

(d) *Review panel.* If the Board grants a request for review of the ALJ's decision, the review will be conducted by a panel of three members of the Board, designated by the Chair or Deputy Chair.

§ 422.1080 Procedures before the Departmental Appeals Board on review.

The parties are given, upon request, a reasonable opportunity to file briefs or other written statements as to fact and law, and to appear before the Departmental Appeals Board to present evidence or oral arguments. Copies of any brief or other written statement must be sent in accordance with 422.1016.

§ 422.1082 Evidence admissible on review.

(a) The Departmental Appeals Board may admit evidence into the record in addition to the evidence introduced at the ALJ hearing, (or the documents considered by the ALJ if the hearing was waived), if the Board considers that the additional evidence is relevant and material to an issue before it.

(b) If it appears to the Board that additional relevant evidence is available, the Board will require that it be produced.

(c) Before additional evidence is admitted into the record—

(1) Notice is mailed to the parties (unless they have waived notice) stating that evidence will be received regarding specified issues; and

(2) The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues.

(d) If additional evidence is presented orally to the Board, a transcript is prepared and made available to any party upon request.

§ 422.1084 Decision or remand by the Departmental Appeals Board.

(a) When the Departmental Appeals Board reviews an ALJ's decision or order of dismissal, or receives a case remanded by a court, the Board may either issue a decision or remand the case to an ALJ for a hearing and decision or a recommended decision for final decision by the Board.

(b) In a remanded case, the ALJ initiates additional proceedings and takes other actions as directed by the Board in its order of remand, and may take other action not inconsistent with that order.

(c) Upon completion of all action called for by the remand order and any other consistent action, the ALJ promptly makes a decision or, as specified by the Board, certifies the case to the Board with a recommended decision.

(d) The parties have 20 calendar days from the date of a notice of a recommended decision to submit to the Board any exception, objection, or comment on the findings of fact, conclusions of law, and recommended decision.

(e) After the 20-calendar day period, the Board issues its decision adopting, modifying or rejecting the ALJ's recommended decision.

(f) If the Board does not remand the case to an ALJ, the following rules apply:

(1) The Board's decision—

(i) Is based upon the evidence in the hearing record and any further evidence that the Board receives during its review;

(ii) Is in writing and contains separate numbered findings of fact and conclusions of law; and

(iii) May modify, affirm, or reverse the ALJ's decision.

(2) A copy of the Board's decision is mailed to each party.

§ 422.1086 Effect of Departmental Appeals Board Decision.

(a) *General rule.* The Board's decision is binding unless—

(1) The affected party has a right to judicial review and timely files a civil action in a United States District Court or, in the case of a civil money penalty, in a United States Court of Appeals; or

(2) The Board reopens and revises its decision in accordance with 422.862.

(b) *Right to judicial review.* Section 422.1006 specifies the circumstances under which an affected party has a right to seek judicial review.

(c) *Special Rules:* Civil Money Penalty—Finality of Board's decision.

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When CMS imposes a civil money penalty, notice of the Board's decision (or denial of review) is the final administrative action that initiates the 60-day period for seeking judicial review.

§ 422.1088 Extension of time for seeking judicial review.

(a) Any affected party that is dissatisfied with a Departmental Appeals Board decision and is entitled to judicial review must commence civil action within 60 calendar days from receipt of the notice of the Board's decision, unless the Board extends the time in accordance with paragraph (c) of this section.

(b) The request for extension must be filed in writing with the Board before the 60-calendar day period ends.

(c) For good cause shown, the Board may extend the time for commencing civil action.

§ 422.1090 Basis, timing, and authority for reopening an Administrative Law Judge or Board decision.

(a) *Basis and timing for reopening.* An ALJ of Departmental Appeals Board decision may be reopened, within 60 calendar days from the date of the notice of decision, upon the motion of the ALJ or the Board or upon the petition of either party to the hearing.

(b) *Authority to reopen.* (1) A decision of the Departmental Appeals Board may be reopened only by the Departmental Appeals Board.

