

Marketing Guidance for California Medicare-Medicaid Plans

Contract Year (CY) 2022

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Introduction

The Centers for Medicare & Medicaid Services (CMS) recently codified guidance contained in the Medicare Communications and Marketing Guidelines by integrating it with existing regulations.¹ Although the codified marketing and communications policies are not new policies, we updated this document to accurately reference the new regulations and follow the section numbers and headings used in the regulations. All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in 42 CFR Parts 422 and 423 apply to Medicare-Medicaid Plans (MMPs) participating in the California capitated financial alignment model demonstration, except as clarified or modified in this document.²

As defined in 42 CFR 422.2260 and 423.2260 prior to the implementation of CMS-4182-F,³ CMS continues to consider all Contract Year (CY) 2022 MMP materials to be marketing materials, including those that promote the organization or any MMP offered by the organization; inform beneficiaries that they may enroll or remain enrolled in an MMP offered by the organization; explain the benefits of enrollment in an MMP, or rules that apply to enrollees; and/or explain how services are covered under an MMP, including conditions that apply to such coverage.

This document provides information only about those sections or subsections of the regulations that are not applicable or that are different for MMPs in California. Information in this document is applicable to all marketing done for CY 2022 benefits.

Additional Guidance for California MMPs

The following are additional California MMP-specific modifications for CY 2022 beyond those included in the new regulations:

Formulary and formulary change notice requirements

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

¹ Refer to CMS-4190-F2, Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, which may be found in the Final Rule published on January 19, 2021 (www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicaid-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare).

² Note that any requirements for Special Needs Plans (SNPs), Private Fee-for-Service (PFFS) plans, Preferred Provider Organizations (PPOs), and Section 1876 Cost-Based Plans (cost plans) do not apply unless specifically noted in this guidance.

³ Refer to CMS-4182-F, Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program, which may be found in the Final Rule published April 16, 2018 (www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare, p. 16625).

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

- Formulary change notices must be sent for any negative formulary change (as described in Chapter 6 of the Prescription Drug Benefit Manual), regardless of whether or not the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan.
- Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on California MMP websites.

Informational and enrollment calls and scripts

We clarify that MMP customer service representatives may conduct activities that do not require the use of state-licensed marketing representatives.

We also clarify that informational calls to plan call centers that become enrollment calls at the proactive request of the beneficiary must be transferred to the state's enrollment broker or utilize the streamlined enrollment process, except in the case of MMPs in the County Organized Health Systems (COHS) counties. Plan customer service staff may not remain on the line once the call has been transferred to the state's enrollment broker.

Additionally, we clarify that, to provide more than factual information, MMP outbound callers must be state-licensed (and, when required, appointed) marketing agents.

We further clarify that telesales and enrollment scripts are considered marketing, and MMPs must submit them in the Health Plan Management System (HPMS) Marketing Review Module. When developing enrollment scripts, MMPs should refer to the Cal MediConnect enrollment forms located by county on the Medi-Cal Managed Care Health Care Options webpage at www.healthcareoptions.dhcs.ca.gov/download-forms.

Marketing MMP and non-MMP offerings

We clarify that organizations offering both MMPs and non-MMP Medicare health plan options in a service area may only market MMP offerings in their MMP materials.

Use of Medicare Mark for Part D sponsors

We clarify that MMPs have been required to sign a licensing agreement to use the official Medicare Mark as part of the three-way contract rather than through the HPMS Contract Management Module.

Disclosure Requirements, Provision of Specific Information, Call Centers

422.111, 422.111(h)

We clarify that hold time messages that include marketing content must be submitted in the HPMS Marketing Review Module.

Additionally, we clarify that MMPs must operate a toll-free call center during usual business hours. In light of the scope and nature of the services and benefits provided by MMPs, CMS interprets usual business hours for customer service call centers for both current and

prospective enrollees as meaning the following: seven (7) days a week, at least from 8 a.m. to 8 p.m. PT, except as provided below. Customer service call center hours and days must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. MMPs may use alternative technologies on Saturdays, Sundays, and state and/or all federal holidays except New Year's Day, in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide required information, and/or allow a beneficiary to leave a message in a voice mail box. A customer service representative must then return the call in a timely manner, no more than one (1) business day later. We also clarify that the remainder of 422.111(h) applies to MMPs.

