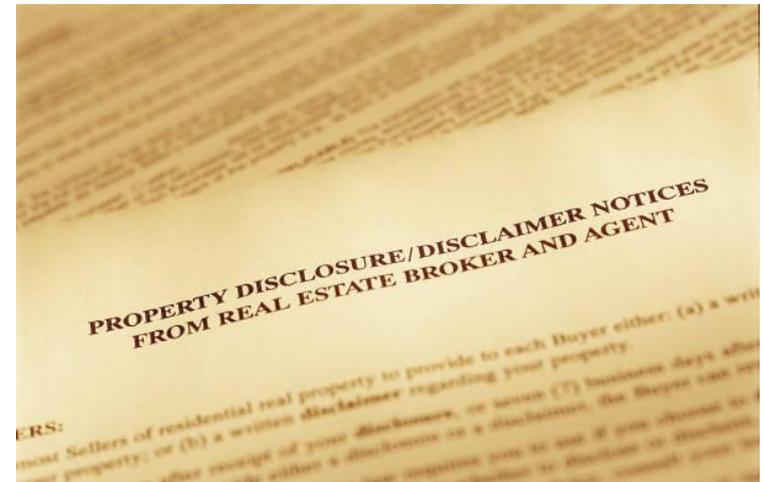


Module 3: 50 - Disclaimers

Some disclaimers were updated to incorporate plain language principles. Example -

- Old: The benefit information provided herein is a brief summary, not a comprehensive description of benefits
- New: The benefit information provided is a brief summary, not a complete description of benefits

Plans are not required to resubmit existing materials to reflect these changes.



Module 3: 60.4 - Directories

- Plan sponsors must send a Provider or Pharmacy Directory at the time of enrollment and at least every three years after that- *New!*
- Change pages no longer required - *New!*
- Plans must make directories available upon request and websites must contain current directories at all times.

Module 3: 60.4 - Directories

- Updates to the Directory
 - Written notice of termination for providers and pharmacists to members that use them
 - Significant changes to the provider/pharmacy network
 - Significant changes defined by the plans
 - CMS may also direct plans if a mailing is needed

Module 3: 60.7 - Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

- ANOC/EOC must be received by members no later than September 30 of each year.

DSNPs

D-SNPs have receipt options

ANOC with SB for receipt by September 30 and EOC for receipt by December 31

Cost Plans

Offer Part D must send ANOC/EOC for receipt by September 30

Not offering Part D must send ANOC/EOC for receipt by December 1

Employer Group Plans

Employer group plans must send ANOC/EOC for receipt no later than 15 days before the beginning of the sponsor's open enrollment period

Module 3: 70.9 - Educational Events

- Educational events may not have marketing, including plan specific benefits -

Note: If plan sponsors hold member-only events, they may not conduct enrollment or sales activities at these events. Additionally, any marketing of these events must be done in a way that reasonably targets only existing members (e.g., direct mail flyers), and not the mass marketplace (e.g., radio or newspaper ad).



Module 3: 70.10.1 – Notifying CMS of Scheduled Marketing Events

- If a sales event is cancelled less than forty-eight (48) hours before its originally scheduled date and time, the plan must notify the RO of the cancellation and cancel the event in HPMS.



Clarification - Plans must only notify the RO if they are unable to cancel the event directly in HPMS.

Module 3: 80.1 - Customer Service Call Center Requirements

October 1 to February 14

- Live customer service representatives
 - 7 days a week
 - 8:00 AM to 8:00 PM according to the time zones for the regions in which they operate
 - Alternative Technologies (IVR/Voicemail)
 - Thanksgiving and Christmas Days

February 15 to September 30

- Live customer service representatives
 - Monday through Friday
 - 8:00 AM to 8:00 PM according to the time zones for the regions in which they operate
 - Alternative Technologies (IVR/Voicemail)
 - Saturday, Sunday, and Federal Holidays

Module 3: Knowledge Check #1

Multiple Choice:

When a beneficiary is provided with enrollment instructions/form, s/he must also receive:

- A. Plan Ratings information
- B. Summary of Benefits
- C. Multi-Language Insert
- D. All of the above

Module 3: Knowledge Check #2

True or False:

Plan sponsors must receive consent from the individual to provide CMS required materials and specify which media and documents are to be sent.

- A. True
- B. False

Module 4: HPMS Updates



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Module 4: General Updates

- The material extract will have several new columns - Errata Material, Disapproval Reason, Comments, and Populated Template Material ID, as well as an indication of Errata Material type.
- Materials submitted for the code 1127 (Combined ANOC/EOC Document) will become accepted the same day as submitted, and can be distributed immediately.
- Organization Material Listing Report will contain totals.
- User Guide Update

Module 4: File and Use

- 10% Report Drill Functionality



Marketing Review Report

File & Use 10% Manual Review Report

Print Date: 4/4/2011

Universe of materials defined as File and Use

ID	Material ID	Material Code	File and use Flag
1	StrangeID1	1002	Yes
2	StrangeID2	1002	No

Sample screenshot only and is subject to change pending release.