(2) A decision of an ALJ may be reopened by that ALJ, by another ALJ if that one is not available, or by the Departmental Appeals Board. For purposes of this paragraph, an ALJ is considered to be unavailable if the ALJ has died, terminated employment, or been transferred to another duty station, is on leave of absence, or is unable to conduct a hearing because of illness.

§ 422.1092 Revision of reopened decision.

(a) *Revision based on new evidence.* If a reopened decision is to be revised on the basis of new evidence that was not included in the record of that decision, the ALJ or the Departmental Appeals Board—

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(1) Notifies the parties of the proposed revision; and

(2) Unless the parties waive their right to hearing or appearance—

(i) Grants a hearing in the case of an ALJ revision; and

(ii) Grants opportunity to appear in the case of a Board revision.

(b) *Basis for revised decision and right to review.* (1) If a revised decision is necessary, the ALJ or the Departmental Appeals Board, as appropriate, renders it on the basis of the entire record.

(2) If the decision is revised by an ALJ, the Departmental Appeals Board may review that revised decision at the request of either party or on its own motion.

§ 422.1094 Notice and effect of revised decision.

(a) *Notice.* The notice mailed to the parties states the basis or reason for the revised decision and informs them of their right to Departmental Appeals Board review of an ALJ revised decision, or to judicial review of a Board reviewed decision.

(b) *Effect—*(1) *ALJ revised decision.* An ALJ revised decision is binding unless it is reviewed by the Departmental Appeals Board.

(2) *Departmental Appeals Board revised decision.* A Board revised decision is binding unless a party files a civil action in a district court of the United States within the time frames specified in 423.1088.

[72 FR 68726, Dec. 5, 2007, as amended at 85 FR 72909, Nov. 16, 2020]

Subpart U [Reserved]

Subpart V—Medicare Advantage Communication Requirements

SOURCE: 73 FR 54220, Sept. 18, 2008, unless otherwise noted.

§ 422.2260 Definitions.

The definitions in this section apply for this subpart unless the context indicates otherwise.

Advertisement (Ad) means a read, written, visual, oral, watched, or heard

bid for, or call to attention. Advertisements can be considered communications or marketing based on the intent and content of the message.

Alternate format means a format used to convey information to individuals with visual, speech, physical, hearing, and intellectual disabilities (for example, braille, large print, audio).

Banner means a type of advertisement feature typically used in television ads that is intended to be brief, and flashes limited information across a screen for the sole purpose of enticing a prospective enrollee to contact the MA plan (for example, obtain more information) or to alert the viewer that information is forthcoming.

Banner-like advertisement is an advertisement that uses a banner-like feature, that is typically found in some media other than television (for example, outdoors and on the internet).

Communications means activities and use of materials created or administered by the MA organization or any downstream entity to provide information to current and prospective enrollees. Marketing is a subset of communications.

Marketing means communications materials and activities that meet both the following standards for intent and content:

(1) Intended, as determined under paragraph (1)(ii) of this definition, to do any of the following:

(i)(A) Draw a beneficiary's attention to a MA plan or plans.

(B) Influence a beneficiary's decision-making process when making a MA plan selection.

(C) Influence a beneficiary's decision to stay enrolled in a plan (that is, retention-based marketing).

(ii) In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience of the activity or material, other information communicated by the activity or material, timing, and other context of the activity or material and is not limited to the MA organization's stated intent.

(2) Include or address content regarding any of the following:

(i) The plan's benefits, benefits structure, premiums, or cost sharing.

(ii) Measuring or ranking standards (for example, Star Ratings or plan comparisons).

(iii) Rewards and incentives as defined under § 422.134(a).

Outdoor advertising (ODA) means outdoor material intended to capture the attention of a passing audience (for example, billboards, signs attached to transportation vehicles). ODA may be communications or marketing material.

Third-party marketing organization (TPMO) means organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under § 422.2, but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR.

[86 FR 6103, Jan. 19, 2021, as amended at 87 FR 27898, May 9, 2022]

§ 422.2261 Submission, review, and distribution of materials.

(a) *General requirements.* MA organizations must submit all marketing materials, all election forms, and certain designated communications materials for CMS review.

