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## 2013 Medicare Marketing Guidelines (MMG)

### Questions & Responses

November 2, 2012

#### Section 10 – Introduction

Number	Question	Response
1.	CMS limits plan's ability to provide clarifying explanation of benefits in the SB and EOC to achieve "full disclosure". Are we now allowed to add clarification to meet 2nd guiding principle?	The EOC should contain a full disclosure of the benefits of the plan. The SB is a summary and as a standardized document, changes in section 1 and 2 are limited. However, section 3 is where plans may further clarify their benefits as bid.

#### Section 20 – Materials Not Subject to Review (Updated)

Number	Question	Response
1.	For materials that are not subject to CMS' review and approval, are plan sponsors still required to assign a marketing material ID and include it on the material?	No, plan sponsors will not be required to include the material ID on materials that are not subject to CMS review.
2.	Are the Value Added Items and Services (VAIS) disclaimer no longer required?	Per Section 20 of the Medicare Marketing Guidelines, VAIS materials are not subject to CMS review. Therefore, VAIS materials do not require a disclaimer. Plan sponsors may refer to Chapter 4 of the Medicare Managed Care Manual.
3.	Do custom (no model available) Claims/Determinations/Appeals/Grievances letters targeting a specific individual/issue qualify as Ad-hoc Enrollee Communications Materials? If these custom letters are not qualified as Ad-hoc Enrollee Communications Materials, are they to be submitted under Category 3000, Code 3032?	Ad hoc enrollee communication materials are targeted towards current enrollees, customized, and apply to a specific situation. They do not require CMS review. These materials include letters describing member-specific claims process issues and customer service correspondence pertaining to a unique question or issue. If you have questions regarding the submission and review of certain materials, please contact your regional office marketing reviewer.

## Section 20 – Materials Not Subject to Review (Updated)

Number	Question	Response
4.	General health promotion materials that do not include plan specific information are exempt from review. Would materials promoting preventive services covered under Original Medicare at zero cost sharing and therefore covered under our plan at zero cost sharing fall under this exemption if the material includes reference to the “zero cost sharing” element or does that make it plan specific such that it would be subject to submission and review?	Plan materials promoting preventive services covered at zero cost sharing are exempt from review.
5.	What are examples of ad-hoc enrollee communication materials?	See appendix 1 of the MMG for a definition and examples of ad hoc enrollee communications.
6.	Ad hoc enrollees - if you are changing your billing format and sending a notice to all members - is that still considered ad hoc as it is going to all members and not a subset?	As each situation is different and unique, plans should consult their Account Manager for assistance in determining whether a material would qualify as ad hoc.
7.	Section 20 of the MMG states that ad hoc enrollee communications are not required to be submitted to CMS for review. If we send out a flyer promoting health fairs and then include a note that these are services provided w/ no co-pay can this still be considered an ad hoc piece?	If the piece contains benefit information, it generally is no longer ad hoc. Questions should be referred to your Marketing Reviewer or Account Manager.
8.	<b>New</b> - For Materials not subject to Review are Sponsors still expected to display the Contract Number on the material?	Materials not subject to CMS review would not have a material ID.
9.	<b>New</b> - It was indicated no unique Material ID required for Materials Not Subject to Review. I thought a Material ID was needed on all materials, regardless if they are submitted to CMS or reviewed internally.	Material IDs are required for materials that must be uploaded into HPMS. Materials that are not subject to review should not be uploaded into HPMS and therefore do not require a material id.

## Section 30 – Plan Sponsor Responsibilities (Updated)

Number	Question	Response
1.	This section states that plans must place the alternate language disclaimer on “all materials as required”--does this mean that this disclaimer must be included on all materials required to be translated per Section 30.7?	Yes, at a minimum, the materials noted in §§ 30.8, 30.9, 30.12 and the Part D Transition Letter must contain the alternate language disclaimer.
2.	If a sales agency's materials are generic (they do not contain plan names or benefits), are those considered to be "plan marketing materials"? (They mention "Medicare Advantage" but not the individual plan sponsor names or plan names.)	The answer is yes. All materials used to market Medicare plans are considered plan marketing materials.
3.	We understand that there is an option to have the required Multi-language insert, (section 30.7.1) to be part of the SB and ANOC/EOC; is there a certain section to include this model in the SB, ANOC and EOC?	CMS does not dictate placement requirements for the Multi-language insert. Plans should follow the guiding principles when determining placement.
4.	Are documents that are developed by the American Red Cross or the Asthma Coalition documents that the sponsor would need to track internally? We would like to hand out educational material developed by these organizations, but these are documents we can't add a CMS material ID on.	If the materials in question are not displaying plan specific benefits or information, they do not require submission in HPMS for review and approval.
5.	What do we use for status at the end of the material ID code for file and use items?	Plan sponsors may use the term “accepted” to denote a file and use material.
6.	Is the Non-English Translation disclaimer required for all advertising/marketing materials or only those indicated in 30.7?	Plan sponsors should include the disclaimer on any materials for which a translated version is available. At a minimum, plan sponsors must translate the materials noted in sections §§ 30.8, 30.9, 30.12 and the Part D Transition Letter.
7.	If the Multi-Language insert (30.7.1 & Appendix 4) has not been modified (other than providing the plan's telephone number) is it still required to be submitted through HPMS, as this does not provide plan specific information and the telephone number is considered one of variable data exempt from the template resubmission requirement (Static Templates)?	The multi-language insert must be submitted file & use in HPMS. A submission code is currently being developed and will be released shortly.

## Section 30 – Plan Sponsor Responsibilities (Updated)

Number	Question	Response
8.	Can a plan put their logo or name on the multi-language insert?	Yes.
9.	Per §30.7.1 – Multi-Language Insert of the new Medicare Marketing Guidelines, the Multi-Language Insert must accompany the Summary of Benefits and the ANOC/EOC. Must plans include the Multi-Language Insert when sending a member a stand-alone EOC (i.e., when no ANOC is required)?	Yes - If the individual is a new member receiving a standalone EOC as part of their required materials at the time of enrollment, No- If the individual is an existing member receiving a standalone EOC because the plan separated the ANOC from the EOC (where allowed) and the member received the insert with the ANOC.
10.	In regards to Member Referral Programs (30.11): Can the member's name be provided to the potential enrollee? Or should the referring member remain anonymous at all times?	Plans can make this determination by contacting the referring member.
11.	In section 30.3 there are NCQA guidelines for SNPs, but is there guidance for non-SNP plans regarding NCQA?	The NCQA approval process for the model of care applies only to SNPs. Therefore, the disclaimer is not applicable to non-SNP plans.
12.	If we create advertising campaigns with materials targeting women only or men only, is this considered discriminatory marketing?	Plan sponsors may highlight benefits that would appeal to differing demographic groups in advertising materials, but may not target those groups specifically. For example, a sponsor may promote breast cancer awareness by creating materials that highlight plan services to help beneficiaries prevent or manage the disease, but these materials could not be distributed to only women. They would have to be distributed to any beneficiary.
13.	Is the guidance for provider owned Health Plans the same as the guidance for co-branding contained in 30.2.1 & 50.9?	The MMG defines co-branding as a relationship between two or more separate legal entities, one of which is an organization that sponsors a Medicare plan. When a provider organization sponsors a Medicare plan, the co-branding rules do not normally apply unless the entity that is sponsoring the Medicare plan is a separate legal entity from the other entities under the provider organization's umbrella.
14.	Can a general statement be made in marketing materials such as "not happy with the poor star rating, enroll with our 5 star plan" or would that be in conflict with section 30.12.1?	Plan sponsors should refrain from making negative statements about lower performing plans when highlighting their 5-star rating.



## 2013 Medicare Marketing Guidelines (MMG)

### Questions & Responses

November 2, 2012

## Section 30 – Plan Sponsor Responsibilities (Updated)

Number	Question	Response
15.	For non-English speaking members receiving translated materials identified in §§30.8, 30.9 and 30.12, are we required to provide them with translated versions of other member materials, e.g., enrollment letters, claims letters, G & A letters, etc.?	Plans are encouraged to make these materials available upon request.
16.	If we translate materials into languages other than Spanish, is it permissible to use the English version, or must we also have the Program Mark translated into those languages?	The Program Mark is proprietary and may not be altered.
17.	When filing Alternate Format, what date should go on the piece after filing? Do we still use the date of the English approval?	The date is not required on marketing materials. Plan sponsors should file the alternative format once the English version has been approved in HPMS.
18.	When will CMS release the new model enrollment form?	The 2013 Enrollment guidance was released in HPMS on August 7, 2012, Revisions to Medicare Advantage and Prescription Drug Plan.
19.	What if a plan is brand new and has no star rating. Do they still need to inform beneficiaries of this in the Summary of Benefits?	No.
20.	Does the plan ratings document need to be filed with CMS?	Yes the plan ratings document should be filed under code 1090.
21.	Should the plan ratings document be in the Enrollment Form?	The plan ratings document should be provided with an enrollment form.
22.	If a plan offers just a PDP plan, can it revise the multi-language insert to remove the reference to health"?	The multi-language insert is a standardized document that should not be modified except as allowed by the instructions. The word "or" was specifically used to account for both MAPDs and PDPs, and any changes would require changing all 15 languages.
23.	The multi-language insert - do we have to list all of the languages? What if we have very few persons in our city who are of that language?	Yes.

## Section 30 – Plan Sponsor Responsibilities (Updated)

Number	Question	Response
24.	Are plans allowed to use a plan logo without a standard plan type when the material is sent to enrollees of all product types?	If the logo is generic enough to properly identify the plan, it would be OK.
25.	Regarding Multi-language insert, if we are utilizing the template by only adding telephone numbers, does it need to be filed for approval? File and Use? Or we can use as is? If we need to add additional language translations, does it need to be filed? What is the filing process?	The Multi-Language insert should be submitted in HPMS using the 4036 code. It is a standardized document that should not be modified except as allowed by the instructions.
26.	This was asked during the draft comment period, but the Multi-Language insert still has Arabic and Hindi missing, and some languages do not download properly. Is this being addressed?	The word document included on our website contains the Arabic and Hindi languages.
27.	Multi-Language Insert - will this be required more than once if all material is bound into a book?	Plans must include the Multi-Language Insert with the Summary of Benefits and the ANOC/EOC. D-SNPs that choose to mail the ANOC and EOC at different times are required to send the Multi-Language Insert in the first mailing and have the option to include in the second mailing.
28.	Does using a window envelop that shows the plan logo through the window, satisfy the requirement to show the logo on the envelope?	Section 50.6 states the plan name or logo must be either on the front envelope or on the mailing, when no envelope accompanies the mailing. Plans should also refer to Appendix 2 of the MMG, Mailing Standards.
29.	How does the Required Materials requirement apply to a telephonic enrollment situation?	Regardless of the enrollment mechanism, the materials listed in Section 30.9 of the MMG must be provided to all new enrollees within CMS' required timeframes.
30.	Are new members required to receive the ANOC/EOC or just the EOC?	Beneficiaries who enroll with your plan must receive an EOC. The ANOC is not required for new members.



