CMS Medicare Manual System
Pub. 100-16 Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
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Red italicized font identifies new material.

CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.

Table of Contents - Changed section title of 30.2.2 to include a cross reference to a QISMC standard, deleted 40.2, corrected spelling of "eligible" in 40.5, added new sections 60.3 and 60.4.

Section 10 - Corrected grammar.

Section 20 - Is revised to include full definitions of acronyms in the note for ACR (Adjusted Community Rate), SB (Summary of Benefits), and EOC (Evidence of Coverage).

Section 30.1:

1. "Operational Items" item 1 - Corrected punctuation of "out of area."

2. "Affiliation Acknowledgements" - Is revised to include full definition of acronym PSO (Provider Sponsored Organization).

Section 30.2.1 - Lock-in Requirements/Selecting a Primary Care Physician - How to Access Care in an HMO" - Deleted paragraph four and replaced it with language that is designed for use by contractors regarding information to be provided to enrollees about full coverage.

Section 30.2.2 - Emergency Care Cross References to QISMC 2.3.1.7 - Is revised to include cross reference to the QISMC standard in the section title.

Section 30.2.4 - Appeal Rights - Is revised to include the words "payment for a" to the second sentence to clarify that payment is denied, not service.

Section 30.2.5 – "Benefits and Plan Premium Information" - The third paragraph is deleted and the last paragraph of the section is inserted to clarify regulations regarding description of low-option plans.

Section 40.2 - Final Verification Review Process - Is deleted (including endnote 8).

Section 40.5.2 - Guidelines for Outreach Program - In Item 10 **-** Contractor is now instructed to ensure that contracts meet Medicare+Choice Administrative Contracting Requirements published in Chapter 11, section 100.5, **instead** of submitting materials to CMS's central and regional office and awaiting approval.

Section 40.5.3 - Submission Requirements

1. CMS now requires a third copy to be submitted via e-mail to the Dual Eligibility Outreach Product Consistency Team PCT. Endnote 15 was added to include the physical address and e-mail address.

2. Item 4 is inserted requiring supporting documentation from the appropriate State Agency describing specific state income requirements for each savings program level. Each item thereafter is renumbered.

Section 40.5.4 - CMS Review/Approval Process

1. Under subsection "Reviewing New Outreach Programs":

    - Each paragraph is numbered beginning with the second paragraph.

- The third numbered paragraph is updated with the new requirement to provide an electronic copy of the material to the Dual Eligibility Outreach PCT.

- The first sentence of the fourth paragraph regarding CMS' Central Office Plan Manager providing a copy of the outreach proposal is deleted.

2. Under subsection "Reviewing Previously Approved Outreach Programs - Footnote 3 is changed to footnote 14.

Section 40.5.5 - Model Direct Mail Letter - The model letter is updated for dates and amounts.

Section 50.3 - Answers to Frequently Asked Questions About Promotional Activities - Renumbered the paragraphs after the note from 1 - 9 to 8 - 16. All are part of the same list.

Section 60.1.2 - Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations - Is revised to include a note at the end of the section regarding the impact on marketing of VAIS by proposed changes to the privacy rule.

Section 60.3 - Non Benefit Providing Third Party Marketing Materials - Is a new section stating that CMS does not review materials originated by non-benefit providing third party entities. Also, a disclaimer must be prominently displayed on the first page of any material provided by non-benefit providing third parties stating that "Medicare has neither reviewed, nor endorses this information."

Section 60.4 - Marketing Material Requirements for Non-English Speaking Populations (QISMC Standard 2.3.3.2) - Is a new section stating that materials should be made available in any language that is the primary language of more than 10 percent of the geographic area, and also in a form for the visually impaired.

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Endnotes

10 - Introduction - (Rev. 11, 08-15-02)

This chapter explains requirements for marketing. The intent of this chapter is to:

- Expedite the process for CMS's review of marketing materials;
- Conserve resources by avoiding multiple submissions/reviews of a document prior to final approval;
- Ensure consistent marketing review across the nation and,
- Enable managed care organizations to develop accurate, consumer friendly, managed care marketing information that will assist beneficiaries in making informed health care choices. [1]

This chapter will be updated as new issues are identified.

Marketing materials, in general, *are* informational materials targeted to Medicare beneficiaries that promote the M+C organization or any M+C plan offered by *the* M+C organization or communicates or explains an M+C plan. [2] (See 42 CFR 422.80(b).) The definition of marketing materials extends beyond the public's general conception of advertising materials to include notification forms and letters used to enroll, disenroll, and communicate with the member on many different membership scenarios. General guidance regarding the marketing review process, including the process for review of materials submitted by national organizations, is provided in §20. In addition, this chapter contains two separate sections devoted to the discussion of guidelines for marketing materials. Section 30 addresses requirements for advertising or "pre-enrollment" materials, and §40 addresses requirements for beneficiary notification materials that are provided for beneficiary currently enrolled in the plan. Materials relating to promotional activities, including health fairs and sales presentations, are also included in the general definition of marketing materials and are discussed in §50.

20 - Marketing Review Process - (Rev. 11, 08-15-02)

Marketing review consists of:

- Pre-approval of marketing materials before they are used by the health plan/M+CO;
- Review of on-site marketing facilities, products, and activities during regularly scheduled contract compliance monitoring visits;
- Random review of actual marketing pieces as they are used in/by the media; and
- "For cause" review of materials and activities when complaints are made by any source.

This chapter deals primarily with the pre-approval of marketing materials. As outlined in regulations at 42 CFR 422.80(a), M+C organizations may not distribute any marketing materials or election forms or make them available to individuals eligible to elect an M+C plan unless such materials have been submitted to CMS at least 45 days prior to distribution and CMS has not disapproved the materials. An M+C organization may also distribute materials before 45 days have elapsed if prior approval has been granted by CMS. There is a limited exception to this requirement for model beneficiary notices, as outlined in §40 of this Chapter. Guidelines for CMS review are further described at 42 CFR 422.80(c). Marketing materials, once approved, remain approved until either the material is altered by the M+CO or conditions change such that the material is no longer accurate. CMS may, at any time, require an M+C organization to change any previously approved marketing materials if found to be inaccurate, even if the original submission was accurate at the time.

Section 613 of the Benefits Improvement and Protection Act of 2000 limits CMS to a 10 day review period (as opposed to the usual 45 days) for review of any marketing material for which an M+C organization follows CMS model language without modification.