(1) The Health Plan Management System (HPMS) Marketing Module is the primary system of record for the collection, review, and storage of materials that must be submitted for review.

(2) Materials must be submitted to the HPMS Marketing Module by the MA organization or, where materials have been developed by a Third Party Marketing Organization for multiple MA organizations or plans, by a Third Party Marketing Organization with prior review of each MA organization on whose behalf the materials were created or will be used.

(b) *CMS review of marketing materials and election forms.* MA organizations may not distribute or otherwise make available any marketing materials or election forms unless one of the following occurs:

(1) CMS has reviewed and approved the material.

(2) The material has been deemed approved; that is, CMS has not rendered a disposition for the material within 45 days (or 10 days if using CMS model or standardized marketing materials as outlined in § 422.2267(e) of this chapter) of submission to CMS; or

(3) The material has been accepted under File and Use, as follows:

(i) The MA organization may distribute certain types of marketing materials, designated by CMS based on the material's content, audience, and intended use, as they apply to potential risk to the beneficiary, 5 days following the submission.

(ii) The MA organization must certify that the material meets all applicable CMS communications and marketing requirements in §§ 422.2260 through 422.2267.

(c) *CMS review of non-marketing communications materials.* CMS does not require submission, or submission and approval, of communications materials prior to use, other than the following exceptions.

(1) Certain designated communications materials that are critical to beneficiaries understanding or accessing their benefits (for example, the Evidence of Coverage (EOC)).

(2) Communications materials that, based on feedback such as complaints or data gathered through reviews, warrant additional oversight as determined by CMS, to ensure the information being received by beneficiaries is accurate.

(d) *Standards for CMS review.* CMS reviews materials to ensure the following:

(1) Compliance with all applicable requirements under §§ 422.2260 through 422.2267.

(2) Benefit and cost information is an accurate reflection of what is contained in the MA organization's bid.

(3) CMS may determine, upon review of such materials, that the materials must be modified, or may no longer be used.

[86 FR 6104, Jan. 19, 2021, as amended at 88 FR 22335, Apr. 12, 2023]

§ 422.2262 General communications materials and activities requirements.

MA organizations may not mislead, confuse, or provide materially inaccurate information to current or potential enrollees.

(a) *General rules.* MA organizations must ensure their statements and the terminology used in communications activities and materials adhere to the following requirements:

(1) MA organizations may not do any of the following:

(i) Provide information that is inaccurate or misleading.

(ii) Use of superlatives, unless sources of documentation or data supportive of the superlative is also referenced in the material. Such supportive documentation or data must reflect data, reports, studies, or other documentation that applies to the current or prior contract year.

(A) Including data older than the prior contract year is permitted provided the current and prior contract year data are specifically identified.

(B) [Reserved]

(iii) Engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the MA organization.

(iv) Engage in any discriminatory activity such as attempting to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas, or vice versa.

(v) Target potential enrollees based on income levels, unless it is a dual eligible special needs plan or comparable plan as determined by the Secretary.

(vi) Target potential enrollees based on health status, unless it is a special needs plan or comparable plan as determined by the Secretary.

(vii) State or imply plans are only available to seniors rather than to all Medicare beneficiaries.

(viii) Employ MA plan names that suggest that a plan is not available to all Medicare beneficiaries, unless it is a special needs plan or comparable plan as determined by the Secretary. This prohibition does not apply to MA plan names in effect prior to July 31, 2000.

(ix) Display the names or logos or both of co-branded network providers on the organization's member identification card, unless the provider names or logos or both are related to the member selection of specific provider organizations (for example, physicians or hospitals).

(x) Use a plan name that does not include the plan type. The plan type should be included at the end of the plan name, for example, "Super Medicare Advantage (HMO)." MA organizations are not required to repeat the plan type when the plan name is used multiple times in the same material.

(xi) Claim they are recommended or endorsed by CMS, Medicare, the Secretary, or HHS.

(xii) Convey that a failure to pay premium will not result in disenrollment, except for factually accurate descriptions of the MA organization's policies adopted in accordance with § 422.74(b)(1) and (d)(1) of this chapter.