Reward and Incentive Programs

422.134

We clarify that MMPs may market rewards and incentives to current enrollees, consistent with the regulation.

Definitions

422.2260, 423.2260

MMPs are generally subject to marketing and beneficiary communications applicable to Medicare Advantage plans in 42 CFR Parts 422 and 423, as well as those applicable to Medicaid managed care organizations in 42 CFR Part 438. We clarify that the definitions of communications and marketing as described in these sections of the regulations are not applicable to MMPs. CMS continues to consider all CY 2022 MMP materials to be marketing materials as stated in the "Introduction" in this document. For any other references to communications throughout 42 CFR Parts 422 and 423, the definition of marketing materials applies, and we provide additional details about materials in Appendix A and Appendix B of this document.

Submission, Review, and Distribution of Materials

422.2261, 423.2261

General requirements

422.2261(a), 423.2261(a)

CMS developed a Joint Review Process (JRP) for MMP materials under each Financial Alignment Initiative capitated model demonstration that combines state and CMS review requirements and parameters. Any references herein to CMS in its role in reviewing marketing materials are also references to the state for purposes of MMP marketing material review.

We also clarify that the multi-plan submission process is intended for third parties that submit materials for multiple organizations and is not applicable to MMPs.

CMS review of marketing materials and election forms

422.2261(b), 423.2261(b)

We clarify that, for purposes of MMP materials, there is no “deeming” of materials requiring either a dual review by CMS and the state or a one-sided state review, and materials remain in a “pending” status until the state and CMS reviewer dispositions match. Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MMPs may obtain more information about the specific review parameters and timeframes for marketing materials in the HPMS Marketing Review Module and User Guide.

We clarify that the File and Use certification process for MMPs is included in the three-way contract.

General Communications Materials and Activities Requirements

422.2262, 423.2262

We clarify that an MMP is a “comparable plan as determined by the Secretary” as described in 422.2262(a) and is available only to, designed for, and marketed to beneficiaries who are dually eligible for Medicare and Medicaid.

As is the case for other Medicare health plans, MMPs are required to include the plan type in each plan’s name using standard terminology consistent with the guidance provided in this section. CMS created the standardized plan type label “Medicare-Medicaid Plan” to refer generically to all plans participating in a capitated financial alignment model demonstration. MMPs must use the “Medicare-Medicaid Plan” plan type terminology following their plan name at least once on the front page or beginning of each marketing piece, excluding envelopes.

MMPs may also use state-specific plan type terminology in their marketing materials (e.g., a plan can state that Medicare-Medicaid Plans are also known as Cal MediConnect Plans in California), provided they comply with the guidance regarding use of the CMS standardized plan type.

We also clarify that MMPs in California that offer Medicare Advantage products, including SNPs, in the same service area as their MMPs, may use the same plan marketing name for both of those products. However, to reduce beneficiary confusion, MMPs must include “Cal MediConnect Plan” in the plan marketing name.

Requirements when including certain telephone numbers in materials

422.2262(c), 423.2262(c)

In addition to the requirements of this section, MMPs in the five counties with the enrollment broker must also provide the phone and TTY numbers and days and hours of operation information for the state’s enrollment broker in marketing materials that are provided prior to the time of enrollment and where a customer service number is provided for current and prospective enrollees to call. In the COHS counties, the MMP must provide the phone and TTY numbers and days and hours of operation information for the MMP customer service line for current and prospective enrollees.

Standardized material identification (SMID)

422.2262(d), 423.2262(d)

The provisions in these subsections of the regulations are modified as follows for MMPs:

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

We clarify that multi-plan materials are not applicable to MMPs.

In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization for materials the third party provides to MMP enrollees. The material must be submitted in HPMS using a separate material ID for the MMP, and that material ID must be included on the material. Non-English and alternate format materials based on previously created materials may have the same material ID as the material on which they are based.

General Marketing Requirements

422.2263, 423.2263

We clarify that the AEP is the Medicare Annual Enrollment Period, also known as the Annual Election Period, which runs from October 15 to December 7 each year.