When an M+C organization indicates that it has followed a CMS model without modification, a determination on the marketing material must be made within 10 days, or else the marketing material is deemed approved. "Without modification" means the M+C organization used CMS model language verbatim and only used its own language in areas where we have given them license to include their own information (such as where they are asked to include their plan-specific benefits). It also means that the M+C organization has followed the sequence of information provided in the model in its own marketing material. In these cases, the regional office may only need to review the M+C organization's language in order to make a determination on the marketing material within the 10-day time frame.

NOTE: Some of the CMS models cannot be approved until an M+C organization's *Adjusted Community Rate* (ACR) is approved. These include the *Summary of Benefits* (SB), Annual Notice of Change (ANOC), and the *Evidence of Coverage*

(EOC) (if it is submitted early in the year). In these cases, the Regional Office will review and approve all non-ACR-related information within the 10-day review period, and will conduct a cursory review of all ACR-related information based on the M+C organization's ACR submission. However, the Regional Office will need to disapprove the release of ACR-related marketing material within the 10-day window, since there is no basis for approving it, and indicate that the material will be approved upon approval of the ACR. The Regional Office will need to promptly review and approve these marketing materials upon approval of the ACR.

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30 - Guidelines for Advertising Materials - (Rev. 11, 08-15-02)

30.1 - Guidelines for Advertising (Pre-enrollment) Materials - (Rev. 11, 08-15-02)

This section provides guidance to health plans/M+C organizations regarding sales packages and language that may be used in marketing materials. Advertising/pre-enrollment material may be defined as material that is intended primarily to attract or appeal to M+C eligible non-members and to promote membership retention by providing general information to enrollees about the health plan. This includes all ads (print as well as radio TV and Internet ads) and certain other material such as sales scripts, sales presentation flyers, and direct mail pieces that contain information of interest to all potential and current enrollees of the plan. This chapter offers a general guide and a matrix describing marketing language that health plans/M+C organizations "Must Use/Can't Use/Can Use."

These guidelines were created by identifying required language frequently omitted by health plans/M+C organizations or revised by CMS. Acceptable language was created to meet both CMS requirements and the needs of the health plans/M+C organizations. Although use of suggested "Can Use" language is not required, its use will expedite the review process and achieve greater consistency among marketing materials. Please note that the specific language and format used in all standardized marketing materials like the standardized Summary of Benefits (SB) is required. Please also note that the language provided in the "Must Use" column of the "Must Use/Can't Use/Can Use Chart" (see §30.3 of this Chapter) is required for all the marketing materials as specified in the chart.

Some phrases in this document may not apply to your health plan's/M+C organization's benefit package or marketing strategy. We caution you to apply the information contained in this document with the understanding that it must be evaluated for applicability to your health plan/M+C organization.

Listed below are items that apply to the various pre-enrollment/member retention marketing scenarios experienced by Medicare managed care contracting entities:

Operational Items

1. For M+C coordinated care plans, the concept of "lock-in" must be clearly explained in all materials. For marketing pieces which tend to be of short duration we suggest: "You must receive all routine care from [name of plan/M+C organization] plan providers" or "You must use [name of plan/M+C organization] plan providers except in emergent care situations or for *out of area* urgent care/renal dialysis." However, in all written materials used to make a sale, a more expanded version is suggested: "If you obtain routine care from out-of-plan providers neither Medicare nor the health plan/M+C organization will be responsible for the costs." Modify materials if the health plan has a Point-of-Service (POS) or Visitors' Program benefit or is a cost contractor or Private Fee-For-Service Plan.

2. All marketing materials must clearly explain the concept of networks and sub-networks and the process for obtaining services including referral requirements.

3. Health plans/M+C organizations must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided. This requirement does not apply to any numbers included on advertising materials for persons to call for more information.

4. Definition of Outdoor Advertising (ODA) - ODA is marketing material intended to capture the quick attention of a mobile audience passing the outdoor display (e.g., billboards, signs attached to transportation vehicles, etc.). ODA is designed to catch the attention of a person and influence them to call for detailed information on the product being advertised. Due to the nature of ODA, CMS is willing to waive the disclaimer information required with other forms of marketing media (e.g., lock-in and premium information). [3]

5. Marketing material identification systems - Health plans/M+C organizations must use the system mandated by the reviewing RO for identifying marketing materials submitted to CMS. If the reviewing RO does not have a system, health plans/M+C organizations may use their own system for identifying marketing materials. The health plan identifier should appear on the lower left or right side of the marketing piece. After the RO approves the marketing piece, the approval date (month/year) should always be posted to the marketing piece. The approval date is the date on the CMS approval letter. This requirement is applicable to all approved internet pages and paper advertisements (e.g. brochures, newspaper ads). Approved radio and television marketing materials need not include mention of the approval date.

6. Where M+C organizations may file separate/distinct Adjusted Community Rate (ACR)s Proposals and the Plan Benefit Package (PBP)s covering the same service area (or portions of the same service area), there is no requirement that all plans be identified in all of the health plan's/M+C organization's marketing materials, although M+C organizations may do so at their discretion. M+C organizations must disclose whether other plans are available in their Annual Notice of Change letter.

7. M+C organizations may market plans directly to beneficiaries of former Medicare plans that have chosen not to renew their contracts as long as the following requirements are met:

   - No such marketing is permitted until after the date the beneficiary has received the plan termination letter; and

   - In addition to the targeted message, the marketing piece must contain a statement indicating that the plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area.

8. Sales scripts, both for in-home and telephone sales use, must be reviewed by CMS prior to use. However, health plans/M+C organizations are not required to adhere to a specific format for submission (i.e. verbatim text or bullet points).

9. Health plans/M+C organizations may not use Medicare member lists for non-plan-specific purposes. If a health plan/M+C organization has questions regarding specific material, which it wishes to send to its Medicare members, the material should be submitted to CMS for a decision.

Affiliation Acknowledgements

1. All marketing materials must include a statement that the health plan/M+C organization contracts with the Federal government. One possible statement is "A Federally Qualified HMO with a Medicare contract." Cost-contractors may use "An HMO with a Medicare contract" and/or "An M+C organization with a Medicare contract" if they are State licensed as HMOs. Medicare+Choice organizations may identify Medicare products as "An HMO with "a Medicare+Choice contract" if they are Federally Qualified or State licensed as HMOs. M+C organizations may also identify their Medicare plans as "An M+C plan with a Medicare+Choice contract," or "A Coordinated Care Plan with a Medicare+Choice contract," if the health plan/M+C organization meets the requirements of §1851(a)(2)(A) of the *Social Security* Act. In addition, an M+C organization may describe its Medicare product as a "Medicare+Choice plan offered by [name of M+C organization], a Medicare+Choice Organization".