(xiii) Use the term "free" to describe a \$0 premium, any type of reduction in premium, reduction in deductibles or cost sharing, low-income subsidy, or cost sharing pertaining to dual eligible individuals.

(xiv) Imply that the plan operates as a supplement to Medicare.

(xv) State or imply a plan is available only to or is designed for beneficiaries who are dually eligible for Medicare and Medicaid, unless it is a dual-eligible special needs plan or comparable plan as determined by the Secretary.

(xvi) Market a non-dual eligible special needs plan as if it were a dual-eligible special needs plan.

(xvii) Target marketing efforts primarily to dual eligible individuals, unless the plan is a dual eligible special needs plan or comparable plan as determined by the Secretary.

(xviii) Claim a relationship with the state Medicaid agency, unless a contract to coordinate Medicaid services for enrollees in that plan is in place.

(xix) Use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way. Use of the Medicare card image is permitted only with authorization from CMS.

(2) MA organizations may do the following:

(i) State that the MA organization is approved to participate in Medicare programs or is contracted to administer Medicare benefits or both.

(ii) Use the term "Medicare-approved" to describe benefits or services in materials or both.

(iii) Use the term "free" in conjunction with mandatory, supplemental, and preventative benefits provided at a zero cost share for all enrollees.

(b) *Product endorsements and testimonials.* (1) Product endorsements and testimonials may take any of the following forms:

(i) Television or video ads.

(ii) Radio ads.

(iii) Print ads.

(iv) Social media ads. In cases of social media, the use of a previous post, whether or not associated with or originated by the MA organization, is considered a product endorsement or testimonial.

(v) Other types of ads.

(2) MA organizations may use individuals to endorse the MA organization's product provided the endorsement or testimonial adheres to the following requirements:

(i) The speaker must identify the MA organization's product or company by name.

(ii) Medicare beneficiaries endorsing or promoting the MA organization must have been an enrollee at the time the endorsement or testimonial was created.

(iii) The endorsement or testimonial must clearly state that the individual was paid for the endorsement or testimonial, if applicable.

(iv) If an individual is used (for example, an actor) to portray a real or fictitious situation, the endorsement or testimonial must state that it is an actor portrayal.

(c) *Requirements when including certain telephone numbers in materials.* (1) MA organizations must adhere to the following requirements for including certain telephone numbers in materials:

(i) When a MA organization includes its customer service number, the hours of operation must be prominently included at least once.

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(ii) When a MA organization includes its customer service number, it must provide a toll-free TTY number in conjunction with the customer service number in the same font size.

(iii) On every material where 1-800-MEDICARE or Medicare TTY appears, the MA organization must prominently include, at least once, the hours and days of operation for 1-800-MEDICARE (that is, 24 hours a day/7 days a week).

(2) The following advertisement types are exempt from these requirements:

(i) Outdoor advertising.

(ii) Banners or banner-like ads.

(iii) Radio advertisements and sponsorships.

(d) *Standardized material identification (SMID)*. (1) MA organizations must use a standardized method of identification for oversight and tracking of materials received by beneficiaries.

(2) The SMID consists of the following three parts:

(i) The MA organization contract or Multi-Contract Entity (MCE) number (that is, “H” for MA or Section 1876 Cost Plans, “R” for Regional PPO plans (RPPOs), or “Y” for MCE, a means of identification available for Plans/Part D sponsors that have multiple MA contracts) followed by an underscore, except that the SMID for multi-plan marketing materials must begin with the word “MULTI-PLAN” instead of the MA organization’s contract number (for example, H1234 abc123_C or MULTI-PLAN_efg456_M).

(ii) A series of alpha numeric characters (chosen at the MA organization’s discretion) unique to the material followed by an underscore.

(iii) An uppercase “C” for communications materials or an uppercase “M” for marketing materials (for example, H1234_abc123_C or H5678_efg456_M).

(3) The SMID is required on all materials except the following:

(i) Membership ID card.

(ii) Envelopes, radio ads, outdoor advertisements, banners, banner-like ads, and social media comments and posts.