## **Section 30 – Plan Sponsor Responsibilities (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
<b>31.</b>	Are the summary of benefits, star ratings insert, and multi-language insert required to be sent with the plan change form (or short application)?	Yes, a plan change form is an enrollment form.
<b>32.</b>	If a new member is enrolled in our plan on July 1st 2012, do we have to send them an ANOC that states the changes from 2011 to 2012?	No.
<b>33.</b>	Is Part D EOB required in non-English language for plan sponsors operating in areas where the five (5) percent language requirement threshold is met?	Plan sponsors are strongly encouraged to make the Part D EOB available in a non-English language.
<b>34.</b>	Can you please review what is required with the enrollment form? Confused as to the wording in 30.9 stating that directories/formularies are required at time of enrollment. Also we used to have to provide Grievance and Appeals with the enrollment. Is this no longer required?	Section 30.8 states that the following documents must be with an enrollment form - Plan Ratings information, the SB, and the Multi-language Insert. Section 30.9 lists the documents that need to be provided to all new enrollees once the enrollment is completed.
<b>35.</b>	Can one set of pre-enrollment documents (like the SB) be sent to a multi-person household? What about enrollment applications? Does this apply to individual and group pre-enrollment?	Pre-enrollment documents (like the SB) can be sent to a multi-person household. However, individual beneficiaries must complete their own enrollment form. The types of documents listed in 30.9.1 are required to be sent to beneficiaries who have enrolled.
<b>36.</b>	Do Employer/Union group pre-enrollment materials have to include the full summary of benefits with Original Medicare benefits included, or is a brief benefits-at-a-glance document compliant for employer/union groups?	Please see Section 130 - Employer/Union Group Health Plans - for information about group enrollments. Plan sponsors offering employer group health plans are no longer required to submit informational copies of their dissemination materials to CMS at the time of use. Chapter 9 of the Medicare Managed Care Manual-Employer/Group Union Sponsored Health Plans also provides guidance on disclosure requirements.
<b>37.</b>	What if an Employer group plan is very small and has no OE period?	Chapter 9 of the Medicare Managed Care Manual-Employer/Group Union Sponsored Health Plans provides guidance on disclosure requirements and open enrollment.



## Section 30 – Plan Sponsor Responsibilities (Updated)

Number	Question	Response
38.	Please confirm that File & Use is no longer required in the CMS ID?	Correct.
39.	The ANOC has a lot of information that does not apply to full benefit dual plans that would be confusing to members. Can the EOC be submitted for file and use and the ANOC be submitted for review to ensure members can understand the changes to their plan?	Per the instructions released with the ANOC/EOC, both the ANOC and EOC must be submitted file & use.
40.	Can the Summary of Benefits (SBs) be filed as a standard template prior to CMS bid approval? The 2012 MMGs allowed for submission of the summary of benefits to be submitted as a template prior to bid approval. However, the 2013 MMGs is now silent on this issue, however still allows for filing of standard templates. Does this mean all plans have to wait to file their SBs until their CMS bids are approved?	The SB may not be filed as a template this year. Plans must wait until their bids are approved to complete and file their SBs. SBs are now file and use, and there is no option for CMS review.
41.	Will the Multi Language Insert be a model document?	The multi-language insert is a standardized document and cannot be modified except to include additional languages.
42.	When will we receive the Marketing material models (ANOC + EOC) in Spanish?	The translated versions of the ANOC/EOC are available on the marketing website.
43.	In relation to the multi-language insert, CMS stated this should be submitted file and use. How should it be submitted if the plan adds additional disclaimers to address other languages supported (as CMS directed plans to do)?	Only additional languages can be added to the insert. The document can still be file and use.
44.	When a non-English speaking beneficiary is provided with enrollment instructions/ form, what required materials must she/he receive?	See section 30.8 of the MMGs.
45.	SB for D-SNPs along with FIDE SNPs is eligible for file & use, correct?	All SBs are file and use.

## Section 30 – Plan Sponsor Responsibilities (Updated)

Number	Question	Response
46.	Regarding the 5-Star SEP, currently CMS allows plans to list their customer service star rating in the Medicare & You Handbook (M&Y); however, beneficiaries may use the 5-star SEP only for those plans that have an overall 5-star rating, not just 5 star customer service rating. This discrepancy has led to confusion among beneficiaries and has resulted in alleged marketing misrepresentation against MEDICARE. When beneficiaries see a 5-star rating, they don't distinguish between the plan's customer service department and its overall performance. In their enrollment instructions, will plans be required to specify whether the published star ratings are overall or for a specific area (i.e. customer service)?	See section 30.1.21 - Referencing Plan Ratings in Marketing Materials - Plans may only reference the contract's individual measures in conjunction with its overall performance rating in marketing materials.
47.	<b>New</b> - When will CMS release the new model enrollment form?	Enrollment models are part of the Enrollment and Disenrollment manuals. Any updates to these models will be incorporated in the Enrollment and Disenrollment manuals, as appropriate.

## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
1.	Section 40.1; are we to submit our marketing material in HPMS referencing <b>only</b> (1) the sponsor's contract number and (2) any series of alpha numeric characters?	The marketing material identification number used when submitting marketing materials in HPMS consists of two parts: 1) the plan sponsor's contract or MCE number followed by an underscore and 2) any series of alpha numeric characters chosen at the plan sponsor's discretion. When placed on actual marketing materials, the material identification number must be followed by either "approved" or "accepted" (or "pending" on websites).

## **Section 40 – General Marketing Requirements (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
<b>2.</b>	Section 40.1, Page 17- The Material ID appears to have been changed and now only requires Plan Sponsor's contract or MCE number and any series of alpha numerical characters immediately followed by approved, pending or accepted. Dates are no longer mentioned in this section? The use of dates helps to make most recent version more readily identifiable. Is this simply no longer mandatory but allowed or must we truly stop using dates after "approved, pending or accepted?"	Plan sponsors have the option to include dates if they choose.
<b>3.</b>	Third bullet removed television ads from the "do not require a marketing material ID number" requirement. How do we obtain an ID number and how is it to be displayed?	The material ID number that is placed on television advertisements should follow the guidelines found in section 40.1, Marketing Material Identification.
<b>4.</b>	Section 40.6, page 20- We understand that we can use unsubstantiated statements in our logo and product tag lines, but can we add a tag line under our logo?	Yes.
<b>5.</b>	How should plan sponsors indicate the status of a marketing material? In the previous version of the Medicare Marketing Guidelines, plans were instructed to include the term "CMS Approved MMDDYY," "File & Use MMDDYYY," "Deemed MMDDYYY," or "Pending CMS Approval" (for websites only), as appropriate, immediately following the marketing material ID. Should plan sponsors continue to use the same format and structure (including the date stamp) for indicating the status of the material?	Per section 40.1, materials must be immediately followed by the status of either approved, pending (for websites only), or accepted (e.g., Y1234_drugx38 CMS Approved). The date is no longer required on materials.
<b>6.</b>	Section 40.1, page 17: Will reviewers expect to see the approved/accepted text on the material at the time of submission to CMS or are we to wait to insert that until the CMS approval/5-day waiting period is complete?	The status of accepted should not be placed on the material that is submitted in HPMS. However, it should be on the piece that is used in the marketplace.

## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
7.	Section 40.1, page 17: CMS did not include TV ads as an exception to the inclusion of the ID (it was included previously). This is problematic due to limited space issues. Was this an oversight?	This was not an oversight. Many plan sponsors already include the material ID number on television advertisements. Now, it is required for all plan sponsors.
8.	In the final ANOC/EOC model letters, CMS included the File & Use date. This conflicts with the instruction in Section 40.1 Marketing Material Identification, which indicates that the date is no longer a required part of the material id. Can you please confirm that the File and Use date is not required on the ANOC/EOC model letters?	The file & use date is not required.
9.	Is use of the plan type required for radio and television ads? Do we need to verbally say for example “HMO-POS” after use of the plan name in the ad? Section 40.13 requires use of the plan type on “all marketing materials when the plan name is mentioned” and I have not found an exemption from this requirement for verbal marketing materials elsewhere in the 2013 Marketing Guidelines.	Per MMG section 40.13, plan sponsors must include the plan type on all marketing materials when the plan name is mentioned. This includes radio and television advertisements.
10.	How should we format website material IDs before they are approved by CMS? The current guidelines do not have the same format as last year and just mention the words 'pending'.	Per section 90.2.2, Plan sponsors may make the website available for public use during the CMS review period; however, plan sponsors must include the status <i>pending</i> on their website until CMS has granted final approval/disapproval. For websites, plan sponsors should include the material ID followed by the word pending.
11.	Marketing Material Identification (40.1): During our website submission, it was once disapproved because it stated “pending” within the material ID itself instead of separately. In order to make sure we do not commit the same mistake, would the material ID status be “pending” (while awaiting approval) or should it have the approved or accepted status and separately state “pending”?	The website should include the term pending as part of the material ID.

## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
12.	Marketing Material Identification Number for Non-English or Alternate Format Materials (40.1.1): Previous version of the MMG stated that the approval date for these materials is the same as the original document (English version). Although the date will no longer form part of the material id, can these be used and distributed once submitted or will the same review/wait period that applied for the original document apply?	Once the English version is approved, the Non-English or Alternate Format material can be uploaded and distributed.
13.	Standardization of Plan Name Type (40.13): The exclusions mentioned on the draft version were removed; does this mean that those exclusions no longer would apply?	Please refer to the guidance in 40.13, the exclusion are provided in this section.
14.	Can you confirm that if marketing material has the status of “deemed” due to neither an approval or disapproval being received with the review time frame that the material ID should be followed by CMS “Deemed” rather than one of the status designations specifically listed in Section 40.1 (i.e., approved, pending, or accepted).	The material ID should not be identified with “deemed” status. Disregard the last sentence in Section 90.3.3.
15.	Can 2 Material IDs (2 different contract #'s) go on one document (i.e. EOC) and then be submitted in HPMS under each contract although it is the same document?	Yes. If a plan sponsor has an MCE (multi-contract entity) number, then the MCE number must be used instead of the contract numbers. If the plan sponsor does not have an MCE number, it should create a material ID that incorporates all of the contract numbers for the contracts that will use the document.
16.	Material ID - If a single marketing piece is created to encompass MCE contracts and a single HXXXX contract, do we place two IDs on the piece, e.g., the MCE ID and the individual Hxxxx ID?	Plan sponsors that submit materials using the MCE contract do not need to show individual contract numbers. The Plan sponsor should select the contract(s) in HPMS under the MCE that will apply to materials.

## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
17.	Material ID - Do TV ads now require the Marketing Material ID to be displayed? If yes, is it required to be displayed during the entire ad?	TV ads must include the marketing material id. The material id should be displayed at the bottom of the ad and is not required to appear during the entire commercial.
18.	Is the Material ID required on TV ads?	Yes.
19.	If you no longer have to have a date with the material id - how will the five day period be measured?	HPMS lists the date the piece can be distributed, which is 5 days after uploading.
20.	Should the material ID include the statement "CMS Approved"?	Per section 40.1, material IDs must be immediately followed by the status of either approved, pending (for websites only), or accepted. The date and CMS, is no longer required on materials.
21.	Can beneficiaries opt out of receiving the materials at all as long as they know how to request or view materials?	Yes.
22.	Do emails to beneficiaries/prospects require the material marketing identification number?	Yes.
23.	Do you need beneficiary okay for alternate media for each and every document, or can one authorization form with checkmarks for each category suffice?	One authorization is acceptable as long as it's clear which documents the beneficiary wishes to receive in alternate media.
24.	Must you advise a member that they have the ability to change their opinion re: receiving information via electronic media?	Yes.
25.	Is it any customer service number or just the plan customer service number?	Any customer service number.
26.	Does the hour of operation requirement apply to the website as well?	Yes.
27.	How do we handle hours of operation on model documents when it indicates that this must be entered in every instance where the customer service number is indicated?	Section 40.8 states: Note: The hours of operation need to only be listed once in conjunction with the customer service number, they do not need to be listed every time a customer service number is provided.



## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
28.	Does the TTY # need to be listed each time or only once for 40.8	The TTY # should be listed each time a customer service phone number is listed per 40.9.
29.	What constitutes a customer service number? Does a departmental phone number, for example, a direct phone number or a billing department phone number constitute a customer service phone number?	The phone number to reach your customer service staff is considered your customer service number. Your examples are not customer service phone numbers as you have stated.
30.	What if an agent represents several plans and they want a generic flyer without specific health plan benefits. Does each plan have to review it or just a lead plan for CMS submission?	This could be "multi-plan material" - see section 90.2.4 for how to file such documents.
31.	If we want to put a date on the Alternate Format filed materials, does it still stay the same date as the English material or the date the alternate format material is submitted in HPMS?	This is plan discretion.
32.	It used to be considered event-specific when an enrollee or prospective enrollee provided an email address. Is this now considered open-ended (provided the person has the option to opt out)?	How the email address was obtained would dictate if it was event specific or not.
33.	If I submit a material to be used during 2012, must I adapt the document to the 2013 guidelines, if I continue to use the document during 2013?	Marketing materials are required to be compliant with current guidance. If a material is no longer compliant for CY 2013, the plan should make the appropriate updates to the material and resubmit the piece.
34.	Last year we did have to wait 5 days for File & Use for the EOC. This was waived because of the earlier ANOC date. Will this be true for this year?	The 5 day wait no longer exists for the ANOC/EOC.

## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
35.	If changes are made to the EOC, are included in the file and use submission?	Plans should file the final copy of their ANOC/EOCs.
36.	In the past, the EOC for SNPs has not been eligible for File & Use because of additional Medicaid information and other changes required. Will SNPs now be able to submit EOCs as F&U?	Yes.
37.	Do I understand correctly that it is no longer required to include "This is an Advertisement" on the front cover of potential enrollee direct mail marketing materials?	No - Section 50.16 lists the mailing statements and their use. If no envelope is used, the statement needs to be on the mailing itself.
38.	We have two new H contracts approved for 2013. We would like to know when we can begin submitting marketing materials for these two new contracts.  Also, will we currently have File and Use status and want to make sure we will be able to submit using File and Use for our new H contracts as well?	Marketing material for new contracts can be filed beginning July 1. Section 90.6 explains the certification process for new contracts.
39.	For the 10% File & Use rule, does that mean that plans which use non-model enrollment letters when those models are available are having that counted against them? Or is it strictly for pieces more like advertising which really should not be CMS reviewed?	Yes, submitting non-model documents, when a model is available is counted against the plan sponsor.
40.	If a letter template does not change from one year to the next, does it need to be re-submitted in HPMS for the new year again?	No.
41.	In Sec. 40.1 (marketing material identification), it appears that CMS Accepted" has replaced "File & Use" in the material ID that is to appear on the final documents. However the 2013 model ANOC/EOC shows "File & Use". Why is there inconsistency here? What is the correct term that plans should use if a model document says one thing and the MMG says something different?	For the ANOC/EOC, plans may use either term "File & Use" OR "CMS Accepted"

## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
42.	Should we leave off "CMS Approved" until the approval has happened? How does CMS want to see 45-day material in regards to the status after the material ID?	Pieces reviewed by CMS prospectively should show "approved".
43.	If you mention only premiums and not detailed benefits information such as copays is this still considered a 45 day review piece?	All advertising is now file and use, except for websites.
44.	Does this mean file and use statements on material ID's are no longer required?	That is correct.
45.	What constitutes a "banner-like" ad? Material? Usage?	An example of a banner-like ad is an ad that scrolls across the bottom of a TV screen.
46.	So TV ads now must have a MID? There may be space/time limitations to include a MID in TV ads.	TV ads do require a material ID, unless they are banner-like ads.
47.	Is "CMS Approved" or "File and Use" still required on the marketing material ID number (i.e. Y1234_123456 CMS Approved)?	No, only the status is required, e.g., approved, accepted, or pending for websites.
48.	Can the cover letter be submitted in HPMS with the ANOC and EOC under the combined ANOC/EOC code?	The letter will need to be filed separately.
49.	Social media site still require CMS review? Just not the material ID correct?	The content of the social media site and messages determines the type of piece it is, and whether it is required to be reviewed, e.g., advertising is file and use.
50.	What status should be included in the material ID for ad hoc communications that no longer have to be filed?	Since Ad Hoc communications no longer are subject to CMS review, no material ID is needed.
51.	We are not required to include the date on materials; however do we need to identify whether or not it is a CMS approved or File & Use document?	The status that is required as part of the material ID, informs the reader of the type of material. If it's approved, it was reviewed by CMS prior to use. If accepted is used, it was submitted as file and use.

## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
52.	Please confirm "CMS Accepted" is to be used on all F&U submissions and "CMS Approved" are those pieces manually reviewed?	Only approved and accepted are now necessary.
53.	Should sponsors refer to section 40.12 - Providing Materials in Different Media Types for guidance concerning alternate materials (i.e. Braille, large font)?	No, section 30.6 - Anti-Discrimination would be more appropriate. "Basic services and information must be made available to individuals with disabilities, upon request."
54.	The Summary of Benefits guidance indicates that this will be able to be submitted file and use this year. However, HPMS does not reflect this. Will HPMS be updated to match the guidance?	HPMS was updated on July 1.
55.	When mailing marketing materials to multiple people at same address (i.e. husband and wife) can plan include a separate ID Card for each member in the same envelope, or must plan send the ID Card to each member in separate envelopes?	Yes, the ID cards can be in the same envelope - see section 30.9.1.
56.	In Ch. 4 of the model EOC, the benefits in the chart must be listed in alphabetical order. What about Spanish-language translations of these documents?	The Spanish translation should follow the order used in the English version.
57.	So if the model exhibit letters currently list the hours of op more than once, if we choose not to list them more than once, does that make the model a non-model?	This example would still be a model document.
58.	How many times hours of operation need to be listed on Application Form if it consists of 3 pieces which are 1) Cover letter 2) App Form and 3) Attestation Form as one binder?	The hours of operation must be listed once on each material. In the example you provided, the Cover letter, application form, and Attestation form would be considered separate materials.
59.	Can a plan sponsor use the MMG 2013 for materials been submitted to be used for 2012? Or can I only use it for materials that will be used in 2013?	Plans may begin using these guidelines immediately.

## Section 40 – General Marketing Requirements (Updated)

Number	Question	Response
60.	Section 40.8.1 requires that materials with an agent/broker phone # must include the plan sponsor's customer service phone number. Please confirm that the plan's number is not required if the materials are generic and do not include any plan sponsor names (i.e. Flyers, BRCs, etc. that only have the agent/broker name and phone #). [Agents are often licensed to sell MA plans for more than one plan sponsor.]	If the plan sponsor is not listed, no customer service number is required.
61.	For file & use is it still 90 % for materials under the File & Use process and 10% for materials under manual review?	Ninety percent of file and use eligible pieces must be submitted as file and use.
62.	Since you are no longer require the approval date, how will we tell if the document is not an updated version?	Sponsors should have an internal tracking system to determine if they have the most updated version. HPMS will also be available to determine the most recent version.
63.	Section 40.1 material ID, when submit a document they have to use for example H1234_testA so once the document is approved they would have to insert CMS Approved into the document?	Plan sponsors should add approved after approval.
64.	<b>New</b> - In regards to the marketing material identification (Sec. 40.1), previous versions required a date placeholder (MMDDYYYY) to be included in the material ID that appeared on final documents (for example, the actual CMS approval date). In the new MMG, the date placeholder is not mentioned at all - but some 2013 model materials such as the ANOC/EOC do show a placeholder for the date. Do plans have the option to include a date on all final documents if they so choose?	The date approved is no longer required. A date can be used, if the plan wishes.
65.	<b>New</b> - Our plan uses Material IDS (without Approval dates) for items that are not submitted. Will that cause any issues for CMS?	Plans are allowed to create and use their own material IDs on materials not submitted in HPMS.

## **Section 50 – Marketing Material Types and Applicable Disclaimers (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
<b>1.</b>	Is the former PFFS disclaimer still required to be read aloud/used at sales presentations?	No.
<b>2.</b>	Please clarify that plans may discontinue filing ads with 5 or more benefits for CMS marketing review 45-day approval and that these materials are now File & Use eligible?	Advertisements that contain plan benefit information must include the required disclaimers and may be submitted File & Use.
<b>3.</b>	Section 50.1 requires either the legal or marketing name be used in the Federal Disclaimer. An extreme legal entity disclaimer for general advertising and member communications would be quite lengthy especially for large organizations with many legal entities and it length legal disclaimer would be very confusing to prospects and members. Can CMS confirm that “Humana” would be the appropriate marketing name referenced in the guidance? For example “Humana is a Medicare Advantage Organization with a Medicare contract.”	The updated MMG gives plan sponsors more flexibility with how they choose to display the Federal contracting statement. Plans may choose to include their legal name or their marketing name. CMS does not dictate requirements for a plan sponsors’ legal or marketing name.
<b>4.</b>	For the new Federal Contracting Disclaimer requirements for Cost plans, are plans required to use the insurer’s legal/marketing name, or the name of the plan itself? It seems like, for this particular statement, it makes more sense to use the name of the product, instead of the name of the insurer.	The updated MMG gives plan sponsors more flexibility with how they choose to display the Federal contracting statement. Plans may choose to include their legal name or their marketing name. CMS does not dictate requirements for a plan sponsors’ legal or marketing name.
<b>5.</b>	Old MMG 50.1.10; 50.1.11; 50.1.14 which I call network disclaimers are not in the new MMG. Again is this because of appearing in model pieces? If we have a product brochure with benefit information what reference material should we refer to make sure we have all required disclaimers?	Plans sponsors should refer to Section 50 of the most recent MMG for required disclaimers.



## Section 50 – Marketing Material Types and Applicable Disclaimers (Updated)

Number	Question	Response
6.	Contracting statement shows legal and marketing name - Does this mean we should not show the plan name?	Plan sponsors should use the legal or marketing name (which could be the plan name) in the disclaimer.
7.	Old MMG 50.1.4 required the bulleted LIS disclaimer on explanatory materials. New MMG does not show this disclaimer anywhere. Is this <u><b>no longer</b></u> a requirement since it is in the Summary of benefits model?	Plans sponsors should follow the most recent MMG for required disclaimers.
8.	Please confirm the Extra Help disclaimer is no longer required on the website? Also, can CMS please clarify if the Extra Help Disclaimer is still required on marketing materials that reference Part D or if this is no longer a required disclaimer outside of model/standard materials that include the disclaimer?	All required disclaimers for websites are listed in Section 50 of the MMG. The LIS disclaimer is no longer required.
9.	We would like confirmation that the following disclaimer is no longer needed on materials for marketing educational materials "This event is only for educational purposes and no plan-specific benefits or details will be shared".	All required disclaimers are listed in Section 50 of the MMG.
10.	Do envelopes that contain more than merely the required plan mailing statement (2013 MMGs Section 50.16) require a 45 day review, or are all envelopes now 5 day File & Use? The 2013 MMGs are now silent on this issue.	Yes, envelopes that contain additional information outside of the mailing statements should be submitted for review.
11.	The 2013 MMGs Section 50.2 indicates that the disclaimers contained in this section must be used when 'benefit information' is included in marketing materials. We were hoping to get further clarification on what is <u><b>meant by 'benefit information'</b></u> . Does this mean that the disclaimers are required when actual benefit dollar amounts are used in?	The term "benefit" is used to describe benefits broadly and is not limited to describing dollar amounts.

## Section 50 – Marketing Material Types and Applicable Disclaimers (Updated)

Number	Question	Response
12.	Where can we find the VAIS guidance regarding how VAIS materials are handled, such as there must be a clear break between true benefit materials and VAIS, and the requirement in the prior MMG about inserting the mention about members with VAIS not having Appeal rights but having grievance rights?	Information about VAIS (value-add item or service) can be found in Chapter 4 of the Medicare Managed Care Manual.
13.	Last year the following disclaimer was only used on materials that were still marketing current year benefits. “[Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance] may change on January 1 of each year.” This year the guidelines state that it should go on all marketing pieces. If we are marketing in October for 2013 benefits isn’t it confusing to the beneficiary that we are saying our plans may change each year?	The disclaimer is required and is still accurate for materials marketing upcoming contract year benefits.
14.	Will the Federal Contracting Statement be required on letters to current members for routine operational issues?	Yes - per Section 50.1, all <b><u>marketing materials</u></b> must include the statement that the plan sponsor contracts with the Federal government.
15.	The 2013 MMGs Section 50.2 indicates that the disclaimers contained in this section must be used when ‘benefit information’ is included in marketing materials. We were hoping to get further clarification on what is meant by ‘benefit information’. Does this mean that the disclaimers are required when actual benefit dollar amounts are used in marketing materials only (e.g. \$0 premium, \$0 co-pay)? Or does ‘benefit information’ also include such statements as ‘low copays’, etc.?’	The term “benefit” is used to describe benefits broadly and is not limited to describing dollar amounts. Any description of benefits will require the use of disclaimers outlined in Section 50.2.