2. A M+C organization may only identify itself as an "M+C *Provider Sponsored Organization (*PSO*)*" or imply that it is one of the PSO options for Medicare beneficiaries under M+C if it has received a State licensure waiver from CMS in accordance with 42 CFR 422.370-.378. State licensed M+C organizations may identify themselves in marketing materials as a "Provider Sponsored Organization (PSO)," a "State licensed PSO with a M+C contract," or any other term generally applied to managed care organizations that are sponsored by health care providers as long as they do not use the specific term "M+C PSO" or imply that they are one of the specific PSO options for Medicare beneficiaries defined by the Balanced Budget Act of 1997 and implementing regulations at 42 CFR 422.350-.356.

3. M+C organizations are permitted to use ethnic and religious affiliation in their plan names, as long as the legal entity offering the plan has a similar proper name/affiliation. For instance, if a plan were affiliated with the Swedish Hospital of Minnesota, it would be permissible for the plan to use the tag line, "Swedish Plan, offered by Swedish Hospital System of Minnesota."

Special Situations

1. Beneficiaries with disabilities must be considered part of the audience that any marketing strategy is intended to reach. Specifically, and in light of the publication of the final M+C regulation, health plans/M+C organizations may not use plan names that suggest that a plan is available only to Medicare beneficiaries age 65 or over, rather than to all beneficiaries. This prohibition generally bars plan names involving terms such as "seniors," "65+," etc. In fairness to M+C organizations with an existing investment in a plan name, CMS will allow the "grandfathering" of existing M+C plan names; that is, plan names established before the final rule took effect.

2. TDD/TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TDD/TTY number must also appear along with the hours of operation, if the inclusion of hours of operation are required (as outlined under "Operational Items," item #3). The font size/style rule is required for all media with the exception of television ads.CMS recognizes that the requirement that the TTY/TDD number be the same font and style as other numbers can result in confusion on a television ad, resulting in some prospective enrollees calling the wrong phone number. Therefore, health plans/M+C organizations are allowed to use various techniques to sharpen the differences between TTY/TDD and other phone numbers on a television ad (such as using a smaller font size for the TTY/TDD number than for the other phone numbers). Health plans/M+C organizations can use either their own or State relay services, as long as the number is included. Health plans/M+C organizations can use either their own or State relay services, as long as the number is included.

3. Review of marketing materials in non-English language or Braille: For marketing with non-English or Braille materials the health plan/M+C organization must submit the non-English or Braille version of the marketing piece, an English version (translation) of the piece, and a letter of attestation from the health plan/M+C organization that both pieces convey the same information. Health plans/M+C organizations will be subject to verification monitoring review and associated penalties for violation of this CMS policy. If national health plans/M+C organizations have submitted materials in English to the lead RO and these have been approved, the same materials in other languages or Braille may be used provided that health plans/M+C organizations submit attestation letters vouching that the non-English or Braille version contains the same information as the English language version.

Section 1876 Cost Contracts Only

1. For §1876 of the Social Security Act, cost-contracting health plans only - In all marketing materials (e.g., brochure narratives and introductions to side-by-side comparisons) the health plan must indicate that it meets Medicare regulatory requirements for providing enrollment opportunity and benefit packages for both Part A and B and Part B-only eligible beneficiaries.[4]

2. Cost-contracting health plans must market a low option or basic benefit package that is identical to the Medicare fee-for-service benefit package (except for any additional benefits the health plan may offer at no charge, for which the health plan claims no reimbursement). Information on the availability of this package must appear in all of the health plan's marketing materials. The health plan/M+C organization may also offer additional optional enriched benefit packages for an additional charge to the extent they wish.

Editorial Items

1. Readability of written materials is crucial to informed choice for Medicare beneficiaries. All member materials that convey the rights and responsibilities of the health plan/M+C organization and the member must be printed with a 12-point font size or larger. Materials subject to this requirement include, but are not limited to, the Evidence of Coverage (EOC) or member brochure and contract, the enrollment and disenrollment applications, letters confirming enrollment and disenrollment, notices of non-coverage (NONC) and notices informing members of their right to an appeals process. CMS is cognizant of the fact that, when actually measured, font size 12 point may vary among different fonts with the result that some font types may be smaller than others. Times New Roman font type is the standard by which font size is measured. Therefore, if M+C organizations choose to use a different font type, it is their responsibility to ensure that the font used is equivalent to or larger than Times New Roman 12 point.

2. The 12-point font size or larger rule also applies to any footnotes or subscript annotations in notices. In all non-notice material (e.g., TV advertisements) the footnote and any text appearing in the material must be the same size font as the commercial message. The term "commercial message" refers to the material, which is designed to capture the reader's attention regarding the health plan/M+C organization. The term does not refer to the commercial membership (i.e., non Medicare/Medicaid members) of the health plan/M+C organization. All non-notice materials must have the same font size for both the commercial message and footnotes. The size is left to the discretion of the health plan/M+C organization and can be smaller than size 12 font, but the commercial message and footnotes must be the same size font.

3. Health plans/M+C organizations must adopt a standard procedure for footnote placement. Footnotes should appear either at the end of the document or the bottom of each page and in the same place throughout the document. In other words, for example, the health plan/M+C organization cannot include a footnote

at the bottom of page 2 and then reference this footnote on page 8; the footnote has to also appear at the bottom of page 8.

Other

1. Marketing through the Internet: CMS considers the Internet as simply another vehicle for the distribution of marketing information. Therefore, all regulatory rules and requirements associated with all other marketing conveyances (e.g., newspaper, radio, TV, brochures, etc.) are applicable to health plan/M+C organization marketing activity on the Internet. CMS marketing review authority extends to all marketing activity (both advertising and beneficiary notification activity) the health plan/M+C organization pursues via the Internet.

2. Health education materials are generally not under the purview of CMS marketing review. However, if such materials are used in any way to promote the M+C organization or explain benefits, then they are considered marketing materials and must be approved before use. If there is any "commercial message" (defined previously in this section) or beneficiary notification information in a health education piece, it must be reviewed by CMS.