Star Ratings

422.2263(c), 423.2263(c)

Because the Medicare-Medicaid Coordination Office (MMCO) is in the process of developing a Star Ratings system for MMP performance, MMPs are not subject to the Star Ratings requirements in these subsections of the regulations. Therefore, we clarify the provisions in these subsections do not apply to MMPs.

Beneficiary Contact

422.2264, 423.2264

Unsolicited contact

422.2264(a), 423.2264(a)

We clarify that California MMPs must include a disclaimer regarding messaging rates in electronic communications.

These subsections of the regulations provide examples of unsolicited direct contact with current and prospective enrollees. We reiterate that marketing via conventional mail and other print media (e.g., advertisements, direct mail) is not considered unsolicited contact and, therefore, is permissible.

In addition to the provisions of these subsections of the regulations, MMPs conducting permitted unsolicited marketing activities, such as through conventional mail and other print media, are required to include the following disclaimer on all materials used for that purpose:

“For information on <plan name> and other Cal MediConnect options for your health care, call the Department of Health Care Services at 1-800-430-4263 (TTY: 1-800-735-2922) or visit www.healthcareoptions.dhcs.ca.gov/.”

For purposes of these subsections of the regulations, enrollment materials sent to passively enrolled individuals are not considered marketing through unsolicited contact.

Contact for plan business

422.2264(b), 423.2264(b)

The requirements of these subsections of the regulations apply with the following clarifications and modifications:

- Calls made by MMPs to current members (including those enrolled in other product lines) are not considered unsolicited direct contact and, therefore, are permissible. Organizations that offer non-MMP and MMP products may call their current non-MMP enrollees (e.g., those in Medi-Cal managed care products), including individuals who have previously opted out of passive enrollment into an MMP, to promote their MMP offerings.
- Plans may use reasonable efforts to contact current non-MMP enrollees who are eligible for MMP enrollment to provide information about their MMP products. Callers with questions about other Medicare program options should be warm transferred to 1-800-MEDICARE or to the Health Insurance Counseling and Advocacy Program (HICAP) for information and assistance.

Events with beneficiaries

422.2264(c), 423.2264(c)

Educational events

422.2264(c)(1), 423.2264(c)(1)

We clarify that, as provided under the three-way contract, the state may request that California MMPs provide current schedules of all educational events conducted for current or prospective enrollees.

Personal marketing appointments

422.2264(c)(3), 423.2264(c)(3)

The provisions of these subsections of the regulations apply to MMPs, with the following modifications:

- MMP-employed sales agents are not permitted to conduct unsolicited personal/individual appointments.
- An individual appointment must only be set up at the request of the member or their authorized representative. An MMP can offer an individual appointment to a member who has contacted the MMP to request assistance

or information. However, MMPs are prohibited from making unsolicited offers of individual appointments.

- An MMP must make reasonable efforts to conduct an appointment in the member's preferred location. An MMP cannot require that an individual appointment occur in a member's home.

In addition, if enrollment applications are distributed during the course of a personal/individual marketing appointment or phone conversation, any and all associated cover pages must remain attached to the application. If plan customer service staff assist potential enrollees in filling out enrollment applications, the staff must direct the potential enrollee to first read any and all associated cover pages attached to the application. If contact is made by phone, staff must offer to read all pages aloud to the enrollee. Plan customer service staff who assist in completing an application must document their name on the application. Applications will then be forwarded to Health Care Options (HCO) to complete the enrollment process.

Websites

422.2265, 423.2265

General website requirements

422.2265(a), 423.2265(a)

We clarify that MMPs should consult the HPMS Marketing Review Module and User Guide for instructions about submitting websites and webpages for review.

Required content

422.2265(b), 423.2265(b)

In addition to the provisions in these subsections of the regulations, MMPs (except those in COHS counties) must also include a direct link to the state's enrollment broker website on their website. MMPs must also include information on the potential for contract termination (i.e., a statement that the MMP may terminate or non-renew its contract, or reduce its service area, and the effect any of those actions may have on MMP enrollees, as required under 42 CFR 422.111(f)(4)), and information that materials are published in alternate formats (e.g., large print, braille, audio).

We clarify that MMPs are not required to post the low-income subsidy (LIS) Premium Summary Chart as this document is not applicable to MMPs.