(iii) OMB-approved forms/documents, except those materials specified in § 422.2267.

(iv) Corporate notices or forms (that is, not MA/Part D specific) meeting the

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definition of communications (see § 422.2260) such as privacy notices and authorization to disclose protected health information (PHI).

(v) Agent-developed communications materials that are not marketing.

(4) Non-English and alternate format materials, based on previously created materials, may have the same SMID as the material on which they are based.

[86 FR 6104, Jan. 19, 2021, as amended at 88 FR 22335, Apr. 12, 2023]

§ 422.2263 General marketing requirements.

Marketing is a subset of communications and therefore must follow the requirements outlined in § 422.2262 as well as this section. Marketing (as defined in § 422.2260) must additionally meet the following requirements:

(a) MA organizations may begin marketing prospective plan year offerings on October 1 of each year for the following contract year. MA organizations may market the current and prospective year simultaneously provided materials clearly indicate what year is being discussed.

(b) In marketing, MA organizations may not do any of the following:

(1) Provide cash or other monetary rebates as an inducement for enrollment or otherwise.

(2) Offer gifts to beneficiaries, unless the gifts are of nominal value (as governed by guidance published by the HHS OIG), are offered to similarly situated beneficiaries without regard to whether or not the beneficiary enrolls, and are not in the form of cash or other monetary rebates.

(3) Provide meals to potential enrollees regardless of value.

(4) Market non-health care related products to prospective enrollees during any MA sales activity or presentation. This is considered cross-selling and is prohibited.

(5) Compare their plan to other plans, unless the information is accurate, not misleading, and can be supported by the MA organization making the comparison.

(6) Display the names or logos or both of provider co-branding partners on marketing materials, unless the materials clearly indicate via a disclaimer

or in the body that “Other providers are available in the network.”

(7) Knowingly target or send unsolicited marketing materials to any MA enrollee during the Open Enrollment Period (OEP).

(i) During the OEP, an MA organization may do any of the following:

(A) Conduct marketing activities that focus on other enrollment opportunities, including but not limited to marketing to age-ins (who have not yet made an enrollment decision), marketing by 5-star plans regarding their continuous enrollment special election period (SEP), and marketing to dual-eligible and LIS beneficiaries who, in general, may make changes once per calendar quarter during the first 9 months of the year;

(B) Send marketing materials when a beneficiary makes a proactive request;

(C) At the beneficiary’s request, have one-on-one meetings with a sales agent;

(D) At the beneficiary’s request, provide information on the OEP through the call center; and

(E) Include educational information, excluding marketing, on the MA organization’s website about the existence of OEP.

(ii) During the OEP, an MA organization may not:

(A) Send unsolicited materials advertising the ability or opportunity to make an additional enrollment change or referencing the OEP;

(B) Specifically target beneficiaries who are in the OEP because they made a choice during Annual Enrollment Period (AEP) by purchase of mailing lists or other means of identification;

(C) Engage in or promote agent or broker activities that intend to target the OEP as an opportunity to make further sales; or

(D) Call or otherwise contact former enrollees who have selected a new plan during the AEP.

(8) Advertise benefits that are not available to beneficiaries in the service area(s) where the marketing appears, unless the advertisement is in local media that serves the service area(s) where the benefits are available and reaching beneficiaries who reside in other service areas is unavoidable.

(9) Market any products or plans, benefits, or costs, unless the MA organization or marketing name(s) as listed in HPMS of the entities offering the referenced products or plans, benefits, or costs are identified in the marketing material.

(i) MA organization or marketing names must be in 12-point font in print and may not be in the form of a disclaimer or fine print.

(ii) For television, online, or social media, the MA organization or marketing name(s) must be either read at the same pace as the phone number or must be displayed throughout the entire advertisement in a font size equivalent to the advertised phone number, contact information, or benefits.

(iii) For radio or other voice-based advertisements, MA organization or marketing names must be read at the same pace as the advertised phone numbers or other contact information.

(10) MA organizations may not include information about savings available to potential enrollees that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary.