Module 4: Marketing and Sales Event

- Additional Field Updates
 - Several new fields are required when submitting and uploading marketing sales events for single contracts and MCE's.

New MCE Event

an asterisk (*) before it is a required field.

Contract Year: 2012

MCE Number/Name: Test MCE

Contract Number: Test Contract

Submission Date: 04/23/2012

Event Period: May 2012

Event Status: Scheduled Event for the above Contract(s)

*Presentation Language:

*Event Type:

*Event Name:

*Event Date: e.g., MM/DD/YYYY

*Event Time:

Brokerage Firm/Agency:

*Facility Type:

*Representative/Agent National Producer Number:

*Representative/Agent

Sample screenshot only and is subject to change pending release.

Module 4: Marketing Material Lookup

Page

- The marketing material lookup page can be sorted on all columns by clicking on the column headers.

Marketing Review - Marketing Code Lookup

<u>Category</u>	<u>Code</u>	<u>Contract Type</u>	<u>Model Available</u>	<u>Review Days¹</u>	<u>File&Use Certification²</u>	<u>Plan Designation</u>	<u>Code Status</u>	<u>Effective Date</u>	<u>Retire Date</u>	<u>CheckList</u>	<u>Standards Available</u>
1000-Enrollment Kit	1061-Summary of Benefits (SB) with Free Form text (Section 3)	MA / PDP	N	45	N	Y	Active	08/22/2011			Y
1004-Provider Directory	1004-Provider Directory	MA	Y	45/10	M	N	Active	01/28/2010			N
1004-Provider Directory	1014-Final Exp Rev Provider Directory	MA	Y	0	N	N	Active	01/28/2010			N
1004-Provider Directory	1044-Provider/Pharmacy Directory	MA / PDP	Y	45/10	M	N	Active	01/28/2010			N
1004-Provider Directory	1045-Final Exp Rev - Provider/Pharmacy Directory	MA / PDP	Y	0	N	N	Active	01/28/2010			N

Sample screenshot only and is subject to change pending release.

Module 4: Agent/Broker Compensation Functionality

- Updated to follow current CMS policy reflected in CMS operational guidance
 - Modify Low and High Values
 - Captive, Employed, Independent, and Referral Fee indications
 - Removal Agent/Broker compensation attestations upon request

Agent/Broker Compensation - Data Entry

Contract Year: 2012
 Organization Name: Test Organization
 Contract Number/Name: H1111 - Test contract
 Progress: 0 of 6 completed

NOTE: Progress indicates (# of plans in contract edited for current year/total plans in contract)

CA - Captive Agent
 EA - Employed Agent
 IA - Independent Agent
 RF - Referral Fee

If "Uses Agents/Brokers" is Yes, either one, multiple or any combination of CA, EA, or IA can be selected. At least one checkbox must be selected.
 If IA is selected, either the current year high range (if single value) or both the current year high and low ranges should be entered.
 If RF is selected, values must be entered for the RF amount.

Note: The Agent Broker data entry process is not complete until an attestation has been performed for all plans/segments.

Plan ID	Segment ID	Plan Type	State	Uses Agents/Brokers?	CA?	EA?	IA?	(IA) - Prev. Yr. Low Range	(IA) - Prev. Yr. High Range	(IA) - Curr. Yr. Low Range	(IA) - Curr. Yr. High Range / Single Value ¹	RF Paid?	RF Amount	Submitted	User Action
002	0	HMO/HMOPOS	NY	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	300	403	<input type="text" value="300"/>	<input type="text" value="402"/>	<input type="checkbox"/>	<input type="text" value="N/A"/>		Edit
018	0	HMO/HMOPOS	NY	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	300	403	<input type="text" value="300"/>	<input type="text" value="402"/>	<input type="checkbox"/>	<input type="text" value="N/A"/>		Edit
025	0	HMO/HMOPOS	NY	Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	300	403	<input type="text" value="300"/>	<input type="text" value="402"/>	<input type="checkbox"/>	<input type="text" value="N/A"/>		Edit

Sample screenshot only and is subject to change pending release.

Final Thoughts and Questions



Course Survey

- Survey available until 5PM ET Friday, June 22nd
<https://www.surveymonkey.com/s/CMS2013MMG>

Website

- For transcripts, recordings of this presentation, and additional materials, please visit our website at:

www.CMSDrugHealthPlanEvents.org

Thank you for attending!