Required posted materials

422.2265(c), 423.2265(c)

The provisions of these subsections of the regulations apply with a modification. As indicated in 422.2263(c) and 423.2263(c) in the "Star Ratings" subsection of this document, MMPs are not subject to Star Ratings requirements and, therefore, are not required to post a CMS Star Ratings document on their websites.

Activities with Healthcare Providers or in the Healthcare Setting

422.2266, 423.2266

Provider-initiated activities

422.2266(c), 423.2266(c)

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

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

Required Materials and Content

422.2267, 423.2267

We clarify that, unless otherwise modified and/or specifically indicated in this section of the document, these sections of the regulations and all of their subsections apply to MMPs.

Standards for required materials and content

422.2267(a)(2), 423.2267(a)(2)

The provisions of these subsections of the regulations apply with the modifications and clarifications included in this section. The standard articulated in this section for translation of marketing materials into non-English languages will be superseded to the extent that California’s standard for translation of marketing materials is more stringent. The Medi-Cal California translation standard is typically equivalent to or more stringent than the Medicare standard for translation for all California MMP service areas. Refer to www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-004.pdf for the Medi-Cal translation standards updated on April 8, 2021. Guidance regarding the translation requirements for all plans, including California MMPs, is released annually each fall via HPMS. The required languages for translation for each MMP are also updated annually, as needed, in the HPMS Marketing Review Module. We expect the California standards for translation of required materials will continue to be the most stringent standard.

CMS and the state have designated materials that are vital and, therefore, must be translated into specified non-English languages.⁴ This information is located in Appendix A of this document.

⁴ CMS makes available Spanish translations of the California MMP SB, Formulary (List of Covered Drugs), Provider and Pharmacy Directory, and ANOC/EOC (Member Handbook). These are posted at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources. CMS makes available a Spanish and Chinese translation of the Part D transition letter to all Medicare health plans at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials.

MMPs must have a process for ensuring that enrollees can make a standing request to receive materials identified in this section, in alternate formats and in all non-English languages identified above and in the HPMS Marketing Review Module, at the time of request and on an ongoing basis thereafter. The process should include how the MMP will keep a record of the member's information and utilize it as an ongoing standing request so the member does not need to make a separate request for each material and how a member can change a standing request for preferred language and/or format.

Model materials

422.2267(c), 423.2267(c)

We modify these subsections of the regulations, in addition to 42 CFR Parts 417 and 438, with the following guidance about model materials.

We note that materials MMPs create should take into account the average reading level established in the three-way contract. Available models reflect acceptable average reading levels. Current Part D models are acceptable for use as currently provided, and MMPs must add required disclaimers included in Appendix B of this document, as appropriate. Adding required MMP disclaimers to Part D models does not render the documents non-model when submitted for review or accepted as File and Use materials.

We refer MMPs to the following available models:

- MMP-specific models tailored to MMPs in California, including model enrollment and disenrollment forms for those California MMPs in the two COHS counties, where the MMPs will facilitate plan enrollments: the Summary of Benefits (SB); an Annual Notice of Changes (ANOC), Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated Formulary (List of Covered Drugs), combined provider/pharmacy directory (Provider and Pharmacy Directory), single Member ID Card, integrated denial notice, welcome letters for opt-in and passively enrolled individuals; and other plan-delegated enrollment notices: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.
- Required Part D materials, including the Excluded Provider Letter, Prescription Transfer Letter, and Transition Letter: www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials.
- Part D appeals and grievances models and notices (including those in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance): www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev and www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.
- Part C appeals and grievances models and notices (including those in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals

Guidance): www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG and www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.

- MMP-specific ANOC/EOC (Member Handbook) errata model: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.

CMS required materials and content

422.2267(e), 423.2267(e)

We clarify that required materials and instructions for California MMPs are in Appendix A and Appendix B of this document, which replace the requirements in 422.2267(e) and 423.2267(e) unless otherwise specifically indicated. As stated in the “Introduction” in this document, CMS continues to consider all CY 2022 MMP materials to be marketing materials. As a result, MMPs submit all materials in HPMS.