(c) The following requirements apply to how MA organizations must display CMS-issued Star Ratings:

(1) References to individual Star Rating measure(s) must also include references to the overall Star Rating for MA-PDs and the summary rating for MA-only plans.

(2) May not use an individual underlying category, domain, or measure rating to imply overall higher Star Ratings.

(3) Must be clear that the rating is out of 5 stars.

(4) Must clearly identify the Star Ratings contract year.

(5) May only market the Star Ratings in the service area(s) for which the Star Rating is applicable, unless using Star Ratings to convey overall MA organization performance (for example, “Plan X has achieved 4.5 stars in Montgomery, Chester, and Delaware Counties), in which case the MA organization must do so in a way that is not confusing or misleading.

(6) The following requirements apply to all 5 Star MA contracts:

(i) May not market the 5-star special enrollment period, as defined in § 422.62(b)(15), after November 30 of each year if the contract has not received an overall 5 star for the next contract year.

(ii) May use CMS' 5-star icon or may create their own icon.

(7) The following requirements apply to all Low Performing MA contracts:

(i) The Low Performing Icon must be included on all materials about or referencing the specific contract's Star Ratings.

(ii) Must state the Low Performing Icon means that the MA organization's contract received a summary rating of 2.5 stars or below in Part C or Part D or both for the last 3 years.

(iii) May not attempt to refute or minimize Low Performing Status.

[86 FR 6105, Jan. 19, 2021, as amended at 88 FR 22335, Apr. 12, 2023]

§ 422.2264 Beneficiary contact.

For the purpose of this section, beneficiary contact means any outreach activities to a beneficiary or a beneficiary's caregivers by the MA organization or its agents and brokers.

(a) *Unsolicited contact.* Subject to the rules for contact for plan business in paragraph (b) of this section, the following rules apply when materials or activities are given or supplied to a beneficiary or their caregiver without prior request:

(1) MA organizations may make unsolicited direct contact by conventional mail and other print media (for example, advertisements and direct mail) or email (provided every email contains an opt-out option).

(2) MA organizations may not do any of the following if unsolicited:

(i) Use door to door solicitation, including leaving information of any kind, except that information may be left when an appointment is pre-scheduled but the beneficiary is not home.

(A) Contact is unsolicited door-to-door contact unless an appointment, at the beneficiary's home at the applicable date and time, was previously scheduled.

(B) [Reserved]

(ii) Approach enrollees in common areas such as parking lots, hallways, and lobbies.

(iii) Send direct messages from social media platforms.

(iv) Use telephone solicitation (that is, cold calling), robocalls, text messages, or voicemail messages, including, but not limited to, the following:

(A) Calls based on referrals.

(B) Calls to former enrollees who have disenrolled or those in the process of disenrolling, except to conduct disenrollment surveys for quality improvement purposes.

(C) Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission to be contacted.

(D) Calls to prospective enrollees to confirm receipt of mailed information.

(3) Calls are not considered unsolicited if the beneficiary provides consent or initiates contact with the plan. For example, returning phone calls or calling an individual who has completed a business reply card requesting contact is not considered unsolicited.

(b) *Contact for plan business.* MA organizations may contact current, and to a more limited extent, former members, including those enrolled in other products offered by the parent organization, to discuss plan business, in accordance with the following requirements:

(1) An MA organization may conduct the following activities as plan business:

(i) Call current enrollees, including those in non-Medicare products, to discuss Medicare products. Examples of such calls include, but are not limited to the following:

(A) Enrollees aging into Medicare from commercial products.

(B) Existing enrollees, including Medicaid enrollees, to discuss other Medicare products or plan benefits.

(C) Members in a Part D plan to discuss other Medicare products.

(ii) Call beneficiaries who submit enrollment applications to conduct business related to enrollment.

(iii) With prior CMS approval, call LIS enrollees that a plan is prospectively losing due to reassignment. CMS

decisions to approve calls are for limited circumstances based on the following:

(A) The proximity of cost of the losing plan as compared to the national benchmark; and

(B) The selection of plans in the service area that are below the benchmark.

(iv) Agents/brokers calling clients who are enrolled in other products they may sell, such as automotive or home insurance.