## Section 50 – Marketing Material Types and Applicable Disclaimers (Updated)

Number	Question	Response
16.	If a single marketing piece advertises multiple plans including a D-SNP plan, do we place two statements on the piece, e.g., <Plan Name> is a Health Plan with a Medicare Contract and <Plan Name> is a Coordinated Care Plan with a Medicare Contract and a Contract with the [state] Medicaid Program?	Plan sponsors are responsible for including only the federal contracting statements that are applicable. Therefore if there is mention of D-SNP in the advertising piece, the sponsor would be responsible for including the disclaimer for D-SNPs.
17.	Is the federal contracting statement required on all materials or just those considered advertising or some sort of attempt to sell a plan?	Section 50.1, first sentence states: "All marketing material must include the statement that the plan sponsor contracts with the Federal government."
18.	The MMG provides that the co. name may appear in the federal contracting disclaimer for MA or MA-PD. What about the Part D standalones?	Section 50.1 applies to PDP sponsors as well as MA plans. This section lists the contracting statements that must be used by PDPs.
19.	Are we required to re-submit any materials due to changes in disclaimers?	No.
20.	Section 50.4 Disclaimer on Availability of Non-English Translations - Our Plan meets 5 percent threshold for Spanish. Do we put this disclaimer on ANOC/EOC, SB, Enrollment Form and all other Marketing Materials" for prospective members direct mail?	Section 30.7 lists the Requirements Pertaining to Non-English Speaking Populations.
21.	Regarding the change to not include a date in the material ID. Does this mean we do not need to include the File & Use date?	Yes.
22.	In regards to disclaimers, when considering the websites, certain pages have content that is targeted to prospects and certain pages are targeted to members. However, both have access to the pages. Is there more guidance on how to apply disclaimers to the website?	Disclaimers should be on the pages with the material that requires the disclaimer.

## Section 50 – Marketing Material Types and Applicable Disclaimers (Updated)

Number	Question	Response
23.	Please clarify- We have Plan Rating Information's, Language insert available online but people can access the enrollment form prior to seeing these if they wish. Must we somehow lock down enrollment apps so that enrollees can't access them until after they've viewed other information?	The requirement is plans must make these materials available prior to accessing an online enrollment form. Plans should use the guiding principles and sound judgment when implementing this requirement.
24.	Section 50.4 Disclaimer on Availability of Non-English Translations - Our Plan meets 5 percent threshold for Spanish. Do we put this disclaimer on ANOC/EOC, SB, Enrollment Form and all other Marketing Materials" for prospective members direct mail?	Section 30.7 lists the Requirements Pertaining to Non-English Speaking Populations.
25.	Will CMS provide a standard Alternate Language Disclaimer for use with written member communication that informs the members or prospective members that the communications are available to them in other languages or formats, or will the plans continue to be responsible for translating the English Disclaimer?	See section 50.4 for the disclaimer.
26.	Per 50.15, if a directory lists all network pharmacies in an entire state; would the state be considered the service area for that directory?	The service area is determined by each contract and PBP's service area.
27.	If we are using stars as a visual symbol, must we include the Disclaimer When Referencing Plan Ratings Information mentioned in 50.14?	Yes.
28.	Where will the CMS gold star icon be found?	The icon will be provided to 5 star plans via their Account Manager. This information is generally provided in October.
29.	Is the VAIS disclaimer (refer to CY2012 MMG, Sec. 110.1) no longer required in marketing materials?	VAIS materials are no longer materials subject to review; thus, the MMG do not dictate VAIS requirements, including disclaimer requirements. Plan sponsors should refer to Chapter 4 of the Medicare Managed Care Manual for VAIS guidance.

## Section 50 – Marketing Material Types and Applicable Disclaimers (Updated)

Number	Question	Response
30.	Some plans want to deviate, using model docs and use their own created docs such as letters etc., is this practice acceptable?	Plan sponsors may create non-model documents; however they must ensure that all elements of the model are in the non-model document. In addition, for those models that make a piece eligible for file and use, plan sponsors should ensure that 90% of file and use eligible pieces are submitted as file and use.
31.	<b>New</b> - The Section 50 disclaimers are also to be said when a CSR is speaking to a beneficiary, correct?	For scripts that are required to be submitted to CMS, yes.

## Section 60 – Required Documents (Updated)

Number	Question	Response
1.	If the Summary of Benefits includes a section III or IV, please confirm that it will still require filing under the 45-day review process.	The SB is now a file & use document, regardless of which sections are included.
2.	Must health plans reissue all ID cards to current members if current cards do not meet these new requirements? Or do they only have to add this new information to cards for new members?	All health plan identification cards must contain the required information. If plan sponsors have issued cards in past years that do not include the required information, they must reissue updated cards that are compliant with the new requirements.
3.	HPIDs have not yet been distributed to health plans. What is the effective date of this requirement, and when does CMS expect that health plans must add this information to ID cards?	<i>CMS will release information about how to obtain HPIDs in the fall.</i>
4.	60.1 Section II – References PDPs. Can MA-PDPs include a premium table?	Yes.
5.	Can MAOs continue to submit the SB as a standard template prior to approval of final bids?	No, the SB can no longer be submitted as a template and should be submitted as final, populated versions.

## Section 60 – Required Documents (Updated)

Number	Question	Response
6.	Please clarify the Health Plan Identification Number (HPID) required to be included on ID cards- is this contract #?	No, the Health plan identification number is a number that will be issued by CMS at a later date.
7.	Section 60.4.3 no longer states that a combined provider/pharmacy directory is 10 day model-please clarify if this is still the case.	Yes, combined provider/pharmacy directories are still considered model materials if no modifications are made to either the pharmacy or provider directory.
8.	Section 60.1 indicates SB's are to be submitted as one document under the File and Use process, but HPMS still reflects 10/45 day review. Please confirm how to process.	HPMS submission codes will be updated to reflect the file & use submission effective July 1, 2012.
9.	Submission of Summary of Benefits with Section III: Can you clarify how an SB that includes a Section III is to be submitted? The HPMS memo dated May 31, 2012 indicates that plans "must submit all sections of the SB as one document under the file & use process." However, the Marketing Code Lookup module in HPMS includes the code 1061-Summary of Benefits (SB) with Free Form text (Section 3) and specifies for that code that 45-day review is applicable and that File & Use is not available.	Plans should submit all sections of the SB as one document under the file & use process. The HPMS codes will be updated to reflect the file & use status effective July 1, 2012.
10.	Can the Summary of Benefits (SBs) be filed as a standard template prior to CMS bid approval? The 2012 MMGs allowed for submission of the summary of benefits to be submitted as a template prior to bid approval. However, the 2013 MMGs is now silent on this issue, however still allows for filing of standard templates. Does this mean all plans have to wait to file their SBs until their CMS bids are approved?	For CY 2013, plan sponsors may not submit the SB as a standard template. All sections of the SB should be submitted as one populated document after bid approval under File & Use.
11.	If the multi-language information is added to the SB or EOC and not an insert would that make the SB or EOC non-model?	No, the SB and/or EOC will still be considered a model with the inclusion of the insert.



## Section 60 – Required Documents (Updated)

Number	Question	Response
12.	Is there a specific location on the Member ID card where the HPID needs to be displayed?	Per section 60.2.1, the location of the HPID must conform to the specifications of the WEDI <i>Health Identification Card Implementation Guide</i> .
13.	Can provider/pharmacy directories be included in the ANOC/EOC mailing?	Yes, plans may mail the provider/pharmacy directory with the ANOC/EOC.
14.	If we include the Summary of Benefits in our ANOC/EOC mailing do we also need to include the Plan Ratings form (as the new Chapter 3 states that we must include the Plan Ratings form with the Summary of Benefits, however, guidance also states that nothing else can be included with the ANOC).	If a plan sponsor chooses to send the SB with the ANOC/EOC mailing the plan ratings information must be included.
15.	Can you clarify if notices to members regarding provider/pharmacy termination referenced in Section 60.4 of the Guidelines require CMS review and approval or would this fall under the definition of an ad hoc material? If the notice required CMS review and submission, what code should plan sponsors use to submit these notices.	Provider/pharmacy termination notices can be considered ad hoc materials and therefore not subject to review.
16.	We will be offering 9 total HMO plans for two contracts in 2013. Of the 9, 8 are MAPD (1 MA-only), 5 are SNP (1 MLTCP, 2 FIDE SNP, 1 ISNP, 1 Partial Medicaid SNP). What is CMS's preference to breaking out the different templates (1 MAPD, 1 MA-only, 1 SNP)? Since we only have one MA-only plan, this will be filed as a populated version. The SNP templates can get complicated since 3 of the 5 will utilize a Section 4 and will therefore be filed as a 45-Day review.	Since the SB now qualifies as a File & Use document, plan sponsors may no longer submit it as a standard template.
17.	Is a new id card needed every year for continuing members?	Only if the card changes.
18.	If plans keep the date in MMID, can it be on the same line as the MMID?	Yes.

## Section 60 – Required Documents (Updated)

Number	Question	Response
19.	If a plan decides to put a date, should we include the < mmddyyyy > on the material when submitting to HPMS?	No.
20.	Where can the WEDI guide be found?	The WEDI Health Identification Card Implementation Guide can be found at the following link: <a href="http://wedi.org/snip/public/articles/details~74.shtml">http://wedi.org/snip/public/articles/details~74.shtml</a> .
21.	Do combination medical and prescription drug ID cards require the plan website to be displayed? Do they require the HPID number that CMS will provide?	CMS will provide additional guidance on the requirements for ID cards.
22.	Is a new id card needed every year for continuing members?	Only if the card changes.
23.	If plans keep the date in MMID, can it be on the same line as the MMID?	Yes.
24.	Section 60.1, Summary of Benefits, indicates it is to be submitted via File & Use. Does this mean it is no longer subject to RO review?	Correct, the SB is no longer subject to prospective CMS review but may be reviewed on a retrospective basis.
25.	<b>New</b> - What is considered significant change?	CMS does not define what is considered a significant change for directories. The plan sponsor must use their judgment in determining what a significant change is.
26.	<b>New</b> - One provider directory is used for multiple plans, 2 different disclaimers are needed as one of the plans is a dual plan. Can both of the applicable statements be included in one directory? Or, is a separate directory required for the Dual plan with the applicable contracting statement?	In the example presented, the plan may place both disclaimers in one directory and still meet CMS requirements.
27.	<b>New</b> - Is written notice required for non-primary care physician changes, i.e. specialists terminating from the network?	Plan sponsors must make a good faith effort to provide written notice of termination of a contracted provider/pharmacy at least thirty (30) calendar days before the termination effective date to all members who regularly use the provider/pharmacy's services. This is true whether the termination was for or without cause.



## 2013 Medicare Marketing Guidelines (MMG)

### Questions & Responses

November 2, 2012

#### Section 60 – Required Documents (Updated)

Number	Question	Response
28.	<b>New</b> - For the Provider Directories - do change pages equal directory inserts (that include Provider terminations and add-ons?)	Change pages are no longer required by CMS.
29.	<b>New</b> - We would like to clarify if the LIS Rider is still required to be sent with the ANOC/EOC as the requirement has been removed from section 60.7	The LIS Rider is considered part of the EOC. CMS strongly encourages plans to send the LIS Rider in the same envelope as the EOC. Please refer to the instructions for the ANOC/EOC on our website.
30.	<b>New</b> - Plans are still required to provide LIS Rider and abridged or comprehensive formularies for the upcoming year for current members, correct?	The LIS Rider and abridged or comprehensive formulary is an annual requirement and must be mailed to the beneficiary annually.

## **Section 70 – Rewards and Incentives, Promotional Activities, Events, and Outreach (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
1.	New regulations state a <i>conference call</i> can be made for a Scope of Appointment. Does that mean a sales agent can facilitate a 3-way call to our recorded line to meet the SOA requirements?	In Section 70.10.3, CMS lists “conference calls” as an example of a means of fulfilling a scheduled appointment. The documentation of the scope of appointment agreement must occur prior to the actual conference call to fulfill the appointment.
2.	Are we required to submit educational events now? Or is it still optional?	Per section 70.10.1, plan sponsors have the option to upload educational events.
3.	The guidelines state that we can enter N/A for agent number –when is that okay to do? Only with Educational Events?	Plans should enter N/A for agent number when the person conducting the event does not have a National Insurance Producer Registry (NIPR) National Producer Number (NPN).
4.	The 2012 MMG had requirements that both the OEV script and the OEV letter contain information regarding how long a member has to notify the plan sponsor if he/she wants to cancel processing enrollment. The 2013 guidelines do not have similar language. Has this requirement been removed from the OEV process?	Plan sponsors should refer to the appropriate Enrollment guidance for cancellation timeframes.
5.	The 2012 MMG also had a link to a model OEV letter and a model OEV script, but the 2013 MMG does not have a similar link. Will CMS issue a model OEV letter and script for 2013?	Yes, updated models will be issued within the next few months.
6.	If the provider agrees to make available and/or distribute generic materials for a sales agency that is licensed to sell ALL Medicare Advantage plans that the provider participates with, would the provider be required to let health plans display their plan-specific materials? (If generic materials are not “plan marketing materials” then the provider is not really displaying any plan materials. Or if the generic materials are “plan marketing materials” is the provider okay to refuse future requests, because the sales agency already represents all of the plans the provider participates with).	A provider is free to determine which type of materials it will make available and/or distribute, as long as they are willing to make available and/or distribute materials from all of the plans with which it participates.

## **Section 70 – Rewards and Incentives, Promotional Activities, Events, and Outreach (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
<b>7.</b>	Sections 70.12.1 - Does the term “sales/appointment forms” include a Business Reply Card (BRC)? The BRC is used by a sales agent to obtain permission to call the beneficiary and discuss Medicare Advantage plans and schedule a marketing/sales meeting.	A business reply card can be used as an appointment form.
<b>8.</b>	Would it be permissible for a provider to offer a Business Reply Card to their patients if this was done during an objective discussion of Medicare Advantage plans and the provider was not assisting with enrollment decisions, but only providing objective information about Medicare Advantage in general?	If a beneficiary requests contact information for a plan sponsor, a provider may offer the beneficiary a business reply card(s).
<b>9.</b>	If a member goes in for a preventive service such as a screening mammogram but then the service becomes diagnostic based on the results, are plans permitted to reward as a preventive service since the member has no control over how the service is billed by the provider (i.e. preventive vs. Diagnostic).	Yes. In the example provided, the member’s appointment began as a preventive service with zero dollar cost-share; therefore, a reward or incentive is permissible.
<b>10.</b>	In addition, we have filed for 2013 to cover a supplemental annual routine physical exam that is above and beyond the annual wellness visit provided by Medicare. Is it permissible for plans to provide rewards and incentives for supplemental routine physical examinations?	No.
<b>11.</b>	We cover Medicare covered preventive services at \$0 cost share beyond those that Medicare covers at 100% such as glaucoma screenings. Is it permissible for plans to provide rewards and incentives for preventive services that the plans charges \$0 cost share where Medicare would require some member cost share?	No, it is not permissible. Rewards and incentives may <u>only</u> be offered to current members for Medicare covered preventive services that have a zero dollar cost-share.

## **Section 70 – Rewards and Incentives, Promotional Activities, Events, and Outreach (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
<b>12.</b>	How long are plans allowed to contact beneficiaries who have responded to Business Reply Cards (BRCs)? The 2012 MMGs stated that permission given by a beneficiary to be called or otherwise contacted (BRCs) is to be considered short-term, event-specific, and may not be treated as open-ended permission for future contacts. This language is not contained in the 2013 MMGs.	Section 70.6 - Marketing through Unsolicited Contacts states the following, "permission given to be called or otherwise contacted must be event-specific, and may not be treated as open-ended permission for future contacts."
<b>13.</b>	Are plans allowed to collect leads through, for example SEP marketing activities, prior to the AEP, for future contact during the AEP?	Please refer to guidance provided in Section 70.6 and 70.7 of the MMG.
<b>14.</b>	Section 70.9 has a note. If this is truly an educational/retention event where no sales information is provided, would we still be able to post an announcement to our Facebook page, where most of the "Friends" are members?	Plans are allowed to advertise educational events (via Facebook and other means) provided they are advertised as such.
<b>15.</b>	In section 70.2 it states, "Plan sponsors must track and document items given to current members." Where is this documented?	Documentation should be kept with the plan sponsor.
<b>16.</b>	CMS clarifies that the SOA should be documented 48-hours in advance of the appointment "when practicable". Does CMS define practicable? Or is this an Organization decision?	CMS does not define practicable. Plan sponsors should use the guiding principles outlined in Section 10 of the MMG to define "practicable".
<b>17.</b>	How long are plans allowed to contact beneficiaries who have responded to Business Reply Cards (BRCs)? The 2012 MMGs stated that permission given by a beneficiary to be called or otherwise contacted (BRCs) is to be considered short-term, event-specific, and may not be treated as open-ended permission for future contacts. This language is not contained in the 2013 MMGs.	Section 70.6 - Marketing through Unsolicited Contacts states the following, "permission given to be called or otherwise contacted must be event-specific, and may not be treated as open-ended permission for future contacts."



## **Section 70 – Rewards and Incentives, Promotional Activities, Events, and Outreach (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
<b>18.</b>	Section 70.9 – how does these guidance impact renewal sales presentations? We currently file advertisements in HPMS and get approval for renewal sales presentations, which then are advertised in our newsletter for current members, to review changes for the new plan year. While there isn't a huge attendance, members appreciate us reviewing changes for the new year in person. Does the note in 70.9 only impact educational events so that we could continue our renewal sessions as sales sessions continuing to list these dates in HPMS? We do review plan specific benefits and premiums at these sessions.	Renewal sessions can be conducted in the example provided, as it targets only current members.
<b>19.</b>	<b>New -</b> AHIP Certification for agents extensively covers fraud waste and abuse will CMS honor this requirement having been met and not expect Plans to repeat this with agents using their own program? If not will CMS allow Plans to accept attestation from agents completing this requirement from a competing Plan so agents don't have to complete this require from 6 different Plans if they are appointed with that many? Thank you.	Plans are responsible for ensuring that agents meet the requirements specified for training and testing. Training and testing facilitated by a third party is acceptable; however the sponsor must be able to provide documentation that training and testing completed by the third party is compliant with the guidance.
<b>20.</b>	<b>New -</b> We are under the impression gift cards are not allowed as they can be transferrable to cash.	Correct-Gift cards that may be readily converted to cash are not acceptable.
<b>21.</b>	<b>New -</b> What does "Medicare limiting charges apply" mean?	Limiting charges are 115% of the Medicare allowable amount for a non-participating Medicare provider. These charges could apply when a beneficiary obtains routine services from a non-contracted provider, e.g., PFFS, PPO, or HMOPOS. The plan's bid determines whether the beneficiary or the plan is liable for the limiting charges.
<b>22.</b>	<b>New -</b> How do you track the \$50 limit when there is a crowd present? Is the \$15 limit to one per visit or can you provide multiple of the \$15 dollar item/service at the same visit.	Plan sponsors are responsible for tracking the nominal limits. CMS does not specify how this should be conducted. There should be a \$15 limit for each beneficiary.



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### Questions & Responses

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## Section 70 – Rewards and Incentives, Promotional Activities, Events, and Outreach (Updated)

Number	Question	Response
23.	<b>New</b> - Are gas cards of \$10 value allowed as a reward for attending a seminar?	Cards that can be converted to cash are not acceptable; therefore gas cards that can be converted to cash are prohibited.
24.	<b>New</b> - If you give out coupon booklets - do the coupons have to be less than a certain amount?	The coupon must meet the requirements for nominal gifts.
25.	<b>New</b> - Would you please clarify the use of gift certificates and gift cards (section 70.1 Nominal Gifts)? Cash gifts are prohibited and gift certificates and gift cards that can be readily converted to cash are prohibited. The speaker used gift cards as an example of a nominal gift. Please clarify what types of gift cards or gift certificates are allowed.	Gift cards or certificates that cannot be readily converted to cash are acceptable.
26.	<b>New</b> - Why require OEV phone calls to members, but not require a phone number on the enrollment application?	A telephone number is an element on the enrollment form.
27.	<b>New</b> - Can a member disenroll during an OEV call?	Members can request that their enrollment be cancelled during the OEV call.
28.	<b>New</b> - Are applications submitted by employees of the health plan also required to have an OEV?	OEV calls apply to all enrollments effectuated by agents/brokers (contracted or employed).
29.	<b>New</b> - For OEV, last year CMS has said that the plan can send the letter first and then do the 3 phone attempts. Is that being changed again for this year?	In accordance with Section 70.8, 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. 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.
30.	<b>New</b> - Please clarify "potential enrollee" and "prospective member."	Potential enrollee and prospective member have the same meaning.

## **Section 70 – Rewards and Incentives, Promotional Activities, Events, and Outreach (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
<b>31.</b>	<b>New</b> - Does CMS categorize money rebate incentive as a gift certificate?	Monetary rebates are not considered gift certificates.
<b>32.</b>	<b>New</b> - Can you advertise Member-Only events via newspapers if they are clearly labeled "Member-Only Events"?	CMS expects that member only events will be advertised in a way that reasonably only targets members. Plans should work directly with the Account Manager if they have a question on a specific advertising strategy.
<b>33.</b>	<b>New</b> - Can we distribute plan change forms at member meetings we hold in October to go through the ANOC with our members?	Plans may distribute plan change forms during the AEP; however this should be entered as a sales event in the events module.
<b>34.</b>	<b>New</b> - Do educational events need to be submitted through HPMS for educational events for members only? For educational events directed for the public (may include non-members)?	CMS does not require submission of educational events in HPMS.
<b>35.</b>	<b>New</b> - Member only events - to help members utilize their benefits -should not be submitted to CMS as sales events - correct?	Member only events designed solely to educate members on existing or upcoming benefits do not need to be entered in HPMS.
<b>36.</b>	<b>New</b> - In regards to section 70.9. The guidance says that the plan can not advertise an educational event and then hold a sales and marketing event immediately following at the same venue, which implies the plan did not advertise the sales/marketing event. Can we assume that the plan CAN hold a sales/marketing event shortly after an educational event if it is advertised?	Marketing and educational events must be separate. If a plan would like to hold a joint sales and education event they may; however it should be uploaded in the sales event module.
<b>37.</b>	<b>New</b> - If a beneficiary chooses to cancel his/her enrollment during an OEV call, are they required to cancel their enrollment within 7 days of the OEV call or letter or by the last day of the month in which the enrollment request was received (whichever is later) or do they truly have either 7 days from the date of the OEV call/letter or by the day prior to effective date, whichever is later?	The beneficiary may cancel their enrollment through the OEV process even if the enrollment has become effective. Please reference the memo released on November 4, 2011-Correction of Timeframe for Cancellation of Enrollment Request Contained in Outbound Enrollment and Verification Communications

## **Section 70 – Rewards and Incentives, Promotional Activities, Events, and Outreach (Updated)**

<b>Number</b>	<b>Question</b>	<b>Response</b>
<b>38.</b>	<b>New</b> - Is there still a 48 hr requirement for an agent to present non-health care products if requested by a bene during a MA/PDP appointment (life insurance, annuities)?	The 48 hour requirement does not apply to non-health care products if the beneficiary has requested information.
<b>39.</b>	<b>New</b> - If a last minute change is made on the day of the event, and a different agent presents, will this count against the plan if not entered prior to the event?	If the agent changes during the sales event this will not count against the plan.
<b>40.</b>	<b>New</b> - Can a provider attend a marketing event to provide health screening activities?	Plan sponsors may not conduct a health screening activity at a marketing event.
<b>41.</b>	<b>New</b> - Is the contracting statement required on health education materials?	The contracting statement is only required on marketing materials. Health promotion materials that do not include any specific plan related information are not considered marketing materials and do not need to be submitted in HPMS.
<b>42.</b>	<b>New</b> - Are OEV calls required to be recorded?	OEV calls must be documented. Plan sponsors may record or use another mechanism for documenting.
<b>43.</b>	<b>New</b> - Do we have to submit member orientation events?	Member orientation events are considered educational; therefore they do not require submission.
<b>44.</b>	<b>New</b> - Are PACE, SPAPs, auto-enrollments & reassignments effectuated by CMS no longer excluded from the OEV requirement?	PACE, SPAPs, auto-enrollment and reassignments are still excluded from the OEV requirement.
<b>45.</b>	<b>New</b> - Do events need to have a plan translator if it is determined that the audience is non-English speaking? Can an audience member do the translating, or do we have to have a plan translator at the event?	CMS expects that plans will provide reasonable accommodations to meet the needs of their audience.
<b>46.</b>	<b>New</b> - Clarification - under educational events a plan's new member meeting can be held which will discuss plan-specific material, but no enrollment may be taken, correct?	Enrollment may not be conducted at member only events designed to educate the member.

## Section 80 – Telephonic Activities and Scripts (Updated)

Number	Question	Response
1.	Draft guidance stated that "From October 1 - February 14, plans sponsors must operate a toll-free call center." Final Version states "Plan Sponsors must operate a toll-free call center..... And Later states "Note: From February 15 to September 30, plan sponsors may use alternative technologies on Saturdays, Sundays and Federal Holidays." Final version also refers back to "During this time period" but has not time period to refer back to. Confirmation that we must now be open <b>10/1-2/14</b> rather than 10/15-2/14.	The 10/1/12 date is correct.
2.	Telephonic contact - Does an auto dialer campaign for marketing topics, e.g., AEP dates, upcoming plan changes, new benefits, etc., require CMS approval?	Per Section 80.2 Expectations for Scripts, informational scripts designed to respond to beneficiary information requests and provide objective information about the plan and Medicare program do not require submission into HPMS for review and approval. However, plan sponsors must retain these scripts and make them available upon CMS request. CMS expects sponsors to incorporate in all their scripts all relevant requirements outline in the MMGs (e.g. hours of operation, TTY number etc.).
3.	Are the requirements for non-English speaking populations applicable for agent call centers?	Plan sponsors are responsible for ensuring that their contractors are compliant with the MMG. To the extent that a plan sponsor has delegated or sub-contracted some of its marketing functions to other entities, all of the requirements that the plan sponsor must comply with translate to the delegated entity or sub-contractor.

## Section 80 – Telephonic Activities and Scripts (Updated)

Number	Question	Response
4.	<b>New</b> - Please confirm 8-8 7 days applies to Part C member service as well as Part D. It used to be "strongly suggested" but I interpret the new guidelines to state it is required.	The customer call center requirements apply to Part C and Part D plans.
5.	<b>New</b> - If a telephonic enrollment starts on an inbound call and the call disconnects, when the beneficiary calls back in to complete the enrollment can the Agent proceed with the enrollment where the call was dropped? Or does the Agent need to start the telephonic enrollment over from the beginning?	If a beneficiary is disconnected from a telephonic enrollment the agent may proceed where the call was dropped off if there is documentation in the system of what had been previously discussed.
6.	<b>New</b> - Is it required to provide the enrollment form and other required information at the time of enrollment if meeting with an agent? Or can it be mailed after the appt?	CMS required materials should be distributed at the time of enrollment.
7.	<b>New</b> - What about Telesales? Do they have to be open from 8am-8PM 7 days a week?	Telesales are not required to be available during the customer service call center hours.
8.	<b>New</b> - Must there be live sales agents available during all the required customer service hours?	Live sales agents are not required during the customer service call center hours
9.	<b>New</b> - Changes to hours of operations don't require a material to be resubmitted, does this hold true for phone number changes also? What about the change from 10/15 to 10/1?	Plan sponsors are not required to re-submit materials if there is a change in the phone number, hours of operation, or the date changing from 10/15 to 10/1.
10.	<b>New</b> - To satisfy the 48 hour advance SOA contact, is the actual time that the SOA is executed required to be captured and compared to the actual appointment time?	The time for the 48 hour requirement should be compared to when the initial appointment was scheduled.
11.	<b>New</b> - Does the employer group Customer Service Center have to adhere to the 8/8, 7 day hours?	No.



## Section 80 – Telephonic Activities and Scripts (Updated)

Number	Question	Response
12.	<b>New</b> - If our offices are located in the CST time zone and we operate in the State of Hawaii, do we need to operate on HI Time Zone of 8-8?	Yes, the call center should operate 8-8, 7 days a week according to the time zones for the regions in which they operate.
13.	<b>New</b> - Section 80.3 indicates Plan Sponsors may not Request beneficiary identification numbers (e.g. Social Security number).	Correct-Plan sponsors may not request beneficiary identification numbers except in instances where it is needed to verify membership, enrollment eligibility or an enrollment request.
14.	<b>New</b> - Section 80.1 - Call Center Requirements - Could you please clarify that live customer service representatives must be available on New Year Day? Thank you.	Unless otherwise directed by CMS, call centers are required to have customer service representatives available on New Year's Day.
15.	<b>New</b> - Please answer whether or not all disclaimers must be said during phone and face to face interactions. (Section 50 and 80)	Disclaimers are required (as applicable) on marketing materials, which include scripts. A face to face interaction is not a marketing material.
16.	<b>New</b> - Are the requirements for non-English speaking populations applicable for agent call centers?	Section 30.7 is applicable to plan sponsors' call centers.
17.	<b>New</b> - Section 80.4 indicates telephone enrollment scripts must be submitted in their entirety (bullets or talking points are not acceptable). Does this mean that CMS expects telephonic enrollment scripts to be read verbatim? If so, are there circumstances which CMS would allow for any deviation (i.e. saying can instead of cannot)? Please note, Section 80.5 CMS indicates that the Telephone Sales Scripts must be read verbatim.	CMS expects that CSR's use the scripts as they are submitted in HPMS.

## Section 90 – The Marketing Review Process

Number	Question	Response
1.	Does CMS plan on releasing any foreign language model documents for 2013?	Yes, this information will be released via HPMS.
2.	When will the Model documents for Enrollment Forms and Scope of Appointment be available?	Updated enrollment models will be released with the updated enrollment guidance. At this point, CMS does not intend to issue an updated scope of appointment form for 2013.
3.	Section 90.2.1, Page 68- Discusses submission of Non-English Materials or Alternative Formats- No Mention of 5% rule? Has this been retracted?	Please refer to Section 30.7 for additional guidance on requirements pertaining to Non-English speaking populations.
4.	How will plan sponsors determine which materials to submit under file & use vs. which materials to submit for a 45-day CMS review?	Please use the material code look-up in the marketing module of the HPMS. This tool indicates the submission status of each code.
5.	Section 90.8 (Template Materials) differentiates between "standard" and "static" templates, but does not advise plan sponsors whether the templates should be submitted under file & use or 45-day review. How should plans determine whether to submit a template under file & use or 45-day review?	Whether a marketing material piece is eligible for file and use is determined by the piece and its category code. Please refer to the Marketing Code Look-up Module for the review time frame.
6.	How should we format website material IDs before they are approved by CMS? The current guidelines do not have the same format as last year and just mention the words 'pending'.	Per section 90.2.2, Plan sponsors may make the website available for public use during the CMS review period; however, plan sponsors must include the status <i>pending</i> on their website until CMS has granted final approval/disapproval. For websites, plan sponsors should include the material ID followed by the word pending.
7.	MMG § 90.7 - Model Materials, lists "adding any applicable disclaimers" as an allowable alteration to CMS model materials. Does this mean that we are required to put applicable disclaimers on model documents (even if they are not included in the model), or does it simply mean that we have the option to add said disclaimers?	If a plan sponsor chooses to modify a model they must include any required disclaimers. Plans sponsors using the model without modification have the option to include applicable disclaimers on the material.

## Section 90 – The Marketing Review Process

Number	Question	Response
8.	Static templates - What is the significance of the reference to File & Use in the definition of static templates? Does CMS intend that static templates <i>cannot</i> be filed for 45 day review, and can only be filed under the File & Use provision?	Static templates may or may not be file & use. The ability of a material to be submitted file & use is dictated by the submission code in HPMS, not by whether something is a static template.
9.	If the plan has material that was approved for CY 2012 and that remains accurate for the 2013 plan year (and the plan wishes to continue to use the material in the marketplace) are we required to update the MMID line?	No.
10.	Static Template: "LIS Rider" was included under "variable data fields exempt from the template resubmission requirement". Do you mean the LIS Rider document is considered a static template?	Yes, the LIS Rider is considered a static template.
11.	The HPMS manual directs us to use the material codes for "Final Expedited Review." But there are not Final Expedited Review codes for every type of material – Most notably file & use advertising. For example, we have uploaded templates using 4002 (F&U Newspaper Ad) But the closest final description "4022 Final Exp Rev – Newspaper Ads with Benefits" which is 45 days for the initial approval, not file & use.	Advertising templates should not be submitted as standard templates since they may be submitted as File & Use.
12.	Section 90.7, Model Materials (page 76). Does this mean that plan is <i>*required*</i> to put applicable disclaimers on model documents (even if they are not included in the model)? Or does it simply mean that plan may <i>*choose*</i> to add said disclaimers?	Plans may choose to add any missing disclaimers.

## Section 100 – Plan Sponsor Websites and Social/Electronic Media (Updated)

Number	Question	Response
1.	Are Health and Wellness websites included in the guidance that live reviews online for websites are needed for the review process and screenshots will no longer meet CMS' expectations?	Health and wellness websites that do not mention benefits are not subject to review.
2.	We have had challenges with previous web page and social media submissions in that the URL submitted for approval must contain "www." in order for the CMS reviewer to view the page. However, many URLs do not contain the "www." prefix any longer, including a major social media site. When "www." is added to the URL for this social media site, it defaults the viewer away from our company web page on the site and to a user login page. Please let us know the proper procedure for submitting web pages that do not use "www." in their URL.	Plan sponsors should submit an active link to the website for review. The reviewer should be able to access the webpage if the URL does not have a prefix.
3.	What if that disapproved portion is a link from other pages - how does that work?	Work with your AM or Marketing Reviewer.
4.	What are the rules around building a social network site in which members talk to each other about the experiences with the plan?	CMS has no policy regarding the portions of social media sites in which customers are allowed to have discussions and share experiences.
5.	When something is disapproved on the website, is there a time limit to make the correction?	Work with your AM or Marketing Reviewer.
6.	Is it acceptable to announce an educational event for current members on Facebook since many current members are on Facebook?	It is acceptable to announce educational events for current members on Facebook as long as the content of the announcement has been submitted to CMS and approved/accepted.
7.	For online store websites should CMS be concerned about formulary data presented as tool finder to beneficiaries? Should a CMS pharmacist look at the website section on formulary area presented by plans?	Plan sponsors are responsible for ensuring the accuracy of formulary information presented on websites. This would include information presented on a plan sponsors' website or information presented on a site with which the sponsor contracts, (e.g., a FMO).



## 2013 Medicare Marketing Guidelines (MMG)

### Questions & Responses

November 2, 2012

## Section 100 – Plan Sponsor Websites and Social/Electronic Media (Updated)

Number	Question	Response
8.	<b>New</b> - Web sites are no longer required to be compliant with Section 508 of the Rehabilitation Act?	Incorrect. Websites are required to be 508 compliant (see Appendix 2 of the MMG).
9.	<b>New</b> - What if that disapproved portion is a link from other pages - how does that work?	Given that each situation is unique, please discuss any specific concerns with your Account Manager and/or Marketing Reviewer.
10.	<b>New</b> - May you go over social media usage...Facebook pages	Plan sponsors may have Facebook pages.
11.	<b>New</b> - What are the rules around building a social network site in which members talk to each other about the experiences with the plan?	Per Section 100, plan sponsors are allowed to use social/electronic media. These tools are still considered marketing materials and subject to the MMG.
12.	<b>New</b> - Can you please confirm that the new Summary of Benefits and Coverage documents added by Section 2715 of the PHS Act do not apply to MA plans?	Medicare health and drug plans are only required to produce the Summary of Benefits document that is generated from HPMS and referenced in Section 60.1 of the MMG.
13.	<b>New</b> - When something is disapproved on the website, is there a time limit to make the correction?	No. However, if any portion of a plan's website is disapproved, the disapproved portion must be removed from the website immediately.
14.	<b>New</b> - Is it acceptable to announce an educational event for current members on Facebook since many current members are on Facebook?	Plan sponsors may announce events through social media provided any marketing guidance for advertising the event is followed.

## Section 120 – Agent/Broker Compensation (Updated)

Number	Question	Response
1.	Beneficiary notifications when Unqualified vs. Unlicensed agents submit applications: Is this notification only required when the agent is unlicensed or should the beneficiary also be notified when the agent hasn't completed the entire certification process?	Beneficiaries must be notified when an unqualified agent/broker has enrolled them in a plan. Unqualified agents/brokers include agents/brokers who are unlicensed or have not completed the certification process.
2.	Do we need to submit the agent/broker attestation?	The agent/broker attestation is part of the annual plan agent/broker compensation amount submission process in HPMS.
3.	Regarding compensation, what are the guidelines for paying FMO's/TMO's. There seems to be some confusion on when, how, and how much over ride to pay the FMO's/TMO's	TMOs typically receive two types of compensation: 1) compensation for enrollment and 2) compensation for other services. TMO compensation for enrollment must follow the compensation rules for independent agents. TMO compensation for other services must be consistent with local market rates for those services.
4.	Do the agents that draw base salaries are considered employed agents are do not fall into CMS guidance?	Agents who receive a fixed amount and sell exclusively for one plan are exempt from the independent agent compensation rules (like employed agents).
5.	Under the agent/broker compensation module, if you employ agents and contract with external agents and brokers; the corresponding amounts you submit must apply to both or include amounts which apply only to external agents/brokers.	When submitting agent/broker compensation information in HPMS, the High/Low amounts entered only apply to independent agents/brokers.
6.	Beneficiaries that enroll in dual plans, their agents may get compensation for both the plans. Can it exceed the FMV approved by CMS since it's the addition of the two plans?	Compensation paid to agents for enrolling beneficiaries in dual plans (e.g., a cost plan and a separate PDP), cannot exceed the FMV amount respectively for each plan.





## 2013 Medicare Marketing Guidelines (MMG)

### Questions & Responses

November 2, 2012

#### Section 120 – Agent/Broker Compensation (Updated)

Number	Question	Response
7.	This may be an enrollment question, but we discussed 120.2, terminated agents. Do beneficiaries have until the date of notification plus 2 months to make a decision to remain in a plan or change?	Plans should refer to the enrollment guidance in Chapter 2 of the MMCM and Chapter 3 of the PDM regarding beneficiary cancellation timeframes.
8.	<b>New</b> - When will 120.3 Annual Up-dates be available?	This information was released via HPMS on August 21, 2012.
9.	<b>New</b> - Has the 2013 agent compensation been released? If so, where is it? If not, when will it be released? Thanks	Compensation rates for CY 2013 were released via HPMS on May 3, 2012.
10.	<b>New</b> - What SEP code should be used if an agent is terminated and the member wishes to make a change.	This situation would be considered an exceptional circumstance SEP.
11.	<b>New</b> - Are plans allowed to collect leads through, for example SEP marketing activities, prior to the AEP, for future contact during the AEP?	Plans should use the guiding principles when determining whether beneficiary contact is appropriate. Note that Section 70.6 states permission to be contacted is considered to be event-specific and may not be treated as open-ended permission for future contact.
12.	<b>New</b> - Regarding agent charge backs: it seems that the guidelines are based on a CY basis. For those of us with only a D-SNP plan (and enroll using SEP), can we pay renewals and charge back on a constant rolling year?	No, agent/broker compensation can only be paid on a calendar year basis, never a rolling year.
13.	<b>New</b> - If an agent is termed for fraud (i.e. forging signature on an enrollment form) does CMS need to be notified?	Plans should notify the appropriate State Authority when an agent is terminated.



## Section 160 – Allowable Use of Medicare Beneficiary Information Obtained from CMS

Number	Question	Response
1.	Can members opt-in via an online form (on plan website or member portal) or are we required to obtain a paper form from member stating they would like to opt-in.	Electronic confirmation is appropriate.

### Appendix 1 – Definitions

Number	Question	Response
1.	Does a member retention letter (urging the member to continue enrollment with the plan) qualify as an Ad Hoc Enrollee Communication?	Ad hoc materials are customized or limited to a subset of enrollees. If a material is being sent to the entire membership, it will not qualify as ad hoc enrollee communication.

### Appendix 2 – Related Laws and Regulations

Number	Question	Response
1.	Are websites required to be 508-compliant? It was not included in the guidelines this year.	Per Appendix 2, all plan sponsors are required to have an Internet website that is compliant with web-based technology and information standards for people with disabilities as specified in section 508 of the Rehabilitation Act.

### Appendix 4 – Multi-Language Insert

Number	Question	Response
1.	In Appendix 4 (the Multi Language Insert) it looks like there was a technical issue with the translations for Arabic and Hindi-- nothing appears on the sheet. Is CMS going to make another, complete version available for health plans to utilize?	The CMS Marketing Web page contains the Multi-language insert in the zip file announcing the release of the MMG. Please click on the link titled 2013 Medicare Marketing Guidelines from the following web page to view the information: <a href="http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.html?redirect=/ManagedCareMarketing">http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.html?redirect=/ManagedCareMarketing</a> .



**2013 Medicare Marketing Guidelines (MMG)**  
**Questions & Responses**  
 November 2, 2012

**General Marketing Questions (Updated)**

Number	Question	Response
1.	Do the 2013 Marketing Guidelines apply to marketing materials that will be used during the AEP season starting this October since they will apply to plans offered in CY 2013 or do we use the 2012 Marketing Guidelines through the end of the year?	The recently released MMG are applicable for CY 2013 materials used during the AEP.
2.	Will a red lined version of to the Medicare Marketing Guidelines be available to plans?	CMS has significantly revised the Medicare Marketing Guidelines in almost every section; therefore a redlined version will not be released.
3.	Will the Medicare Marketing Guideline Training be recorded and when will the recording be available?	The webinar was recorded and is available anytime by clicking on the following link: <a href="http://www.visualwebcaster.com/CMS/87543/event.html">http://www.visualwebcaster.com/CMS/87543/event.html</a> .
4.	We have multiple customer service phone numbers for our various Medicare plans. We typically create materials such as our formulary, pharmacy directories, and letters to target multiple plans. Model documents generally include references to one Customer Service phone number (and TTY) throughout the material. For plans with multiple phone numbers would it be OK to list all phone numbers once and then refer the beneficiary back to that page at each reference in the document thereafter? Or even better, could we insert a contact page in the document and refer the beneficiary to that page?	Plan sponsors with multiple customer service numbers should submit these documents in HPMS as static templates with a placeholder for the customer service number. See Section 90.8.2 of the MMG for more information on static templates.



**2013 Medicare Marketing Guidelines (MMG)**  
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 November 2, 2012

### General Marketing Questions (Updated)

Number	Question	Response
5.	We note that the draft Medicare Marketing Guidelines eliminated the distinction between general advertising and explanatory marketing materials; and that change has carried through to the final Medicare Marketing Guidelines released on June 7, 2012. We have also noted that the new guidelines have dispensed with the list of File & Use eligible materials, and instead refer to the Material Code LookUp function in HPMS to determine what materials may be submitted File & Use. With the elimination of explanatory marketing materials as a category, we interpret that the impact of this change is to classify all advertising material as eligible for File & Use submission, with the exception of: 4006 – Internet Web Pages 4011 – Scope of Sales Appointment Confirmation Form (if non-model) all Final Expedited Review codes. Is this a correct interpretation?	CMS no longer makes the distinction between general advertising and explanatory marketing materials. Instead, CMS requires materials that contain benefit information to include the disclaimers in §50.2.
6.	What does OMB mean?	OMB is the acronym for the White House Office of Management and Budget.
7.	When ad-hoc enrollee code is removed, what marketing codes should plans use to submit plan created material that would require a 45 day review because it contains benefit information?	Advertising materials that include benefit information are required to contain the disclaimers in Section 50.2 and can be submitted using File & Use.
8.	Does the NCDs uploaded through the plan sponsor website, needs to be reviewed by CMS?	No.
9.	If stuff was cut from MMG but is not replaced by information that contradicts it--in other words if it is just cut, does that mean the rules cut no longer apply?	In the 2013 MMG update, CMS removed a lot of the prescriptive language found in previous versions of the MMG. This does not mean in every instance that those rules no longer apply. What it does mean is that when organizations develop their marketing strategies and activities, they should use the guiding principles (MMG, section 10) along with the requirements contained in the other MMG sections to determine the best approach.



**2013 Medicare Marketing Guidelines (MMG)**  
**Questions & Responses**  
 November 2, 2012

### General Marketing Questions (Updated)

Number	Question	Response
10.	Why was the decision made to make the guidelines public prior to the training or an HPMS memo?	That has been our process for quite some time. The MMG was loaded onto our website before the release of the HPMS memo to ensure that the most recent MMG were available when they were announced. Additionally, it is important for individuals to have an opportunity to review the MMG prior to the training so that they can ask questions accordingly.
11.	Is the marketing mailbox going to be available and will the slides presented today be distributed?	The marketing mailbox is still available. It is available to both the ROs and plan sponsors. This presentation materials are available on the following site: <a href="http://www.cmsdrughealthplanevents.org/cms/">http://www.cmsdrughealthplanevents.org/cms/</a> .
12.	Do we have a word version of the MMG for internal use so cut/paste activities for cheat sheets would be available?	There is not a word version that is available.
13.	How can we tell if a document is standardized or not? Is there a list somewhere?	At the present time, the Summary of Benefits, ANOC/EOC, Plan Star Ratings document, and Multi-Language Insert are standardized documents.
14.	<b>New</b> - Are appeals and grievances procedures still required to be in presale materials?	No.
15.	<b>New</b> - How do these MMG's affect or impact the "Dual Eligibles" Medi/Medi clients in CA?	The MMG are applicable to all health and drug plan sponsors, including Dual Eligible Special Needs Plans.
16.	<b>New</b> - If we have a pending contract, when will we be able to submit documents?	Plans can submit materials for a pending contract as soon as the contract is available in HPMS. These materials will be conditionally approved until the contract approval is final.
17.	<b>New</b> - Will you be discussing changes to EOBs at all or will there be another training session to discuss those specifically?	At this time, CMS does not have plans to hold training specific for the EOB.



**2013 Medicare Marketing Guidelines (MMG)**  
**Questions & Responses**  
 November 2, 2012

## General Marketing Questions (Updated)

Number	Question	Response
18.	<b>New</b> - What do you do if you come across referenced sections that have been removed? Example 80.1.3	The reference to 80.1.3 should read 80.3 in the MMG.
19.	<b>New</b> - Will templates be provided for Financial Alignment Demonstration plans?	Models for certain documents will be released for the FAD plans, now known as MMP (Medicare/Medicaid Plans).
20.	<b>New</b> - On the sales event reporting template, is there a difference between the newly added representative name field and the event contact field?	The representative field should be the agent's name which may or may not be the same individual as the event contact.
21.	<b>New</b> - Will you be discussing the changes to the Federal Contracting number?	Requirements for the Federal Contracting Number are located in Section 50.1 of the MMG.
22.	<p><b>New</b> - At a minimum, plan sponsors must develop scripts that respond to inquiries from prospective and current enrollees about certain subjects. Please clarify the scope of the following item, is it no longer limited to Part D?</p> <p><b>Old verbiage:</b> How to access the Part D grievance, coverage determination (including exceptions) and appeals process*</p> <p><b>New verbiage:</b> Grievance, coverage determination (including exceptions) and appeals process</p>	Plans should be prepared to respond to inquiries on grievance, coverage determinations, and appeals for all plan benefits; this includes health and drug benefits.
23.	<b>New</b> - How long are plans allowed to contact beneficiaries who have responded to Business Reply Cards (BRCs)? The 2012 MMGs stated that permission given by a beneficiary to be called or otherwise contacted (BRCs) is to be considered short-term, event-specific, and may not be treated as open-ended permission for future contacts. This language is not contained in the 2013 MMGs.	CMS does not define a specified timeframe for BRC contact. Plans should use the guiding principles when determining an appropriate amount of time to honor a BRC. Note that Section 70.6 states permission to be contacted is considered to be event-specific and may not be treated as open-ended permission for future contact.





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**General Marketing Questions (Updated)**

Number	Question	Response
24.	<b>New</b> - Are claim EOBs/notices of denial of payment considered marketing materials?	OMB forms are not subject to review per section 20 of the MMG. An EOB for drugs or health claims is considered a marketing material.
25.	<b>New</b> - The EOB appendices were not received with the 2013 model. Will 2013 appendices be issued or are plans to use the 2012 versions.	We plan to update the 2012 exhibits in the near future, but we do not anticipate significant changes. The models will be posted on the Part D Model Marketing Materials webpage at: <a href="http://www.cms.gov/Medicare/Prescription-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html">http://www.cms.gov/Medicare/Prescription-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html</a> .
26.	<b>New</b> - What is the Rewards Incentives.pdf? Does the information there supplement what is in the Medicare Marketing Guidelines? If so, does this limit the number of activities that can be incentivized?	The PDF in Section 70.3, Rewards and Incentives, provides resources for the most current listing of Medicare covered preventive services with a zero dollar cost-share. Plan sponsors may only provide rewards and incentives for Medicare covered preventive services with a zero dollar cost-share.
27.	<b>New</b> - When will the Enrollment Form Guide be available?	Any updates to the enrollment form will be released with the MA and PDP Enrollment/Disenrollment Guidance. CMS issued updated versions of Enrollment and Disenrollment Guidance on Aug 7, 2012.
28.	<b>New</b> - When will CMS release the Financial Demo Evidence of Coverage Model document?	Questions on the FAD/MMP should be sent to the <a href="mailto:mmcocapsmodel@cms.hhs.gov">mmcocapsmodel@cms.hhs.gov</a> mailbox.
29.	<b>New</b> - What member materials qualify for file and use opposed to 45 day review? If there is no model available?	Plans should use the material code look-up function in HPMS to determine whether a material is eligible for file & use.



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## HPMS (Updated)

Number	Question	Response
1.	When will CMS release an update to the HPMS Marketing Module to align with the new 2013 MMG (e.g., providing SB codes that qualify for File & Use submission)? When a new Marketing Module is released, will CMS notify the industry, e.g., via HPMS Memo or some other means?	<i>As listed in the Call Letter calendar, marketing materials for CY 2013 will be accepted after June 30, 2012. Therefore, on July 1, 2012, the updated codes for 2013 materials will be available. CMS does not intend to issue further guidance on this subject.</i>
2.	In HPMS, plans are required to include an organization marketing name. We have two contracts: one includes individual HMO and HMO SNP plans, as well as EGWP HMO plans; and H2411, the other includes only EGWP PPO plans. To address the fact that we have different types of HMO plans under one contract, we have entered "Fallon Senior Plan or NaviCare" as our organization marketing name. (For H2411, we have entered "Fallon Senior Plan" as our org. marketing name.) Our HMO and PPO plan names under these contracts all start with "Fallon Senior Plan" (e.g. H9001: PBP 021 Fallon Senior Plan Saver Enhanced Rx HMO, PBP 803 Fallon Senior Plan Premier HMO, and PBP 001 Fallon Senior Plan Standard HMO; H2411: PBP 803 Fallon Senior Plan Premier PPO), and our HMO SNP plan is called "NaviCare HMO SNP." We would like clarification that when marketing our family of Fallon Senior Plan plans, we are allowed to market and refer to them as "Fallon Senior Plan."	You may market your family of plans as "Fallon Senior Plan," as long as you make the distinctions when highlighting plan features.
3.	HPMS does not have an expedited rev code for final populated templates and corresponding alternate format of final populated. How should plans document these?	Codes with corresponding "final expedited review" codes are the only ones that qualify for standard template submission. Static templates should be submitted under the code that best represents the content of the material; there is no submission code specific for static templates. Plan sponsors should consult with their marketing reviewers and/or account managers when having difficulty identifying appropriate submission codes.



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## HPMS (Updated)

Number	Question	Response
4.	Ad-Hoc materials no longer require review. Will the HPMS code for ad-hoc be retired?	Yes.
5.	Will someone provide updates to Humana when codes are added and/or retired in HPMS?	CMS is currently working on a way to notify plan sponsors of category and code changes in HPMS. For now, if new categories or codes are created, CMS will provide notice through HPMS.
6.	What types of materials are to be submitted under code 1127?	1127 is the Combined ANOC/EOC code.
7.	While you are updating the HPMS submission codes, are you also going to update the type of submission flags? Some codes have a 45 day review flag but under file and use" have a status of "yes".	The 45-day review flag means that if File & Use is not selected, the material will receive a 45-day review.
8.	Where in HPMS is the report showing the File & Use 10%?	In the "Reports" tab within the Marketing Module.
9.	What is the national producer number for agents?	The National Producer Number (NPN) is assigned when an agent has registered in the National Insurance Producer Registry (NIPR).
10.	The new MMG chapter removed the guidance around the way you submit explanatory vs. non-explanatory materials, and has not added any information on how to submit prospect vs. member materials. The HPMS Marketing Module and coding does not address this change. As an example, could you please advise us on how to go about submitting the following document: a plan sponsor creates a direct mail (standard) template that contains premium information in a variable text field? Under the current marketing ID codes, the plan sponsor would assign code 4001" to the master template. If the plan sponsor has file & use privileges should the plan sponsor request that the standard template with premium information be reviewed manually?	The plan sponsor should not submit advertisements as templates. Advertisements may be submitted as static templates, but benefit information like premiums and cost-sharing must be displayed. When including benefit information, the plan sponsor must include the required disclaimers.



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## HPMS (Updated)

Number	Question	Response
11.	How do we retire old material in HPMS or is it necessary to do so?	Plan sponsors should indicate in HPMS, "No longer in use."
12.	What is the difference between the Accepted and Approved designation for the tracking ID?	Approved indicates that a material has been prospectively reviewed and approved by CMS. Accepted indicates that a material has been accepted using File & Use and may be retrospectively reviewed by CMS.
13.	When can we upload materials for CMS review for new contracts that are not yet showing in HPMS?	Plans that are in a pending status may upload documents in HPMS.
14.	What does MCE stand for?	Multi-Contract Entity. It is used to group contract numbers together in the HPMS Marketing Module.
15.	Regarding 10% Report Drill Functionality in HPMS - do plans have access to this report? If no, can the AM share the report with their plan?	Yes. Please refer to the report titled File and Use 10% Manual Review in the marketing module of HPMS.
16.	<b>New</b> - Module 1: "Must have complete information to make informed decisions" will be helpful to members but will likely put plans in conflict with the 10% F&U threshold as including benefit information into material such as direct mail/advertising qualifies them as a 45-day review. Can CMS elaborate on any upcoming HPMS Category changes?	HPMS category changes can occur at any time. Plan sponsors should continue to scrutinize the codes in HPMS to ensure materials are submitted under the appropriate codes. All advertising, except websites, are file and use, regardless of any benefit information included.
17.	<b>New</b> - What types of materials are to be submitted under code 1127?	1127 is the Combined ANOC/EOC code.



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## HPMS (Updated)

Number	Question	Response
18.	<b>New</b> - When looking at the HPMS Report for File & Use 10% Manual Review Report the parameters that can be selected are either the contract year or received date range or both. In the past, we have looked at our percentage on a monthly basis to ensure the number of file and use versus the number of 45-day review documents are both meeting the requirements. However, the reporting capability indicates that this percentage may be looked at on a rolling annual basis. After reviewing the new requirements in Chapter 3 Section 90.6.1, this section does not indicate a time frame for monitoring the 10% requirement. What we are questioning is can we monitor this requirement on a rolling year basis? Any guidance you can provide would be helpful.	From a monitoring perspective, CMS reviews the data from this report both monthly and cumulatively based on contract year material submissions.
19.	<b>New</b> - While you are updating the HPMS submission codes, are you also going to update the type of submission flags? Some codes have a 45 day review flag but under file and use" have a status of "yes".	Yes. CMS is continually looking at codes to ensure they are coded in the system appropriately.
20.	<b>New</b> - Where in HPMS is the report shows the File & Use 10%?	In the "Reports" tab within the Marketing Module.
21.	<b>New</b> - What is required for the "National Producer Number" in HPMS when submitting a marketing/sales event? Our producers don't have a national number. Should I input the state license number?	The intent is to have the National Insurance Producer Registry's (NIPR) National Producer Number (NPN) placed in the field. If the producer does not have a NPN, plan sponsors may enter the state license number or NA.
22.	<b>New</b> - Does the event type still need to be included in the event name?	Plans should include one of the following terms, as appropriate, in the event name field: "informal", "formal", or "educational".
23.	<b>New</b> - Is the Representative the plan's staff member?	The term representative includes anyone who is representing the plan, not just a staff member.
24.	<b>New</b> - Can you view in HPMS seminar events submitted under the required 7-day timeframe?	Plans can see their events in HPMS, including when they submitted it and the event date.



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## HPMS (Updated)

Number	Question	Response
25.	<b>New</b> - The new MMG chapter removed the guidance around the way you submit explanatory vs. non-explanatory materials, and has not added any information on how to submit prospect vs. member materials. The HPMS Marketing Module and coding does not address this change. As an example, could you please advise us on how to go about submitting the following document: a plan sponsor creates a direct mail (standard) template that contains premium information in a variable text field? Under the current marketing ID codes, the plan sponsor would assign code 4001" to the master template. If the plan sponsor has file & use privileges should the plan sponsor request that the standard template with premium information be reviewed manually?	In the example provided, the plan may submit the direct mail standard template under code 4001 as file and use. The direct mail populated templates would be uploaded under code 4021.
26.	<b>New</b> - Is it possible to enter multiple national producer numbers for a single event in HPMS?	No.
27.	<b>New</b> - How do we retire old material in HPMS or is it necessary to do so?	Plans may indicate a material is no longer in use by using the Update Material functionality in HPMS. Please refer to the User Guide for additional instructions.
28.	<b>New</b> - Will CMS create a star rating model document to be translated into other formats vs. providing a PDF download on the HPMS web site that cannot be modified?	At this time, CMS does not have plans to translate the star ratings document.
29.	<b>New</b> - What do we use for status at the end of the material ID code for file and use items?	Per Section 40.1, plans should use the term "accepted" for file & use materials.
30.	<b>New</b> - Is it possible to provide more information on HPMS memos to show whether the memo has an action item or just informational in its purpose?	CMS will consider this request.





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Number	Question	Response
31.	<b>New</b> - What is the difference between the Accepted and Approved designation for the tracking ID?	Materials submitted under the file & use process should contain the "accepted" status. Materials submitted for CMS review should contain the "approved" status.
32.	<b>New</b> - When can we upload materials for CMS review for new contracts that are not yet showing in HPMS?	Plans must wait for a contract to show in HPMS prior to submitting a material in HPMS for that contract.