Agent, Broker, and Other Third Party Requirements

422.2274, 423.2274

The state’s enrollment broker (or COHS plans) continue to process all MMP enrollments. We clarify that CMS does not regulate compensation of employed agents. Employed MMP staff conducting marketing activity of any kind, as defined in this document, must be licensed in the state (and, when required, appointed) as an insurance agent or broker.

For CY 2022 enrollments, we clarify that California MMPs approved by the California Department of Health Care Services will be permitted to use and compensate independent agents or brokers for MMP enrollments in accordance with requirements of the CMS memorandum, “California MMPs: Update to Agent/Broker Compensation Policy for Contract Year 2019,” dated June 11, 2018, and issued through HPMS.

We further clarify that California MMPs are permitted to compensate independent agents or brokers in two scenarios, as described in Appendix C of this document. MMPs may compensate independent agents or brokers in situations where individuals opt in to MMPs offered by the same parent organization as their previous coverage (e.g., a Dual Eligible Special Needs Plan or D-SNP) and an independent agent or broker facilitated enrollment into the previous coverage. This situation can occur in the middle of the initial compensation year or in a subsequent year in which the agent or broker is receiving renewal compensation for retention in that Medicare Advantage (MA) plan.

Essentially, this policy permits the MMP to continue compensating an independent agent or broker based on the circumstances in which the same independent agent or broker would have received compensation had the member stayed in the parent organization’s MA product instead of opting into the MMP. This prevents independent agents or brokers from experiencing a financial penalty if a member stays with the same parent organization but eventually elects to join the parent organization’s MMP.

Additionally, we clarify reporting responsibilities for all MMPs. Annually by the last Friday in July, MMPs must enter information in HPMS and attest to their intention to use agents or brokers in

the upcoming plan year. MMPs must report their use of employed, captive, or independent agents or brokers in accordance with California and CMS guidelines. For further instructions, refer to the “Agent/Broker Compensation” sections of the HPMS Marketing Review Module and User Guide. Following the reporting deadline, MMPs may not change their decisions related to agent or broker type until the next plan year.

Appendix A. Required Materials and Instructions for MMPs

The tables on the following pages contain required materials for California MMPs and high-level information for each material. MMPs should review any noted “Guidance and Other Needed Information” as applicable. Additionally, MMPs should consult the HPMS Marketing Review Module and User Guide for instructions about uploading required materials.

MMPs may enclose additional benefit and plan operation materials with required materials, unless specifically prohibited in instructions or prohibited as noted for each material. Additional materials must be distinct from required materials and must be related to the MMP in which the beneficiary enrolled.

Annual Notice of Changes (ANOC)	
<i>To Whom Required:</i>	Must be provided to current enrollees of plan, including those with October 1, November 1, and December 1 effective dates.
<i>Timing:</i>	<ul style="list-style-type: none"> • MMPs must send for enrollee receipt no later than September 30 of each year. (Note: ANOC must be posted on MMP website by October 15.) • Enrollees with October 1, November 1, and December 1 enrollment effective dates must receive the ANOC for the upcoming year by one (1) month after the effective date of enrollment but not later than December 15.
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> • Refer to the HPMS Marketing Review Module and User Guide. • Must be submitted prior to mailing ANOCs.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • California MMP model required for current CY. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • Actual Mail Dates (AMDs) and number of recipients (not the number of ANOCs mailed) must be entered into HPMS within 15 days of mailing. This includes mail dates for alternate materials. MMPs that mail in waves should enter the AMD for each wave. MMPs may enter up to ten (10) waves of mailings. For instructions on meeting this requirement, refer to the “Manage Material AMD/Beneficiary Information” section of the HPMS Marketing Review Module and User Guide. (Note: For a single mailing to multiple recipients, MMPs should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed.) • Plans may include the following with the ANOC: <ul style="list-style-type: none"> ○ Summary of Benefits ○ Provider and Pharmacy Directory ○ EOC (Member Handbook) ○ Formulary (List of Covered Drugs) ○ Notification of Electronic Documents • No additional plan communications unless otherwise directed.
<i>Translation Required:</i>	Yes.