(v) MA organizations may not make unsolicited calls about other lines of business as a means of generating leads for Medicare plans.

(2) If the MA organization reaches out to beneficiaries regarding plan business, as outlined in this section, the MA organization must provide notice to all beneficiaries whom the plan contacts at least once annually, in writing, of the individual's ability to opt out of future calls regarding plan business.

(c) *Events with beneficiaries.* MA organizations and their agents or brokers may hold educational events, marketing or sales events, and personal marketing appointments to meet with Medicare beneficiaries, either face-to-face or virtually. The requirements for each type of event are as follows:

(1) Educational events must be advertised as such and be designed to generally inform beneficiaries about Medicare, including Medicare Advantage, Prescription Drug programs, or any other Medicare program.

(i) At educational events, MA organizations and agents/brokers may not market specific MA plans or benefits.

(ii) MA organizations holding or participating in educational events may do any of the following:

(A) Distribute communications materials.

(B) Answer beneficiary-initiated questions pertaining to MA plans.

(C) Distribute business cards.

(D) Make available and receive beneficiary contact information, including Business Reply Cards, but not including Scope of Appointment forms.

(iii) MA organizations holding or participating in educational events may not conduct sales or marketing presentations or distribute or accept plan applications.

(iv) MA organizations may schedule appointments with residents of long-term care facilities (for example, nursing homes, assisted living facilities, board and care homes) upon a resident's request. If a resident did not request an appointment, any visit by an agent or broker is prohibited as unsolicited door-to-door marketing.

(2) Marketing or sales events are group events that fall within the definition of marketing at § 422.2260.

(i) Marketing events are prohibited from taking place within 12 hours of an educational event, in the same location. The same location is defined as the entire building or adjacent buildings.

(ii) MA organizations holding or participating in marketing events may do any of the following:

(A) Provide marketing materials.

(B) Distribute and accept plan applications.

(C) Collect Scope of Appointment forms for future personal marketing appointments.

(D) Conduct marketing presentations.

(iii) MA organizations holding or participating in marketing events may not do any of the following:

(A) Require sign-in sheets or require attendees to provide contact information as a prerequisite for attending an event.

(B) Conduct activities, including health screenings, health surveys, or other activities that are used for or could be viewed as being used to target a subset of members (that is, "cherry-picking").

(C) Use information collected for raffles or drawings for any purpose other than raffles or drawings.

(3) Personal marketing appointments are those appointments that are tailored to an individual or small group (for example, a married couple). Personal marketing appointments are not defined by the location.

(i) At least 48 hours prior to the scheduled personal marketing, the MA plan (or agent or broker, as applicable) must agree upon and record the Scope of Appointment with the beneficiary(ies), except for:

(A) SOAs that are completed during the last four days of a valid election period for the beneficiary.

(B) Unscheduled in person meetings (walk-ins) initiated by the beneficiary.

(ii) MA organizations holding a personal marketing appointment may do any of the following:

(A) Provide marketing materials.

(B) Distribute and accept plan applications.

(C) Conduct marketing presentations.

(D) Review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns.

(iii) MA organizations holding a personal marketing appointment may not do any of the following:

(A) Market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary, and documented by the plan in a Scope of Appointment, business reply card, or request to receive additional information, which is valid for 12 months following the date of beneficiary's signature date or the date of the beneficiary's initial request for information.

(B) Market additional health related lines of plan business not identified prior to an individual appointment without a separate Scope of Appointment, identifying the additional lines of business to be discussed; such Scope of Appointment is valid for 12 months following the beneficiary's signature date.

(C) Market non-health related products, such as annuities.

[86 FR 6106, Jan. 19, 2021, as amended at 88 FR 22335, Apr. 12, 2023]

§ 422.2265 Websites.

As required under § 422.111(h)(2), MA organizations must have a website.

(a) *General website requirements.* (1) MA organization websites must meet all of the following requirements:

(i) Maintain current year contract content through December 31 of each year.

(ii) Notify users when they will leave the MA organization's Medicare site.

(iii) Include or provide access to (for example, through a hyperlink) applicable notices, statements, disclosures, or

disclaimers with corresponding content. Overarching disclaimers, such as the Federal Contracting Statement, are not required on every page.

(iv) Reflect the most current information within 30 days of any material change.

(v) Keep MA content separate and distinct from other lines of business, including Medicare Supplemental Plans.

(2) MA organization websites may not do any of the following:

(i) Require beneficiaries to enter any information other than zip code, county, or state for access to non-beneficiary-specific website content.

(ii) Provide links to foreign drug sales, including advertising links.

(iii) State that the MA organization is not responsible for the content of their social media pages or the website of any first tier, downstream, or related entity that provides information on behalf of the MA organization.

(b) *Required content.* MA organization's websites must include the following content:

(1) A toll-free customer service number, TTY number, and days and hours of operation.

(2) A physical or Post Office Box address.

(3) A PDF or copy of a printable provider directory.

(4) A provider directory searchable by every element required in the model provider directory, such as name, location, specialty.

(5) When applicable, a searchable pharmacy directory combined with a provider directory.

(6) Information on enrollees' and MA organizations' rights and responsibilities upon disenrollment. MA organizations may either post this information or provide specific information on where it is located in the Evidence of Coverage together with a link to that document.

(7) A description of and information on how to file a grievance, request an organization determination, and an appeal.

(8) Prominently displayed link to the Medicare.gov electronic complaint form.

(9) Disaster and emergency policy consistent with § 422.100(m)(5)(iii).

(10) A Notice of Privacy Practices as required under the HIPAA Privacy Rule (45 CFR 164.520).

(11) For PFFS plans, a link to the PFFS Terms and Conditions of Payment.

(12) For MSA plans, the following statements:

(i) “You must file Form 1040, ‘US Individual Income Tax Return,’ along with Form 8853, ‘Archer MSA and Long-Term Care Insurance Contracts’ with the Internal Revenue Service (IRS) for any distributions made from your Medicare MSA account to ensure you aren’t taxed on your MSA account withdrawals. You must file these tax forms for any year in which an MSA account withdrawal is made, even if you have no taxable income or other reason for filing a Form 1040. MSA account withdrawals for qualified medical expenses are tax free, while account withdrawals for non-medical expenses are subject to both income tax and a fifty (50) percent tax penalty.”

(ii) “Tax publications are available on the IRS website at <http://www.irs.gov> or from 1-800-TAX-FORM (1-800-829-3676).”

(13) Instructions on how to appoint a representative including a link to the downloadable version of the CMS Appointment of Representative Form (CMS Form-1696).

(14) Enrollment instructions and forms.

(c) *Required posted materials.* MA organization’s website must provide access to the following materials, in a printable format, within the timeframes specified in paragraphs (c)(1) and (2) of this section.

(1) The following materials for each plan year must be posted on the website by October 15 prior to the beginning of the plan year:

- (i) Evidence of Coverage.
- (ii) Annual Notice of Change (for renewing plans).
- (iii) Summary of Benefits.
- (iv) Provider Directory.
- (v) Provider/Pharmacy Directory.

(2) The following materials must be posted on the website throughout the year and be updated as required:

- (i) Prior Authorization Forms for physicians and enrollees.

(ii) When applicable, Part D Model Coverage Determination and Redetermination Request Forms.

(iii) Exception request forms for physicians (which must be posted by January 1 for new plans).

(iv) CMS Star Ratings document, which must be posted within 21 days after its release on the Medicare Plan Finder.

[86 FR 6107, Jan. 19, 2021, as amended at 87 FR 27898, May 9, 2022; 88 FR 22336, Apr. 12, 2023]

§ 422.2266 Activities with healthcare providers or in the healthcare setting.

(a) *Where marketing is prohibited.* The requirements in paragraphs (c) through (e) of this section apply to activities in the health care setting. Marketing activities and materials are not permitted in areas where care is being administered, including but not limited to the following:

- (1) Exam rooms.
- (2) Hospital patient rooms.
- (3) Treatment areas where patients interact with a provider and clinical team (including such areas in dialysis treatment facilities).
- (4) