CMS 2013 Medicare Marketing Guidelines Webinar

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Verbatim Transcript:

Good morning and welcome to the CMS 2013 Medicare Marketing Guidelines Training.

We are so glad that you could join us for this important update, especially those of you who had to wake up a little bit early today. The webinar today contains several interactive features that we would like to point out to you before we begin. Please look at the bottom portion of your screen. I would like to draw your attention to the three tabs listed underneath the slide viewer. First, we have a downloading tab. Clicking on this tab will allow you to download items related to this webinar. The next tab is the "ask a question" tab. You can click on this tab any time during the webinar to submit a question or ask for technical support. The third tab and the one furthest to the right is the "answered questions" tab. Click here to see responses to questions asked via the "ask a question" tab. The fourth feature is the "closed captioning window" which appears under the CMS logo. If you are having difficulties seeing the live captioning, this would be a good time to let us know via the "ask a question" tab. You do, however, have the option to display or hide the captions by clicking on the closed captions icon. Finally, we will present several knowledge check questions during the webinar. These questions will appear on your screen just as a sample question and the choices. I will then read the questions and you will then have 10 seconds to enter and submit your response. Let's give this one a try.

We are going to go ahead and bring up the polling questions. I will read the question – what is your favorite color? Is it A. Red? B. Blue? C. Orange? or D. Pink? You simply click in the circle that is your answer choice, and then hit the "submit" button. Go ahead and give that a try. You will have 10 seconds to do this. Oh, and did I mention that you need to pay attention because we will be showing the overall results? At this time we are going to show the results. We have 49% of our viewers chose blue as their favorite color. And then after that the poll will close and this particular screen will go away. Pretty simple, that is all there is to it.

Technical support is immediately available throughout the webinar. You may submit a technical question using the ask a question tab under your slide viewer or you can send an email to our technical team at the email address shown on your screen. We have a number of people dedicated on our end to respond to your needs and your requests.

Your comments are important in meeting the goals and expectations of future webinars. We ask that you take a few minutes, either at the end of the webinar or anytime up until this Friday, June 22nd at 5:00 p.m. Eastern Standard Time to provide us with your feedback. The survey link will be displayed again at the end of the webinar and included in a post webinar email.

We have a number of guides that will lead us through our training today. Your guides today include Chevelle Thomas - Chevelle is a Health Insurance Specialist in Baltimore and has been for thirteen years. He works with the health plans on interpreting medical managed care guidelines. Our next guide is Cindy Fletcher. Cindy is a Health Insurance Specialist from the Kansas City office. She currently works as a caseworker, marketing reviewer, and serves on the consortium training team. Mila Bohaker - Mila is an account manager in the Atlanta Regional Office, and is currently on the marketing PCT as the RO lead. Last year she served a four-month marketing detail in central office. Next we have Jenny Kehm. During Jenny's nine years with CMS, her focus has been serving beneficiaries through education and outreach. She has held a variety of positions in CMS including Marketing Policy Expert. Vashti Whissiel-Wren has been a Health Insurance Specialist for four years and has worked to streamline the 2013 Medicare Marketing Guidelines. And, Tim Hoogerwerf, Tim is a Senior Analyst with the division of plan data where he is responsible for several HPMS modules in functional areas including marketing. A series of four modules will be discussed today. We will kick it off with module 1, guiding principles. Module 2 – key focus areas will follow. Then we will move to module 3, policy clarifications. The last module is HPMS changes. The session will wrap up with final thoughts and questions.

Our training today will begin with the course objectives. By the end of this course you will be able to 1. Identify the 2013 marketing Medicare guidelines; 2. Recognize key focus areas; 3. Comprehend policy clarifications; and 4. Apply the correct procedures to use HPMS. Without further adieu, I would like to introduce to you our first speaker who will kick things off for us with module 1 – guiding principles - Chevelle Thomas, over to you Chevelle.

Thank you Stacey. I would like to begin the training by setting the context in which we've made the changes. As you have noticed by now, significant changes have been made to the guidelines for 2013, compared with previous years. We began a process last Fall where we really looked critically at the guidelines and tried to accomplish several things. One was that we wanted to make sure that the guidelines focused on the marketing requirements in the marketing section of the Medicare regulations of Part B as well as the disclosure requirements section found at 422111 and 423128. We also wanted to eliminate redundancy, consolidate requirements, and be less prescriptive. What we discovered is that the guidelines were becoming so prescriptive that every time a plan sponsor wanted to try something new, they would look to the guidelines for that to be specifically addressed. People are very creative, so it's just not possible to create guidelines that will address every specific example of a type of activity that a plan sponsor might want to do. So, this resulted in over seventy pages being eliminated from the guidelines and as a result there was a trade off, less prescriptiveness meant that we needed to provide more guidance into how plan sponsors should be making their decisions, and so we came up with some guiding principles and we thought they would give you enough information that you could take a common sense approach to developing your activities and your materials. The guiding principles are spelled out in section 10 of the marketing guidelines. The next slide shows the three principles and I will talk about each one of them in a

little more detail. So the first principle is about compliance, and if you recall from previous versions of the guidelines, sprinkled throughout the guidelines we would say phrases like the plan sponsor is responsible for the activities of their agents, the plan sponsor is responsible for activities of their downstream entities or their delegated entities. That principle pretty much is still in place, but we felt like rather than mentioning it over and over again, if we laid out in front that the activities that the plan sponsor are responsible for include things that they delegate or subcontract to other entities. You can see on the slide some of the examples of these other entities that these responsibilities would be delegated to. Not only are we focusing on the delegated entities, but actually the activities that might go on. So this includes marketing events, it includes marketing materials, distribution of materials, collecting or disseminating information. The plan sponsor is the ultimate entity that's responsible for insuring that the guidelines are adhered to, as well as the other regulations and guidance that CMS provides.

The second guiding principle. This is about disclosure, and so as I said before, we were very specific with things that needed to be discussed or needed to be included in materials, and we felt like there is a general perception in the guiding principle that when you're discussing benefits or plan operations or anything related to a plan that you need to disclose the information that's necessary for the bene to understand. So we would consider things like errors, an error or something that is missing from a material, as well as anything that might have purposely been put in to; that wouldn't address the issues that are important to bene for them to make the decision. These are the kinds of things that would fall under this principle. The benes need enough information to make an informed decision. It has to be complete information and sound judgment should be used. So I'll give you a couple of examples just so you kind of get the idea. We have the 5-Star ratings and the 5-Star ratings – you may be talking in the materials at the contract level but you have five plans and three of them aren't 5-Star plans, well an advertisement that just says that our plans are 5-Stars would not provide the beneficiary enough information to know that some of the plans that you offer are not 5-Star plans. So that would be something that would be important to be disclosed in your information related to your plan description. Another example, say you have an agency that does your marketing and they go out and they find beneficiaries, and they sell your plan, and they have an exclusive relationship with your plan or they may have a financial interest in your plan. Those things are important for benes to know so we would expect that in your discussion or in your materials it is clear to the bene that this person is contacting you and they potentially have an interest in one plan over another or whatever the relationship is, it would be important for the bene to understand that this is not necessarily an objective person or organization that is contacting them. The third principle is about documentation, and so documentation includes having systems and processes in place that meet the marketing requirements, but also in addition to that, you need to have oversight of those systems, so it is not sufficient just to say: We have a process that addresses a certain requirement, but you've got to be able to ensure that the process is addressing that requirement effectively and efficiently, and then you need to have it clearly documented, your processes spelled out, your oversight spelled out. Example: Say you have a process by which you do an outbound verification call and it goes through a contractor

and there's a script that is read and there is an automated system that captures the call. It's good to have that system. It's good that you have the documentation of how that system works, but the next step that you need to have is how do we know it is working properly? This comes about from some of our experience in our audits last year. Where we found that some of the outbound verification systems, there were some bugs. For instance, the calls were recorded as completed, but the time frame in which the call happened, it was impossible to complete an OV call in that time frame. So say it takes maybe ten or fifteen minutes to go through the whole script, well the call showed that it was completed in five minutes. So that should be an indicator to the plan sponsor that there might be a problem with their system if calls are being completed in five minutes and you know that the script takes fifteen minutes to go through. Now I will turn it over to Stacey for the first knowledge check.

Thank you Chevelle. It is time for our first knowledge check of the day. Knowledge check number one for module number one. Remember, I will read the question and the answers, the poll will then open, you will have ten seconds to respond. The poll will close and then we will view your results.

1. A field marketing organization (FMO) trains and tests the agents for a given plan. They document their procedures and ensure they are within the MMG. During an audit, the plan does not have the FMO's documentation. Who is responsible for producing the documentation?
   A. The FMO, since they are doing the work and documenting the procedures. Or is it
   B. The plan, since they have delegated the responsibility to the FMO.

Okay, the poll will now open. You will have ten seconds to make your choice. You simply need to click in the circle next to your answer choice, and then you will hit the "submit" button. Your results will show, and it is tell me that no one responded. There we go, much better. Great, 95% of us chose B which was the correct answer. The plan, since they have delegated the responsibility to the FMO. This follows the guiding principle of compliance with CMS' current marketing regulations and guidance, including monitoring and overseeing the activities of the delegated entities. Nice job, the poll is now going to close.

Next we will be discussing module number two, the key focus areas within the 2013 Medicare Marketing Guidelines. Leading us through this module is Cindy Fletcher and Mila Bohaker. Over to you. Thank you Stacey and good morning everybody. As Stacey said, module two discusses focus areas within the Medicare Marketing Guidelines. Section 30.12 of the Medicare Marketing Guidelines discusses plan ratings information from CMS. The plan ratings information documents must be distributed with the enrollment form or the summary of benefits, and must be on the website. Plan sponsors may only reference the contracts individual measures in conjunction with its overall performance rating and marketing materials. The distinction needs to be made between requirements for the document and documents for discussing plan star ratings as a whole. Plans may add their logo to the document. The plans

will be required on a yearly basis to use updated plan ratings information within fifteen days of the release. Not just take steps to update the material. New plans are not required to provide plan ratings information until the next contract year. Plan sponsors' marketing may not reference or include poor performance status information as a means to circumvent enrollment and disenrollment election period rules. Plan sponsors with an overall 5-Star rating have the option to include CMS' gold star icon on marketing materials. CMS will provide the gold star icon to the plan. Plans cannot create materials that imply that all of its contracts achieved this rating. The Multi-Language Insert is not a disclaimer. This insert is something that is new for the 2013 year. It is a document that contains the following sentence that is translated into multiple languages, and here is the sentence: "We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at – and the plan lists the number. Someone who speaks whatever language the person is looking for can help you. This is a free service." Plans must include the Multi-Language Insert with the summary of benefits and the ANOC/EOC. They also have the option to incorporate the insert as a part of these materials, or provide it as a separate document. It is very important that the plans understand that this Multi-Language Insert cannot be modified except to include additional languages, and if additional languages are included or if additional language is included, the statement must be translated. This next slide talks about section 60.2 of the Medicare Marketing Guidelines in regard to health plan ID card requirements. Health plans must have member identification cards. This is new. This applies to MA and cost plans, and CMS will issue health plan ID numbers to all sponsors. The ID card must comply with the most recent version of the work group for electronic interchange or the WEDI, health identification card implementation guide. There are several criteria that must be included on the health identification card, that includes the plan sponsor and the plan website address, the plan sponsor's customer service number, the phrase "Medicare limiting charges apply" and this is on MAPPO or PFFS cards only and must still include the CMS contract and PBP number. And now I would like to turn the presentation over to my colleague, Mila Bohaker.

(Mila) Thank you Cindy and good morning everyone. I will begin by addressing several areas of section 70 of the 2013 Medicare Marketing Guidelines. Beginning with section 70.1 which addresses nominal gifts. Nominal gifts versus promotional activities. Generally, nominal gifts are those used to attract attention of potential enrollees. Generally, promotional activities are those that are designed to attract the attention of prospective members and/or encourage retention of current members. Both of these must adhere to the nominal value, which is an individual item/service worth $15 or less. Plan sponsors must track and document items given to current members. Plan sponsors are not required to track pre-enrollment items on a per-person basis; however, they may not willfully structure pre-enrollment activities with the intent to give people more than $50 per year. For example, a plan can offer beneficiaries a $10 gift card at a promotional activity. However, the plan is not required to track which card was handed to which prospective enrollee. While it is okay for the plan to hand out one $10 card per person, it is not acceptable for the plan to have say a table with $10 gift cards available for ten different

stores by which someone could easily obtain more than the $50 cap. This is an example of willfully structuring an activity in an inappropriate way.

Section 70.3 addresses rewards and incentives. Rewards and incentives may only be offered to your current members for any Medicare-covered preventive service that has a zero dollar cost-share. Examples are screenings, immunizations, welcome to the Medicare visit. The $50 cap no longer applies. Now I want to highlight that the previous guidelines had a list of services and plans could only apply rewards or incentives for the services listed in the MMG. However, the updated MMG expanded guidance to allow rewards and incentives for all zero dollar preventive services. The removal of that $50 cap is only applicable to rewards and incentives, but will still apply to promotional activities. Rewards and incentives items must be offered in connection with the whole service, be offered to all members without discrimination, must have a monetary cap not to exceed $15 per reward item, (which is based on the retail value of that item) they must be tracked and documented during the contract year, and they must comply with all relevant fraud and abuse laws, anti-kickback stature, civil monetary penalty prohibiting inducements to beneficiaries. Additionally, reward items cannot be items that are considered a health benefit~~, for~~, for example, a free checkup. They cannot be items that consist of lowering or waiving co-pays, they must not be offered in the form of cash or other monetary ~~rebates;or~~rebates; or be used to target potential enrollees. For example, they cannot be used in enrollment advertising, marketing or promotion of your plan. They cannot be structured to steer enrollees to particular providers, practitioners or suppliers, and they cannot be tied directly or indirectly to the provision of any other covered item or service.

On this slide, which covers section 70.3, you will see the resources for the most current listing of Medicare covered preventive services that have a zero dollar cost-share. This listing is also included in the current MMG.

Moving on to section 70.8 which addresses outbound enrollment and verification requirements. All plan sponsors must verify enrollments facilitated by independent and employed agents or brokers. Plans must ensure that enrolling beneficiaries understand the plan rules. These calls should be made after the sale and not at the point of sale. Plans may not use an automated calling technology for this call. Plan sponsors must make a minimum of three documented attempts to contact the applicant by phone within fifteen calendar days of receipt of the application. However, the first two attempts must be made within the first ten days. If the enrollment application is incomplete, plan sponsors should concurrently conduct the OEV process while obtaining the missing information needed to complete that application. The visual you see here takes you through that outbound enrollment verification process where you can see that attempts one and two must be made within the first ten days, while the third attempt, if necessary, should still be conducted before fifteen calendar days. Plan sponsors that do not successfully reach the beneficiary on the first or that second attempt must send the applicant an enrollment verification letter in addition to trying to make that third outbound verification call within the fifteen day time frame. As you can see here that enrollment verification letter can go

out either after the first attempt or after the second attempt. New guidance allows plans to send after the first or second telephonic attempt.

I will move on now to section 90.2 of the new 2013 MMG which addresses submission for websites for CMS review. Websites are available for public use during the CMS review period. If any portion of the website is disapproved, the plan sponsor must remove the disapproved portion immediately. Submission through HPMS will be required through links through the website and not through screen shots or text documents. Guidance has been consolidated for website requirements. Reviewers and plan sponsors will note that CMS removed Appendix one, but included all of those elements into section 100 of the current MMG. There is a clear section on general website requirements and there is another section dedicated to the required content of said websites. Plan sponsors are allowed to use social/electronic media such as Facebook and Twitter. These tools are considered marketing materials and are as such subject to these guidelines.

Section 120.2 addresses the plan reporting of terminated agents. When a plan sponsor discovers incidents of an unlicensed agents or brokers submitting applications, they must terminate that agent or broker, report them to the authority in the state which the application was submitted, and notify beneficiaries enrolled by the unqualified agent to advise of that agent's status. Plan sponsors are also required to report the reason for the termination. Beneficiaries affected by this may request to make a plan change. Plan sponsors must notify CMS annually whether they intend to use independent agents or brokers for the upcoming plan year and the amounts they will pay them. Plan sponsors must pay independent agents/brokers an amount that is at or below the adjusted fair market value cut off amounts released each spring by CMS. This is known as a compensation structure. However, employed agents are still exempt. And now I will pass it back to Stacey for the knowledge check portion of module two.

Thank you Mila. Module two has a number of module checks. I hope you were paying attention. Knowledge check one: A plan sponsor offers five Medicare plans. Of those, three are 5-Star plans. In an advertisement in a local newspaper, the plan sponsor highlights its 5-Star rating and lists all five plans underneath the 5-Star rating. Upon review by CMS the account manager is notified. What do you think was CMS' concern?

A. The appropriate disclaimers were missing.
B. There is no mention of the 5-Star SEP.
C. Beneficiaries do not know which plans are the 5-Star plans.

The poll will now open. You will have ten seconds to make your choice. Simply click in the circle next to your answer choice and then go ahead and click the "submit" button. All right. Let's view your results and see how you did. The correct answer was C and 92% of you chose correctly. The beneficiaries do not know which plans are the 5-Star plans. This screen will go ahead and close and we will move on to our next knowledge check, knowledge check number

two. This is a multiple choice question and it reads: Which of the following elements must be on the health plan ID card? Is it

A. The social security number and the Healthcare Insurance Claim Number (HICN),

B. CMS contract number and PBP number,

C. Customer Service Number and plan website,

D. Choice A and C, or

E. Choice B and C.

We tried to give you lots of choices here. Okay, the poll will go ahead and open. You will have ten seconds to make your choice by clicking in the circle and then hit the "submit" button. All right, let's see how you chose this time. All right, wonderful, 87% of you chose E, which is B and C, the CMS contract number and the PBP number and the customer service number and plan website. Nice job. Okay, this screen will close and we will move on to knowledge check number three. Knowledge check number three is a true/false question. Plans can offer rewards and incentives for any of their covered services. Is that A. True or B. False? You will have your ten seconds to choose either A or B, true or false, by clicking the circle and then simply hit the "submit" button. Since there's only two choices here we will go ahead and look at the results. The answer is B, False. Plans can only offer rewards and incentives for zero dollar Medicare preventive services. All right, we are half way through the knowledge checks for module number two. The screen is going to close and we will move on to number four. Number four is a true/false. In the summary of benefits in the ANOC/EOC documents are sent separately to beneficiaries, then the Multi-Language Insert must be sent with each document. Is that A. true, or is that B. false? The poll is now going to open. You have ten seconds to make your selection and then hit the "submit" button. We will review your results. And the correct answer was A. true. It seems 90% of us chose A. true, very good. Moving on to knowledge check number five. This screen will now close and we will be taking a look at a multiple choice question. The standardized plan ratings information document must be included with which of the following media distributions?

A. Enrollment form distribution?
B. Summary of benefits distribution?
C. Plan websites?
D. All of the above.

The poll will now open. You will have ten seconds to make your choice. Click the circle and hit the "submit" button and we will then view your results. Let's see how we did this time. The answer is D. All of the Above, and 88% of us chose that which includes the enrollment form, summary of benefits distribution, and plan websites. The screen will now close and we are now going to move on to the last knowledge check for module number two, which is knowledge choice number six which is another multiple choice.

How many outbound enrollment verification calls should be made in the first ten days? I think they have that underlined because they want us to pay attention. Is it:

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

The poll is now open. Please choose your selection and hit the "submit" button. Paying attention to the first ten days. Let's view the results and see how we did. Very good, the answer was C; two calls need to be made within the first ten days. Okay, that screen is going to close.

Leading us through module number three which is 2013 Medicare Marketing Guidelines policy clarifications, we have Jenny Kehm and Vashti Whissiel-Wren, so Jenny, over to you. Thank you Stacey. Happy Wednesday everyone. Module three is really going to focus on policy clarifications. I'm going to start out with slide #47, materials not subject to review. You can see here that we have added new items to the list of materials not subject for review. They now include ad-hoc enrollee communication materials, OMB forms, VAIS materials, and mid-year enrollee notification as those not subject to review. This means that these materials should not be uploaded in HPMS and they do not require a unique material ID on them. It is important to note that plan sponsors are still responsible for tracking and maintaining these materials, and if CMS should request them, you must make them available upon CMS request. One thing I did want to point out is that we have gotten a lot of questions as to why there continues to be an ad-hoc enrollee communication submission code in HPMS if this is now a material not subject to review. We are in the process of updating these submission codes, and so within the next few weeks this code will actually be removed or retired from HPMS. For a complete list of materials not subject to review, I encourage you to visit section 20 of the marketing guidelines. The next slide here is slide 48 and this is related to required materials with an enrollment form. You can see here that when an enrollment form is distributed, the plan must also give the beneficiary the plan ratings document, which is commonly referred to as the star ratings document, a summary of benefits, and the Multi-Language Insert. It is important to note that these are really minimum requirements and plans may distribute additional information within their enrollment packets. One of the things that you may have noticed is that the term "enrollment kit" was removed from the MMG, and this was actually very intentional. CMS does not require or define criteria for an enrollment kit. What we do is specify that certain materials must be distributed with an enrollment form. But again, plans may have their own enrollment packets that they want to put together, and they can include additional information in those packets provided the criteria here on the screen are also included. So continuing with required materials with an enrollment form, this is really an expansion on the last slide that indicates for online enrollments materials must be made prior to the completion and submission of the enrollment request. So in other words,

you must make these materials available prior to someone accessing the online enrollment form.

Our next slide here is required materials for new and renewing members at time of enrollment and thereafter. As the slide indicates, the following materials must be provided at the time of enrollment. So we have the annual notice of change/evidence of coverage which you commonly hear referred to as the ANOC/EOC. You have the comprehensive formulary or abridged formulary, pharmacy directory, provider directory as applicable, and membership identification card. So one of the changes you may have noticed is that the header of this section was updated to read “At the time of enrollment and thereafter” as opposed to “annually thereafter” and this section was updated to reflect n fact that not all of these documents are required to be sent yearly. So that is a change from previous guidance where the materials on the screen used to have to be sent to a member on an annual basis. That is not the case anymore, and my colleague, Vashti, will spend a little more time discussing relevant time frames for applicable documents in later slides. Our next slide here is mailing materials to addresses with multiple members. This is new guidance that expands on mailing requirements and provides an option for plan sponsors to mail one packet of information to multiple members with the same address. So previously you may recall that this guidance was only applicable to directories, and based on the public comments, CMS now allows one version of ANOC/EOC, formulary and directory documents to be mailed to members with multiple addresses. So if a plan chooses this option they must include all names of the members either on the envelope, or list one name on the envelope and include all other names on say a cover letter that accompanies the mailing. So what does multiple addresses mean? So we do clarify individuals in apartment buildings are only considered to be at the same address if the apartment number is the same. So I mean I think that is pretty clear, but if you have an apartment building where the address is the same but there are 200 different members living in this apartment building, you cannot send one to the front desk and then say make sure that everybody in the following apartments gets this information. It also clarifies that individuals living in community residencies such as group homes must each receive their own materials, and we further clarify that all members must receive their own ID cards. So in other words, you cannot send one ID card to a husband and wife team and say just make sure whoever is going to the doctor that day has the ID card in their wallet. Each person or each member must receive their own ID card.

Our next slide here is specific to the marketing material identification number. This updated guidance clarifies the requirements for the material ID. It now states that the material ID is made up of two parts. The first being the plan’s contract number, and the second being a series of alpha numeric characters chosen by the plan. You will notice that one of the changes in this section is that the date was removed as part of the material ID. This was, again, in response to public comments and we wanted to clarify that plans have the option but are not required to include the date on materials. And that is one of the questions that came in repeatedly, that we were asked to address during the industry training. So I do want to repeat it again just to make sure you guys hear it. Plans have the option, but they’re not required to include the date on

materials as part of the material ID. The other clarification we wanted to provide is that if your material ID or your material already has a date on it, that's ok. You are not required to resubmit those materials. You are not required to remove the date from it. It's again, ok, that the date is on the materials, it is just no longer required. All right, continuing with some material marketing identification, this slide really serves as a reminder that all marketing materials must have a material ID number. We do have a few exceptions, those being the member ID card, envelopes, radio advertisements, outdoor advertisements, banner or banner-like ads, or social medial comments or posts. I also wanted to take this opportunity to remind everyone that OMB forms and ad hoc enrollee communications are materials no longer subject to CMS review and they don't need a material ID. But again, if you have these materials and they are out in the marketplace and there are no updates to the models themselves in the case of OMB forms, you do not need to rein all of those back in and take the material ID off and redistribute them to everyone. They are ok as is, in the marketplace, with the material ID number. It's just that moving forward as OMB forms are updated, plans are no longer required to submit those OMB forms in HPMS and include a material ID on them.

Okay, the next slide here is providing materials in different media types. So CMS does allow plan sponsors to provide materials in alternate media. So for example, electronic or portable media like email, CDs or DVDs, these are all acceptable formats. If a plan sponsor chooses to exercise this option, they must receive beneficiary consent prior to providing material in this format. So in other words, a beneficiary must opt in to receiving materials in this format, not opt out. So I want to give an example in hopes to clarify this. So if your plan wanted to send the beneficiary a letter saying check here if you want to start receiving your EOC via email and stop receiving it via hard copy, no problem. A beneficiary checks and says email sounds good to me, so they send that back in, you've documented that, so moving forward you can go ahead and send the EOC electronically and you do not have to send a hard copy of that. What you can't do though is send the beneficiary a letter saying that going forward you will no longer receive a hard copy of the EOC unless you request it, so check here if you want to receive future copies in the mail, otherwise we are just going to start sending these electronically. That is not appropriate. And when requesting consent, the plan must specify to the beneficiary the media type, so again, email for example, and the documents to be sent. My next and final slide is related to the hours of operation requirements for marketing materials. So hours of operation must be listed on every material where a customer service number is provided for current and prospective enrollees to call. A subtle but extremely important change from last is that the plan sponsors are no longer required to include the hours of operation every time they list a phone number. You now must include the hours of operation one time on a material where a phone number is given. So for example, if you say have a direct mail flyer and in that flyer you list your customer service phone number four different times, you only must include the hours of operation one time when you list the phone number, and the remaining three you are not required to include it. If you choose to include it, that's great and that's your choice, but you're only required to include it once. So the reason for this change is what we found is that listing it every time was really a disruption in the reading process and broke up the flow of the message

and were hopeful that this change will enhance the end user experience for those who read marketing materials, and in particular, the beneficiary. So that completes my portion. I'd now like to turn it over to my colleague, Vashti Whissiel-Wren, who will begin discussing section 50 – disclaimers.

Thanks Jenny, good morning everyone. Like Jenny said I'm going to continue with section 50 of the guidelines – disclaimers. So in the past marketing materials have been grouped into two categories, explanatory marketing materials and advertising. Depending on how these materials were used, a particular disclaimer was required to be on that document. We have found over time that the term explanatory marketing materials was getting too broad and could at times seep into advertising and because of that, sometimes it made it unclear as to which disclaimer was required on that material. So new for this year we have eliminated the term explanatory marketing materials from the guidelines and rather than focusing on the type of material, we decided to focus on the audience. Thus you can see here on this slide that we are grouping materials into two distinct categories: materials directed to potential enrollees; an example of this would be a direct mail piece advertising plan options for an upcoming year, and communications to existing enrollees. An example would be the plan ANOC or another operational type communications. In addition, we have clarified in the guidance that, unless otherwise noted on a specific disclaimer, all disclaimers are required on all materials created by the plan. Also, some disclaimers were updated to incorporate plain language principles. As you can see in this example, the old version of the disclaimer when benefits is mentioned says that the benefit information provided herein is a brief summary not a comprehensive description of benefits, which really isn't beneficiary friendly. The new version says the benefit information provided is a brief summary, not a complete description of the benefits which we find is a little more beneficiary friendly and really incorporates the plain language principles that are out there. In addition, we have done an overall assessment of the disclaimers listed in section 50 and really took a hard look at all of the disclaimers listed. We took a look to sort of see who the disclaimers really are directed to and that really is our beneficiaries. Over the years we found that we kept adding disclaimers and we've never really revisited them. So you will see this year that some of the disclaimers have been modified or condensed. For example, the private fee for service disclaimer went from being a very long paragraph to just one sentence. And we just really want to point out that plan sponsors are not required to resubmit existing materials to make changes to disclaimers.

The next step is section 60.4 – directories. New this year, plan sponsors may send out provider and pharmacy directories every three years without using change pages. In the past, if a plan sponsor wanted to send out their provider or pharmacy directory every three years, they were required to send change pages to their members with all of the network changes within the past year. We have eliminated that requirement. Plan sponsors are still required to send provider and pharmacy directories to new enrollees, make it available upon request and post their most current version to their website and make it available at all times. We also want to point out that we recognize that in section 60.4.1 it makes references to change pages, but the guidance in

60.4 is correct, the annual mailing and change pages are no longer required. Continuing with 60.4 – directories, updates to the directories. Plan sponsors must still provide written notice to effected members when their primary providers or pharmacies terminate with or without cause. These terms have not changed, the plans still must contact effected members at least thirty days before the termination is effective. CMS does still retain the right to require the plan to notify members and print new directories when there is a significant change to plan sponsors, provider/pharmacy network outside the three-year window mentioned previously and we may require you do a special mailing in addition to that. We also have given plan sponsors latitude in determining if there is a significant change on your own and the need for an additional update to your directory.

Next is 60.7, annual notice of change ANOC and evidence of coverage. Except as described below, all members must get their ANOC/EOCs by September 30th of each year. Dual SNPs have a couple of options, first they can send their ANOC with an SB for receipt by September 30th and then you need to send the EOC for receipt by December 30th or they can send a combined ANOC/EOC for receipt by September 30th and then you don't have to send an FB. Cost plans without part D have to send the ANOC/EOC for receipt by December 1st. Cost plans with part D have to send their ANOC/EOC for receipt by September 30th. Employer group plans must send the ANOC/EOC for receipt no later than 15 days before the employer union open enrollment period. New this year, the options listed above under D SNPs were limited to FY D SNPs this year but were expanded to all dual SNPs this year. Also new this year, all EOCs are to be submitted filing use. In the past some were submitted for review but this year we have expanded to all EOCs submitted filing use.

Next is 70.9, educational events. Just like last year educational events are primarily designed to inform beneficiaries of Medicare, Medicare advantage prescription drug programs in general or other health related topics. They are not designed to steer or entice beneficiaries to enroll in a particular plan. Plan sponsors can't distribute marketing materials or collect applications at educational events, but new this year plan sponsors may hold member only events to discuss benefit information. Some common examples of this type of meeting are new member orientations or meetings to discuss plan changes for the upcoming year. We want to be clear that plan sponsors are not allowed to conduct enrollment or sales activities at these member only events. You can't collect or distribute enrollment applications. In addition, when you are advertising for these events you need to make sure that you make reasonable efforts to target only members. For example, you should be sending invitations only to direct members not advertising these events through an ad in the newspaper for example.

Next is 70.10.1 – notifying CMS of scheduled marketing events. Previously HPMS did not allow a plan to cancel an event in the system up to the day of an event. As such, plans were required to notify their regional office account manager of any cancellations. HPMS was recently updated and enhanced to allow plans the ability to cancel an event in the system up to the same day of the event. As such we want to clarify that plan sponsors need to only notify their CMS

account manager if for some reason they are unable to cancel the event in HPMS. We recognize the guidance in 70.10.1 says that the plan sponsor should notify their CMS account manager and cancel the event in HPMS, but again, we want to clarify that our expectation is that the plan sponsors should only be notifying their CMS account manager if for some reason they are unable to cancel the event in HPMS themselves.

And my final slide is 80.1 – customer service call center requirements. We have updated the requirements in the guidance to better coincide with the annual enrollment/disenrollment periods. From October 1st through February 14th plan sponsors must have live customer service representatives available seven days a week from 8 a.m. to 8 p.m. in the time zones for the regions in which they operate. Plans may use alternative technologies on Thanksgiving and Christmas Day. From February 14th through September 30th plan sponsors must have live customer service representatives Monday through Friday available from 8 am to 8 p.m. according to the time zones for the regions in which they operate. Plans may use alternative technologies Saturday, Sunday and on federal holidays. In addition we added the requirement that plans must inform customers that call in that interpreter services are available for free. As a reminder, if the only changes to the materials are they need to update the hours of operation, you don't need to resubmit materials to HPMS.

So that wraps up module three. Back to you, Stacey, for the knowledge checks. Thanks.

Thank you Vashti. Moving right along for the knowledge checks for module three. There are two questions in this section. We've given you a little break here since we had so many questions in module two. The first question is multiple choice:

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

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

The poll is now going to open. Please go ahead and select your answer choice and then hit the "submit" button. We will then review the results and see how you did this time. And it looks like 97% of us chose correctly, which is D. All of the above. Must provide the plan ratings information, summary of benefits and Multi-Language Insert. Great. That screen is going to close and we will move on to knowledge check number two in module three which is a true/false question.

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

A. True

B. False

The poll will now open and you will have ten seconds to make your choice. Click next to A, true or B, false and then go ahead and click the submit button. We will now view the results of your selection, and 77% of us chose the correct answer which was A-true. Very nice job.

Our last module today is module 4 – HPMS updates. This module will be led by Tim Hoogerwerf. And I will turn it over to you now Tim.

Hi. Thank you Stacey. I will be going over an explanation of the changes that were released in the HPMS marketing module maintenance release. This release happened on the 6th of June and those of you who receive HPMS emails probably would have gotten an HPMS email on or around the 15th describing some of this functionality, but we will be going though at a high level some of the updates. Some of the general updates in the update were number one that the marketing material extract will have several new fields in the extract. It will have whether it is an errata material, the disapproval reason, comments and a populated template material ID if it exists, as well as an indication of whether the material was of an errata material type. The second general update is that materials submitted for the code 1127, which is the combined ANOC/EOC document, become accepted the same day as submitted and can be distributed immediately. What this means as well, is that the actual mail date and the number of beneficiaries entries for the 1127 submissions that you make can be entered the day that the 1127 is submitted into the HPMS. The third one, organization material listing report now contains totals and this was a recommendation from industry that they would like to see totals on that report. Of course, the HPMS user guide update. The HPMS user guide was updated as it is with each major release and it describes in detail all of the changes made, particularly if you were to look at the beginning of the document, it actually has an overview of the updates. And all functionality is described in the guide with screen prints.

One additional item I would just like to mention that is not on the screen is that the HPMS module was updated to accept the receipt of financial alignment demo materials once those organizations come online. We will now move on to the next slide and I will walk through just a couple other updates that we made. For those of you who do self monitoring of the filing use 10% report, as you know you have a report in the HPMS that allows you to see the data for your filing use and non-filing use submissions. One update that we have made this year is that the report is now drillable. So in the past we would describe – we would give you a number of those materials eligible for filing use and then the number of materials that were eligible for filing use but didn't require a manual review, and it was not possible to drill on those numbers to actually see the material IDs that constituted them. So this year you can now go in and drill on those numbers and it will show you the material IDs so that you can do further research. The next slide has to do with marketing sales event updates. Several new fields are now required. Several additional new fields are now required when submitting marketing material, marketing sales events. This applies for both single contract submissions, multi-contract entity

submissions, and it also applies if you are entering your sales events either via the HPMS interface or doing the sales event upload functionality. And very quickly I will just describe that these new fields are presentation language, event type, facility type, representative agent, national producer number, and representative agent name. Again, that is presentation language, event type, facility type, representative agent, national producer number and representative agent name. All of these fields as well as the values for each of these fields are available in the read me file that is available in the module. Moving on to the next slide now – the marketing material look up page. This is another one of those updates that we made in response to organization users. As you know, in the marketing module we have a marketing material look up page, and on the page it describes all of the attributes for marketing materials and it also lists active and retired codes. So this year with the release, we've updated this function in the system so that you actually drill, in other words click on the column headers, and it will report the results based on the column header that you have selected.

Additionally the report, the default sorting of the report will list all active codes first and then you would see the retired codes after that. Additionally, related to this, I would recommend if you are ever interested in the attributes of a specific material, to use this look up as a resource to know what the material attributes are. In other words, if you wanted to know if the material is file and use eligible, or if material has a model available, et cetera, this is a very good resource for you to use to get that information. And finally, we have updated the agent/broker compensation functionality within the HPMS marketing module to reflect the changes in the CMS operational guidance. So we have modified the low and high value. Obviously, requirements based on the current thresholds. And additionally, as in the past, we have required the indication of whether or not independent agents and brokers were used, and then of course you would put your compensation amount for independent agents and brokers. Additional fields this year are an indication of whether or not you used captive, employed, of course independent returns from last year. And additionally, if you do pay referral fees, and if you do pay referral fees, you can put in the amount of that referral fee.

One other thing that I have actually had several questions about is the ability of CMS, upon request, to unattest or in other words remove the attestations to the agent/broker broker compilation. I want you to know that CMS will not be unattesting to any agent/broker compensation without the request of the organization. This functionality essentially, if the organization has submitted their agent/broker compensation information into the HPMS and then you realize you may have made a mistake in data entry or you need to make a change. As you know once the attestation is processed you are locked out of being able to do any of the updates. What this would allow is for you to contact your CMS marketing reviewer or account manager and they can get you in contact with the process to have just the attestation taken out of the page so that you can go in and do modifications as needed. And then of course you would have the ability to reattest. That is all that I have and I will be turning it back over to Stacey now. Thank you very much.

Thank you Tim. Next I am going to turn it over to Chevelle Thomas who will facilitate the question and answer portion of today's webinar. Chevelle, over to you.

(Q&A started)