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

Coverage/Organization Determination, Discharge, Appeals and Grievance Notices	
<i>To Whom Required:</i>	<ul style="list-style-type: none"> • Must be provided to enrollees who have requested an appeal or have had an appeal requested on their behalf. • Grievances may be responded to electronically, orally, or in writing.
<i>Timing:</i>	Provided to enrollees (generally by mail) on an ad hoc basis, based on required timeframes in three-way contract.
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Other CMS models; modifications permitted.
<i>Guidance and Other Needed Information:</i>	Three-way contract, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
<i>Translation Required:</i>	Yes.

Evidence of Coverage (EOC)/Member Handbook	
<i>To Whom Required:</i>	Must be provided to all enrollees of plan.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must send to current enrollees of plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current CY, as well as an EOC (Member Handbook) document for the upcoming CY. We clarify that, for these members, the ANOC may be included in the EOC (Member Handbook) or provided separately, as well as the Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the Formulary), and the Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) for the upcoming year, must be received by one (1) month after the effective date of enrollment, but not later than December 15.
<i>Method of Delivery:</i>	<ul style="list-style-type: none"> • New enrollees – must send hard copy (required) • Existing (not new) enrollees – may send notice informing them how to access the EOC (Member Handbook) electronically instead of mailing hard copies of the document
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> • Refer to the HPMS Marketing Review Module and User Guide. • Submitted prior to October 15 of each year.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • California MMP model required for current CY. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	No additional information.
<i>Translation Required:</i>	Yes.

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

Explanation of Benefits (EOB) – Part D	
<i>To Whom Required:</i>	Must be provided anytime an enrollee utilizes their prescription drug benefit.
<i>Timing:</i>	Sent at the end of the month following the month when the benefit was utilized.
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Part D EOB model; modifications permitted.
<i>Guidance and Other Needed Information:</i>	Three-way contract and 423.2267(e)(2).
<i>Translation Required:</i>	Yes.

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

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

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

Mid-Year Change Notification to Enrollees	
<i>To Whom Required:</i>	Must be provided to all applicable enrollees when there is a mid-year change in benefits, plan rules, formulary, provider network, or pharmacy network.
<i>Timing:</i>	Ad hoc, based on specific requirements for each issue as defined in 422.2267(e)(9).
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted. If the mid-year change affects a document that the MMP has not sent to the member in hard copy (e.g., the EOC (Member Handbook)), the MMP is not required to send a hard copy mid-year change notification.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Model not available; must include required content.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • Notices of changes in plan rules unless otherwise addressed in a regulation must be provided 30 days in advance. • National Coverage Determination (NCD) changes announced or finalized less than 30 days before effective date, notification required as soon as possible. • Mid-year NCD or legislative changes must publish no later than 30 days after the NCD is announced. MMPs may include change in next plan mass mailing (e.g., newsletter), provided it is within 30 days and must be reflected on their website. • Medicare Managed Care Manual - Chapter 4. • Medicare Prescription Drug Benefit Manual - Chapter 6 and forthcoming guidance effectuating 423.120(b)(5) on formulary changes and required notice to beneficiaries and other entities. • National Coverage Determination website.
<i>Translation Required:</i>	Yes.

Non-Renewal and Termination Notices	
<i>To Whom Required:</i>	Must be provided to each affected enrollee after MMP decides to non-renew or reduce its plan's service area or before the termination effective date.
<i>Timing:</i>	At least 90 days before the end of the current contract period.
<i>Method of Delivery:</i>	Notices must be hard copy and sent via U.S. mail. First class postage is recommended.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • California MMP model required for current CY. • Modifications permitted per instructions.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until notice is received from CMS and the state. • MMPs may elect to share Non-Renewal and Service Area Reduction (NR/SAR) information only with first tier, downstream, and related entities (FDRs) or anyone that the MMP does business with (i.e., contracted providers). • Additional NR/SAR notice information can be found in the annual CMS memorandum "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models." • For terminations, relevant notice requirements are provided in 42 CFR 422.506, 422.508, and 422.512.
<i>Translation Required:</i>	Yes.

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

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

Plan-Delegated Enrollment and Disenrollment Notices	
<i>To Whom Required:</i>	Must be provided as outlined in National Enrollment and Disenrollment Guidance for States and MMPs.
<i>Timing:</i>	Varies; must follow required timeframes as outlined in National Enrollment and Disenrollment Guidance for States and MMPs.
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • California MMP model required for current CY. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • National Enrollment/Disenrollment Guidance for States & MMPs. • California Enrollment Guidance Appendix 5. • MMPs must follow specifications in the HPMS Marketing Review Module, along with the enrollment/disenrollment guidance, to determine how to submit appropriately.
<i>Translation Required:</i>	Yes.

Pre-Enrollment Checklist (COHS MMPs Only)	
<i>To Whom Required:</i>	<ul style="list-style-type: none"> • Must be provided to potential enrollees with the enrollment form. • May be provided to potential enrollees with the Summary of Benefits (SB) when the SB is accompanying an enrollment form.
<i>Timing:</i>	Prior to enrollment.
<i>Method of Delivery:</i>	In the same format the SB was provided.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • Model required. • Modifications to disclaimer language are not permitted.
<i>Guidance and Other Needed Information:</i>	Refer to the model in Appendix D.
<i>Translation Required:</i>	Yes.

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

Provider and Pharmacy Directory	
<i>To Whom Required:</i>	Must be provided to all current enrollees of the plan.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must be sent to current enrollees of Plan for receipt by October 15 of each year. Must be posted to plan website by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be provided to current enrollees upon request, within three (3) business days of the request. • Must update directory information any time they become aware of changes. All updates to the online provider and pharmacy directories are expected to be completed within 30 days of receiving information. Updates to hard copy provider and pharmacy directories must be completed within 30 days; however, hard copy directories that include separate updates via addenda are considered up-to-date.
<i>Method of Delivery:</i>	Hard copy or via Electronic Notice of Documents, or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.

Provider and Pharmacy Directory	
<i>Format Specification:</i>	<ul style="list-style-type: none"> • California MMP model required for current CY. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • MMPs are required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. MMPs may print separate directories for primary care physicians (PCPs) and specialists provided both directories are made available to enrollees at the time of enrollment. • The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits. • For MMPs with multi-county service areas, the combined Provider and Pharmacy Directory may be provided for all providers by county, provided the directory includes a disclaimer that the directory only includes providers in that particular county (or counties), that a complete directory is available on the plan's website, and that the enrollee may contact the plan's customer service call center to request assistance with locating providers in other counties or to request a complete hard copy Provider and Pharmacy Directory. • California MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the California MMP Provider and Pharmacy Directory. • As applicable, refer to the language and guidelines issued in the CMS memorandum dated August 16, 2016, "Pharmacy Directories and Disclaimers" for the pharmacy portion of the combined directory.
<i>Translation Required:</i>	Yes.

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

Summary of Benefits	
<i>To Whom Required:</i>	Enrollees who are passively enrolled. Optional with the ANOC and as requested for other enrollees.
<i>Timing:</i>	<ul style="list-style-type: none"> • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be available by October 15 of each year, but can be released as early as October 1 of each year. Must be posted on MMP website by October 15 of each year.
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> • Refer to the HPMS Marketing Review Module and User Guide. • Submitted prior to October 15 of each year.
<i>Format Specification:</i>	<ul style="list-style-type: none"> • California MMP model required for current CY. • Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> • The SB must contain a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including applicable copays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.
<i>Translation Required:</i>	Yes.

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

Required Materials for New MMP Enrollees

The following tables summarize the required materials, and timing of receipt, for new MMP enrollees.

Table 1: Required Materials for New Members – Passive Enrollment

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Passive enrollment	<ul style="list-style-type: none"> • Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • SB 	20 calendar days prior to the effective date of enrollment ⁵
Passive enrollment	<ul style="list-style-type: none"> • Member ID Card • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC) 	No later than the day prior to the effective date of enrollment

⁵ Note that for plans electing to conduct early Health Risk Assessments (HRAs) – that is, HRAs prior to the effective date of enrollment – the timing for receipt of these materials is no later than 30 days prior to the effective date of enrollment. Plans electing to conduct early HRAs will receive separate guidance on timelines and other requirements.

Table 2: Required Materials for New Members – Opt-in Enrollment

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received more than ten (10) calendar days before the end of the month) ⁶	<ul style="list-style-type: none"> • Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC) 	No later than the last day of the month prior to the effective date
Opt-in enrollment (with enrollment confirmation received less than ten (10) calendar days before the end of the month) ⁶	<ul style="list-style-type: none"> • Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook (or a distinct and separate notice alerting enrollees how to access or receive the EOC) 	No later than ten (10) calendar days from receipt of the CMS confirmation of enrollment

⁶ We clarify that this group of enrollees who opt in includes individuals who are eligible for passive enrollment but select a different MMP or initiate an earlier enrollment date than their passive enrollment effective date. MMPs should refer to the date of the Daily Transaction Reply Report (DTRR) that has the notification to identify the start of the ten (10) calendar-day timeframe.

Appendix B. State-specific MMP Disclaimers

We clarify that MMPs include specific disclaimer language in the table below. We also clarify that, as applicable, MMPs include additional disclaimers contained in subsections 422.2267(e) and 423.2267(e) of the regulations. In addition, we clarify that MMPs are not required to include disclaimers on the following material types: Member ID Cards, call scripts not related to sales or enrollment, banners and banner-like ads, envelopes, outdoor advertising, text messages, and social media.

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Federal Contracting	<Plan’s legal or marketing name> is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.	Required on materials except those specifically excluded above
Benefits – “This is not a complete list...”	This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the <plan name> Member Handbook.	Required on the SB and all materials with ten (10) or more benefits except the Member Handbook (EOC)
Availability of Non-English Translations	ATTENTION: If you speak <language of disclaimer>, language assistance services, free of charge, are available to you. Call <Member Services toll-free phone and TTY numbers, and days and hours of operation>. The call is free.	Required in applicable non-English languages in those models in Appendix A for which the last row of the table indicates, “ <i>Translation required: Yes</i> ”
Non-plan and Non-health Information	Neither Medicare nor Medi-Cal has reviewed or endorsed this information.	Required on non-plan and non-health related information once prior authorization from the enrollee is granted to receive materials

Note: For model materials, MMPs must continue to include disclaimers where they currently appear in the models. For non-model materials, MMPs may include disclaimers as footnotes or incorporate them into the body of the material.

Appendix C. Permissible Options for Compensating Independent Agents or Brokers

Information in the table below describes the two scenarios for which California MMPs are permitted to compensate independent agents or brokers when a member opts in to an MMP that is offered by the same parent organization as their previous coverage. In the initial compensation scenario in the table's first row, consistent with information in subsection 422.2274(d)(2) of the regulation, the MA plan would be required to pro-rate the compensation paid to the agent for the months the enrollee was no longer enrolled in the MA plan.

Original Enrollment	New Enrollment	Relationship between New and Old Enrollments	Method of Enrollment into the New Plan	Current Compensation Situation	Compensation Situation after MMP Enrollment
MA plan	MMP	Same parent organization	Member-initiated opt-in enrollment through the state's enrollment broker (or COHS plan)	MA plan is currently paying initial compensation for MA plan enrollment	MMP may elect to pay an agent or broker a pro-rated initial compensation payment, as applicable depending on the timing of the enrollment, and may make renewal compensation payments for subsequent compensation cycle years.
MA plan	MMP	Same parent organization	Member-initiated opt-in enrollment through the state's enrollment broker (or COHS plan)	MA plan is currently paying renewal compensation for MA plan enrollment	MMP may elect to pay an agent or broker a pro-rated share of the renewal compensation payment, depending on the timing of the enrollment, and may make renewal compensation payments for subsequent compensation cycle years.

Appendix D. Model Pre-Enrollment Checklist for COHS MMPs Only

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at *[insert Member Services phone number]*.

This plan is a Medicare-Medicaid Plan (MMP). Your ability to enroll will be based on verification that you are entitled to both Medicare and Medi-Cal.

Understanding the Benefits

- The Member Handbook (Evidence of Coverage) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit *[insert COHS MMP website]* or call *[insert COHS MMP phone number]* to view a copy of the Member Handbook (Evidence of Coverage).
- Review the Provider and Pharmacy Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the Provider and Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the Formulary (List of Covered Drugs) to make sure your drugs are covered.

Understanding Important Rules

- Benefits *[insert if applicable: and/or copays]* may change on January 1, *[insert year]*.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider and Pharmacy Directory).