3. M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, etc. as long as specific study details are given (at a minimum source, dates, sample size, and number of plans surveyed). M+C organizations may not use study or statistical data to directly compare their plan to another. If M+C organizations use study data that includes information on several other M+C organizations, they will not be required to include data on all organizations. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

4. CMS recognizes the difference of purpose and intent between company logos/product tag lines and other advertising marketing materials. The guidelines regarding specifically the use of unsubstantiated statements that apply to advertising materials do not apply to logos/taglines. Contracting health plans may use unsubstantiated statements in their logos and in their product tag lines (e.g., "Your health is our major concern," "Quality care is our pledge to you," "First Care means quality care," etc.). This latitude is allowed only in logo/product tag line language. Such unsubstantiated claims cannot be used in general advertising text regardless of the communication media employed to distribute the message. Not withstanding the ability to use unsubstantiated statements as indicated above, the use of superlatives is not permitted in logos/product tag lines (e.g., "First Care means the first in quality care" or "Senior's Plus means the best in managed care"). Refer to the Must Use/Can't Use/Can Use chart in §30.3 of this Chapter for full information on restrictions associated with the use of superlatives.

30.2.1 - Lock-in Requirements/Selecting a Primary Care Physician - How to Access Care in an HMO - (Rev. 11, 08-15-02)

Health plans/M+C organizations must describe rules for receipt of primary care, specialty care, hospital care, and other medical services in their EOC. These rules may vary by health plan/M+C organization. Health plans/M+C organizations must disclose specific rules for referrals for follow-up specialty care in their EOC. Prior to enrollment, prospective members must be able to obtain information regarding the health plan network coverage and rules in sufficient detail to make an informed choice.

When a beneficiary enrolls in a plan/M+C organization, he/she agrees to use the network of physicians, hospitals, and providers that are affiliated with the plan for all health care services, except emergencies, urgently needed care, or out-of-area renal dialysis services.

Contractors with a POS benefit or Visitors Program benefit should list plan-specific requirements and level of coverage found in your EOC.

A plan member selects a primary care physician (PCP) to coordinate all of the member's care. A primary care physician is usually a family practitioner, general practitioner, or internist. The primary care physician knows the plan's network and can guide the member to plan specialists when needed. The member always has the option to change to a different primary care physician. Changes in PCP will be effective according to the plan guidelines that, in some instances, could be the first or the 15th day of the following month as opposed to immediately.

Neither the health plan/M+C organization nor Medicare will pay for medical services that the member receives outside of the network unless it was authorized, or it is an emergency, urgently needed care, or out-of-area dialysis service. The member may be responsible for paying the bill.

In the case of enrollees in §1876 Cost Contracts, enrollees must be informed that after enrollment is effective, in order for them to receive the full coverage offered, services other than emergency and urgently-needed services must be obtained through the HMO or CMP. In the case of cost enrollees, however, they may receive services that are not provided or arranged by their HMO or CMP, but they would be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare program. They also would be liable for any charges not covered by the Medicare program[5].

30.2.2 - Emergency Care *(Cross References to QISMC 2.3.17)* - (Rev. 11, 08-15-02)

Members are not required to go to health plan-affiliated hospitals and practitioners when they experience an emergency. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are:

1. Furnished by a provider qualified to furnish emergency services; and

2. Needed to evaluate or stabilize an emergency medical condition.

For information on M+C organization responsibility for emergency care stabilization and post-stabilization requirements see 42CFR422.113(b)(3),(c)(2)(i) through (iii).

Describe precisely where emergency coverage will be available under the health plan/M+C organization (e.g., the United States and its Territories, worldwide, etc.).

30.2.4 - Appeal Rights - (Rev. 11, 08-15-02)

Members have a right to appeal any decision the health plan/M+C organization makes regarding, but not limited to, a denial, termination, payment, or reduction of services. This includes denial of *payment for a* service after the service has been rendered (post-service) or denial of service prior to the service being rendered (pre-service).

30.2.5 - Benefits and Plan Premium Information - (Rev. 11, 08-15-02)

Premium information must include the statement: "You must continue to pay your Medicare Part B premium."

When specifying benefits, annual limits (e.g., $1,000 annual maximum for prescription drugs), annual benefit payout (e.g., $700 for eyeglasses every 2 years) and applicable copayments (e.g., $5 copayment for a doctor visit) must be specified. Major exclusions and limitations must be stated clearly. For example, restriction of pharmacy benefits to a specific formulary or a restricted set of pharmacies must be explained. Health plans/M+C organizations must state clearly all monetary limits, as well as any restrictive policies that might impact a beneficiary's access to drugs or services. When annual dollar amounts or limits are provided, the health plan/M+C organization must also mention the applicable quarterly or monthly limits, and whether any unused portion of that benefit can be carried over from one calendar quarter to the next. Include a closing statement such as: "For full information on [plan/M+C organization name] (e.g., drugs, routine physical exam, eyeglasses, dental, etc.) benefits, call our Customer Service Department at [plan/M+C organization phone number]."

Also, a statement must be made that the (Health Plan/M+C organization's Name) contract with CMS is renewed annually, and that the availability of coverage beyond the end of the current contract year is not guaranteed.

Cost contractors must describe their premiums and cost-sharing for services received through the HMO or CMP, and any optional supplemental benefit packages they offer. They must also indicate that premiums, cost-sharing, and optional supplemental benefits may change each year, and that the HMO or CMP may decide not to renew its contract for a given calendar year.

40.5.2 - Guidelines for Outreach Program - (Rev. 11, 08-15-02)

In order to assure CMS that M+C organizations' outreach programs effectively assist members while protecting them from undue pressures or privacy violations, M+C organizations[13] must adhere to the following guidance.

M+C Organizations MUST:

1. Provide outreach to all levels of dual eligibles, including those levels that do not provide M+C organizations with additional capitation amounts from CMS. All outreach materials (e.g., member letters (see §40.5.5 for a model Direct Mail Letter), telephone scripts) must include eligibility information that includes QI-1 and QI-2 levels. [See footnote 12 for clarification.]
2. Clarify in outreach materials that the member may voluntarily offer information, including financial information, but that the member is not obligated to provide this information.
3. Clarify in outreach materials and discussions with members that the member's failure to provide information will in no way adversely affect the beneficiary's membership in his or her health plan.
4. State in materials and discussions with members that the M+C organization will not share the information with any other entity not directly associated with determining eligibility or under contract to participate in the outreach process.
5. Clarify in outreach materials that the M+C organization is only providing an initial eligibility screening and that only the appropriate State Agency can make a final eligibility determination.
6. Provide guidance to a member on how to proceed with the application process even if the M+C organization's screening process indicates that the member is probably not eligible for assistance under any of the dual eligibility programs.
7. Provide adequate training to staff conducting the outreach. If the M+C organization subcontracts this effort to another entity, it must ensure that the subcontractor's staff is adequately trained to provide outreach.
8. Include alternate sources of information in outreach materials. Member letters and/or brochures that contain outreach information telephone numbers must also include the telephone number for the State Health Insurance Assistance Program

(SHIP) and the appropriate State Agency. Outreach materials may also include the telephone number for the Medicare Service Center (1-800-MEDICARE).

9. Include privacy guidelines in outreach materials, telephone scripts, and internal processes and/or contracts with entities performing outreach for the M+C organization. Contractual privacy guidelines must clearly state that all financial information collected from members of the M+C organization will not be used for any other purpose by the entity collecting the data. Privacy guidelines must also state that entities involved in the outreach will not share member information with anyone not involved in the outreach process.

10. *Ensure that contracts with entities taking part in some aspect of outreach activities meet Medicare+Choice Administrative Contracting Requirements listed in the Medicare Managed Care Manual, Chapter 11, Section 100.5*

11. Work closely with CMS's Regional Office staff during the outreach submission and review process so that CMS can work cooperatively with stakeholders (e.g. SHIPs, State Agency) to ensure better education and preparation prior to the outreach process initiation.

M+C Organizations MAY

1. Conduct outreach for only a portion of its plan membership. Selection of the focus population may be based upon demographic data and/or may focus on a specific geographic area. However, the organizations must provide outreach to all individuals within those pre-identified population segments. Additionally, if the organization receives an inquiry from a Plan member not previously identified in the targeted group, it must provide assistance to that member as if he or she had been included on the outreach list.

2. Provide hands-on assistance to the member in completing all necessary applications for financial assistance including submitting the paperwork to the appropriate State office. This assistance can be in the member's home only if the member requests such a visit.

3. Use the "Authorization to Represent" limited to the specific purposes of completing and submitting paperwork on behalf of the member, discussing the member's case with case workers, representing the member in cases of appeal, and gather information from and on behalf of the Plan member. The "Authorization to Represent" form must specify that the authorization is limited to securing benefits under "the Medicare savings program" or "the Medicaid Program" and cannot extend to other programs unless agreed upon and noted by the member. "Authorization to Represent" shall not give the outreach specialist the authority to sign any documents on behalf of the member nor make any enrollment decisions for the member.

4. Follow-up with members who do not respond to the initial member letter. This follow-up may be in the form of a second and/or third letter or telephone calls. If the member does not respond to the third effort, the M+C organization refrain from contacting the member for at least six months following the last outreach attempt.

5. Provide assistance to members reapplying for financial benefits if and when required to do so by the state agency.
6. Subcontract all outreach efforts to another entity or entities. In such cases, while the M+C organization retains all responsibility for meeting CMS's requirements, it must still submit all documentation to CMS for approval including contracts held by the subcontractor with all entities related to the program. The M+C organization must also coordinate changes and revisions between the subcontractor and CMS.

M+C Organizations Shall NOT:

1. Conduct door-to-door solicitation or outreach prior to receiving an invitation from the member to provide assistance in his or her home.
2. Share any member information, financial or otherwise, with any entity not directly involved in the outreach process.
3. Store or use member financial information for any purpose other than the initial screening eligibility, the submission and follow-up of an application for benefits, for recertification purposes, and as required by law.
4. Contact any member who has refused outreach assistance or who has not responded to the telephone call or follow-up letter until at least six months following the last outreach attempt.
5. Infer in any written materials or other contact with the member that the organization has the authority to determine the member's eligibility for state assistance programs.

40.5.3 - Submission Requirements - (Rev. 11, 08-15-02)

To facilitate CMS's review of outreach programs, an M+C organization must submit one copy of the materials listed below to its Central Office Plan Manager, one copy to its Regional Office Plan Manager, *and one electronic copy to the Dual Eligibility Outreach Product Consistency Team (PCT)*[15]*.*

1. Detailed description of each step in the outreach process and the entity responsible for each step. (CMS recommends a flow-chart showing the result of each action.)
2. Timeline showing the proposed dates of outreach activities, the number of members involved in each activity, and the service area (e.g., county) included in the activities. This is to allow CMS to more accurately coordinate outreach activities with its partners (e.g., SHIP, State Agencies).
3. Contracts with all external entities involved in the outreach process. This includes contracts with any subcontractors taking part in the activities.
4. *Supporting documentation from the appropriate State Agency providing specific state income requirements for each savings program level.*
5. Outreach letters and other materials (e.g., brochures) going to plan members.

6. Internal training programs the organization is using to educate staff involved in outreach.
7. Telephone scripts or other outreach assistance scripts that will guide representatives in answering members' questions or discussing the assistance available to them. Such scripts must include a privacy statement clarifying that the member is not required to provide any information to the representative and that the information provided will in no way affect the beneficiary's membership in the plan.
8. Internal plan for protecting the confidentiality of the member's financial or other personal information gathered in the outreach process.

In some instances, an M+C organization may chose to submit an outreach proposal that CMS has already approved for use by another M+C organization. This is common when an M+C organization is part of a national organization with multiple contracts, each of which is conducting its own outreach. This is also common when a subcontracting entity designs and conducts the outreach. These subcontractors often seek to contract with multiple M+C organizations and conduct the same outreach programs for each of their clients.

If an M+C organization submits an outreach proposal that (a) CMS previously approved on or after April 1, 2002; (b) That CMS approved within the twelve months prior to the submission; and (c) That does not contain substantive changes [14] to qualify it as an "initial" proposal, the M+C organization must submit the items listed above (1 - 7) in addition to the following:

9. An attestation from either the M+C organization or its contracted outreach vendor stating (a) That the proposal has been approved by CMS, (b) The date of that approval, and (c) That the new submission does not contain substantive changes to the approved program.

Section 40.5.4 contains a description of CMS's review process and time frames for both initial and previously approved proposals.

40.5.4 - CMS Review/Approval Process - (Rev. 11, 08-15-02)

NOTE: The CMS review process for new outreach proposals differs from the review process or previously approved outreach proposals. The processes for both submissions are stated below.

Reviewing New Outreach Programs

1. The M+C organization is responsible for submitting the outreach proposal to CMS and working with CMS through the review and approval process even if a subcontractor developed the proposal. The CMS will hold the M+C organization fully responsible for all the provisions of the outreach program and for assuring the members of their rights and protections outlined in the M+C program regulations.
2. In that CMS considers outreach materials to be a form of marketing, CMS will review outreach proposals according to current time frames for reviewing marketing material. The agency will conduct its initial review and provide

comments to the M+C organization within 45 days of receipt of a new (not previously approved) proposal.

3. As noted in §40.5.3, M+C organizations must submit one complete copy of the materials listed in §40.5.3 to the CMS Central Office Plan Manager, a second copy of the same materials to the CMS Regional Office Plan Manager, *and an electronic copy of the materials to the Dual Eligibility Outreach (PCT)* [15]*.*

   The Dual Eligibility PCT will review all the enclosed documentation in conjunction with the Plan Managers and will provide comments to the Central and Regional Office Plan Managers. The Regional Office Plan Manager will relay CMS comments back to the M+C organization will gather revisions (when necessary) and will finish the review and approval process based upon the M+C Organization's revisions.

4. The Regional Office Plan Manager will share outreach materials with the appropriate State agency as a way to verify the accuracy of the information contained in the proposal and to receive input from state partners.

5. Upon final approval of the proposal and outreach materials, the Regional Office Plan Manager will send an approval letter to the M+C Organization.

6. The Regional Office will then contact its partners (SHIPs, State Medicaid Offices, etc.) to notify them of the outreach effort and possible increase in beneficiary inquiries. The Regional Office will share copies of outreach letters with the State Agencies to prepare them for incoming questions.

Reviewing Previously Approved Outreach Programs

If an M+C organization submits an outreach proposal that CMS has already approved and that does not contain substantive changes (outlined in §40.5.3), then the CMS Regional Plan Manager will only review the targeted membership information (audience number and outreach dates), the contract(s) between the M+C organization and its outreach subcontractor(s), the updates to benefit levels and income and resource criteria, and the attestation. CMS will respond to the M+C organization within the 10-day time frame CMS has established for reviewing standardized marketing materials. CMS's Regional Office will file the outreach proposal for future reference.

The CMS recognizes that the M+C organization will have to make simple periodic changes to their outreach programs in order to update minimum income levels, etc. As stated previously (*in footnote 14*), CMS does not consider these updates to be "substantive changes" in that they do not prompt a full review of an outreach proposal. However, the M+C organization is still responsible for submitting such changes to the appropriate CMS regional office for marketing review to ensure accuracy of such changes.

If the M+C organization wishes to make substantive changes to the outreach process, it must submit those changes to the appropriate CMS Central Office and Regional Office Plan Managers for review through the PCT according to the review process above.

40.5.5 - Model Direct Mail Letter - (Rev. 11, 08-15-02)

(data valid for 200*2*)

August 25, 2001

Mr. Frank Smith
123 Maple Lane
Anywhere, USA 12345

Dear Mr. Smith,

Did you know you may be able to save up to *$648* a year on Medicare expenses?

There are programs that save millions of people *$54.00* to $600 in their Social Security checks, each year! If you answer "yes" to ALL three of these questions, then you may qualify for Savings for Medicare Beneficiaries.

- Do you have Medicare Part A, also known as hospital insurance? If you are eligible for Medicare Part A, but do not have it because you cannot afford it, you may still qualify because there is a program that will pay the Medicare Part A premium.
- Are you an individual with a monthly income of less than *$1,313* or a couple with a monthly income of less than *$1,762*?
- Are you an individual with savings of $4,000 or less or a couple with savings of $6,000 or less? Savings include things like money in a checking account or savings account, stocks, or bonds. When you are figuring out your savings, do not include your home, a car, burial plots, up to $1,500 for burial expenses, furniture, or $1,500 worth of life insurance.

Enclosed is a brochure that gives you more information about the programs that can help you save on your medical expenses, information on who qualifies, and how to apply for the programs.

I hope you will call me between 9 a.m. and 5 p.m. Monday through Friday at (your phone number here) for more information or for help joining one of these programs. All information that you share will only be used to determine if you may be able to get help with your medical expenses. I will not share the information with anyone else. I encourage you to call to see if you can receive help with your medical expenses, but the choice is yours. You are not required to call. If you like, you can also receive information about the programs by calling a representative of the State Health Insurance Assistance Program at XXX or a State representative at XXXX. Deaf or hearing-impaired people who use a TTY/TDD can call Medicare's national help line at 1-800-486-2048. When you call, ask about programs that can help with Medicare expenses.

50.3 - Answers to Frequently Asked Questions About Promotional Activities (Rev. 9, 04-01-02)

1. **Q**- We purchased books on health maintenance that we plan to give away to anyone attending one of our marketing presentations, regardless of whether or not they enroll in our health plan/M+C organization. Because we purchased a large number of these books, we were able to buy them at a cost of $14.99 per book. However, on the inside jacket, the retail price is shown as $19.99. May we give these books away at our marketing presentation?

   A - No. The retail purchase price of the book is $19.99, which exceeds CMS's definition of nominal value.

2. **Q**- We are participating in a health fair during which we will have marketing staff present. During the fair, we will offer a number of free health screening tests to people who attend. The value of these tests, if purchased, would be considerably more than $15. Is this permissible?

   A - No. You may not offer these tests for free because their value exceeds CMS's definition of nominal value.

3. **Q**- At our health plan/M+C organization, we offer gifts of nominal value to people who call for more information. We then offer additional gifts if they come to marketing events. Each of the gifts meets CMS's definition of nominal value, but taken together, the gifts are more than nominal value. Is this permissible?

   A - Yes.

4. **Q**- Listed below are some possible promotional items to encourage people to attend marketing presentations. Are these types of promotions permissible?

   - Meals
   - Day trips
   - Magazine subscriptions
   - Event tickets
   - Coupon book (total value of discounts is less than $15)

   A - Yes. All these promotional items are permissible as long as they are offered to everyone who attends the event regardless of whether or not they enroll and as long as the gifts are $15 or less. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount.

5. **Q**- Can a health plan/M+C organization advertise eligibility for a raffle or door prize of more than nominal value for those who attend a marketing presentation if the total value of the item is less than $15 per person attending?

   A - No. You cannot have a door prize of more than nominal value. Such gifts or prizes are prohibited by CMS. However, the raffle or door prize can exceed the

$15 limit if the M+C organization is jointly sponsoring the prize with other health plans/M+C organizations at a health fair. See §5.1 for a discussion of rules pertaining to health fairs.

6. **Q**- What about post-enrollment promotional activities? Are there any rules prohibiting such items or activities as coupon books, discounts, event tickets, day trips, or free meals to retain enrollees?

   A - Currently, the Medicare Managed Care Manual states that health plans/M+C organizations may not offer post-enrollment promotional items that in any way compensate beneficiaries for lower utilization of services. Any promotional activities or items offered by health plans/M+C organizations, including those that will be used to encourage retention of members, must be of nominal value, must be offered to all eligible members without discrimination, and must not be in the form of cash or other monetary rebates. The same rules that apply to pre-enrollment promotional activities apply to post-enrollment promotional activities.

7. **Q**- Can health plans/M+C organizations provide incentives to current members to receive preventive care and comply with disease management protocols?

   A - Yes, as long as the incentives are:

   - Offered to current members only;
   - Not used in advertising, marketing, or promotion of the health plan/M+C organization;
   - Provided to promote the delivery of preventive care; and
   - Are not cash or monetary rebates.

   NOTE: If these products are in the CMS approved contracted health plan/M+C organization benefit package (ACR and PBP) under "Preventive Services," the provision of such incentives are within the purview of the medical management philosophy of the M+C organization and do not require additional review by CMS for marketing accuracy/compliance. The nominal value rule **does not** apply.

8. **Q** - Can a health plan/M+C organization offer reductions in premiums or enhanced benefits based on the length of a Medicare beneficiary's membership in the health plan/M+C organization?

   A - No. Longevity of enrollment is not a basis for reductions in premium or enhanced benefits.[18]

9. **Q** - Can a health plan/M+C organization provide discounts to beneficiaries who prepay premiums for periods in excess of 1month?

   A - No. Health plans/M+C organizations can not provide any discounts to Medicare beneficiaries for prepayment of premiums in excess of 1 month.

10. **Q** - Can a health plan/M+C organization take people to a casino or sponsor a bingo night at which the member’s earnings may exceed the $15 nominal value fee?

A - No. The total value of the winnings may not exceed $15 and the winnings **cannot be in cash or an item that may be readily converted to cash**.

11. **Q** - Can M+C organizations send a $1 lottery ticket as a gift to prospective members who request more information?

    A - Offering a $1 lottery ticket to prospective members violates the "no cash or equivalent" rule discussed above, whether or not the person actually wins since, generally, the "unscratched" ticket has a cash value of $1.

12. **Q** - Can M+C organizations pay beneficiaries that sign up to be "ambassadors" a flat fee for transportation?

    A - If the M+C organization employs a beneficiary to be an "ambassador" and travel reimbursement is part of the employment compensation, then CMS has no oversight over this issue. If the beneficiary is not considered an employee, then the M+C organization cannot pay the beneficiary, including reimbursement for transportation.

13. **Q** - Can M+C organizations hold marketing presentations in clinics or hospitals?

    A - Yes, marketing presentations are allowed in clinics, hospitals or physicians offices (or other health care delivery locations) provided that the presentations are held in common areas (i.e., community or recreational rooms) and that patients being treated at the facility are not coerced in to attending.

14. **Q** - Can M+C organizations that own nursing homes conduct health fairs and distribute enrollment forms to nursing home residents?

    A - Yes, M+C organizations that own nursing homes may conduct health fairs and distribute enrollment forms if the sales presentations are confined to a common area (i.e., community or recreational rooms) or if a member volunteered for an individual presentation. Promotional activities and sales presentations cannot be made in individual resident rooms without a prior appointment for a "home" visit. Such activities would be considered door-to-door solicitation and are prohibited. The M+C organization is required to meet all health fair/sales presentation and enrollment requirements as currently outlined in the Marketing Guide and regulations.

15. **Q** - What information should an active member be asked to release to a health plan/M+C organization concerning a potential member lead?

    A - The health plan/M+C organization can ask for referrals from active members, including names and addresses, but cannot request phone numbers. Health plans/M+C organizations can then use this information for soliciting by mail.

16. **Q** - Can physician groups that contract with health plans/M+C organizations hire marketing firms to cold call from non-health plan/M+C organization member listings?

    A - Yes, as long as the marketing guidelines for provider marketing are followed.

60.1.2 - Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations - (Rev. 11, 08-15-02)

M+C organizations can market, either through oral presentations or written materials, Value-Added Items and Services (VAIS). Organizations can also mention VAIS in their newsletters. VAIS may not appear in the Plan Benefit Package (PBP) or the Standardized Summary of Benefits (SB) (including in the M+C organization special features §30 at the end). However, organizations will be permitted to reference their pharmacy discount program in Section 3 of their SB, provided they also include the disclaimers included in this section. In addition, the SB must clearly state (in the location that the program is described) that the discount drug program will be available for the entire contract year.

Any description of VAIS must be preceded by the following prominently displayed language:

1. The products and services described on this page are neither offered nor guaranteed under the M+C organization's contract with the Medicare program, but are made available to all enrollees who are members of [Name of M+C organization].
2. These products and services are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the [Name of M+C organization] grievance process.
3. Should a problem arise with any Value-Added Item or Service, please call [Name of M+C organization] for assistance at [M+C organization customer service number]. Our customer service hours are [Enter hours].

Organizations may include VAIS along with their Annual Notice of Change (ANOC) and Summary of Benefits (SB) in one bound brochure as long as the value-added services are clearly distinct from the ANOC and SB (such as on a different color piece of paper), and the information on value-added services includes all the disclaimers required in this chapter.

Because VAIS does not meet the definition of a benefit under the M+C program, neither the actual costs of the VAIS nor associated administrative costs may appear in the ACR. Furthermore, because they are not contained within the contracted health benefits package, these services are not subject to the Medicare appeals process. VAIS may not be described in Medicare Compare or the "Medicare and You" handbook.

CMS will not require prior approval of materials describing VAIS, since VAIS are not benefits as described within CMS regulations. CMS will review these materials on monitoring visits to ensure compliance with these requirements. CMS may initiate a monitoring visit if it becomes aware that materials have been distributed describing VAIS without the appropriate disclaimers or in violation of the requirements stated herein. CMS will also investigate complaints by beneficiaries regarding VAIS, just as it would other possible violations of CMS requirements.

NOTE: *The proposed changes to the privacy rule may impact the marketing of VAIS. If the proposed changes become effective (mid-year 2003), M+COs may have to request a member's authorization, in writing, prior to marketing*

any VAIS. If a member does not authorize receipt of such marketing, M+COs would have to honor the member's request and not send any VAIS communications without an authorization. M+COs should monitor the privacy rule requirements and consider them before making any marketing material printing decisions.

60.3 – Non-Benefit Providing Third Party Marketing Materials - (Rev. 11, 08-15-02)

CMS does not review marketing materials originated by non-benefit providing third party entities. For the purpose of marketing review, non-benefit providing third party entities are defined as any organizations or individuals that supply information to an M+C organization's membership which is paid for by the M+CO or by themselves. An example of a non-benefit providing third party would be a managed care research firm that provides managed care data relating to managed care organizations.

If a non-benefit providing third party wishes to market to an M+C membership, they must submit their materials to the M+C organization, who in turn, can distribute the materials to their membership. It is the responsibility of the M+C organization to ensure that all non-benefit providing third party marketing materials contain the disclaimer, "Medicare has neither reviewed, nor endorses this information." This disclaimer must be prominently displayed at the bottom center of the first page of the material and must be of the same font size and style as the commercial message.

60.4 - Marketing Material Requirements for Non-English Speaking Populations (QISMC Standard 2.3.3.2) - (Rev. 11, 08-15-02)

Health plans/M+C organizations should make marketing materials available in any language that is the primary language of more than 10 percent of the geographic area. In addition, basic enrollee information should be made available to the visually impaired.

Endnotes

[1] The primary CMS/health plan contractual frame of reference in the Guide is a coordinated care plan contracting under the Medicare + Choice program. Where applicable, alternative language is provided for cost contractors as well as scenarios involving the point-of-service (POS) and Visitor Program features which may be applicable for M+C an/or cost contractors. **Back to Text**

[2] The guidelines throughout this document apply to Medicare + Choice Organizations (M+Cos) as well as Section 1876 of the Act cost contractors unless stated otherwise. Therefore, for ease of review and reference, the term "health plan" is used throughout the document to include requirements specific to both Medicare + Choice Organizations and §1876 cost contractors. **Back to Text**

[3] See §30 of the Chapter for specific application requirements for Outdoor Advertising (ODA.) **Back to Text**.

[4] Under M + C, individuals who are not already member - those that are grandfathered in - must have both Parts A and B of Medicare in order to eligible for enrollment. **Back to Text**.

[5] The health plan/M+C organization must be sure to offer adequate explanation of Medicare card use with out-of-plan utilization that is not an emergency or an urgently-needed service. **Back to Text**

[6] Note to health plan/M+C organization - CMS has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in health plan/M+C organization operations. **Back to text**.

[7] Note to health plan/M+C organization - A member of the health plan/M+C organization may use a superlative in relating their personal experience with the health plan/M+C organization so long as the testimonial is preceded with the phrase "in my opinion" (e.g., "I have been with the health plan/M+C organization for 10 years and in my opinion they have given me the best care possible.") If the member does not preface the superlative statement with the "in my opinion" phrase, the member must substantiate the statement with an acceptable qualifying information source. **Back to text**.

Note 8 has been deleted.

[9] In accordance with the National Marketing Guidelines, this information should be provided in at least 12-point font size. **Back to text**.

[10] M+C organizations may choose to disseminate an errata sheet or addendum during the year to update members with respect to changes in provider's addresses and phone numbers. However, in accordance with 42 CFR 422.111(c), M+C organizations must make a good faith effort to disclose any changes to the provider information upon request and, under 422.111(e), must make a good faith effort to provide written notice at least 30 calendar days before the termination effective date. M+C organizations should consult the M+C regulations for further information. **Back to Text**.

[11] In accordance with the National Marketing Guidelines, the applicable TDD/TTY number must also be provided, including the hours of operation. **Back to text**.

[12]The CMS's monthly capitation rate to an M+C Organization for an M+C member is higher for an enrollee who is a Medicaid recipient because, statistically, the Organization incurs higher medical costs due to higher utilization than that of a non-Medicaid recipient. However, CMS does not pay the Medicaid adjustment factor for QI-1s or QI-2s because CMS created those categories of Medicaid recipients after it established the standard monthly payment upon which it bases all capitation payments. **Back to text**.

[13]Because CMS holds the M+C Organization ultimately responsible for all outreach functions, CMS directs these Guidelines to the M+C Organization. However, if the M+C Organization contracts with another entity for any part of this outreach, the contracting entity must abide by these Guidelines as well. **Back to text.**

[14]CMS considers the following to be examples of substantive changes to an outreach program that would make the proposal and/or attached member materials an "initial" proposal: changes to the steps involved in the outreach process, changes to the language in the outreach letters, revisions to the telephone scripts, changes to the network of

subcontractors participating in the outreach efforts, etc. CMS considers the following to be examples of changes allowable without designating the proposal as "initial": contact telephone numbers, letterhead, mailing dates and targeted member numbers, updates to income and resource criteria and benefit levels as updated by the State. **Back to text.**

[15] Electronic copies of outreach proposals should go to the PCT Lead, Ann Knievel, CMS San Francisco Regional Office, 75 Hawthorne Street, Suite 401, San Francisco, CA 94105, Aknievel@cms.hhs.gov, phone: 415-744-3625, fax: 415-744-3761. reviewing the outreach proposal and member materials. The PCT will, at that point, relinquish its role in the review process. **Back to text.**

[16] Section 1851(e)(3) of the Act and 42 CFR 422.10(b). **Back to text**.

[17] An Enrollment by Mail Forms (EBMF) may be either:

1. A specifically designed enrollment application form which is attached to health plan/M+C organization marketing materials; or
2. A standard health plan/M+C organization enrollment application form with instructions that the form must be mailed back to the health plan M+C organization.

The key feature of the EBMF is that it must be completed by the beneficiary in the absence of health plan/M+C organization marketing influences and returned to the health plan/M+C organization by mail. (Self-addressed, postage paid, return envelopes may be provided by the health plan/M+C organization.). **Back to text**.

[18] This "no" statement also applies to "zero" premium plans that might want to award a nominal value gift as a reward for longevity of enrollment. **Back to text**.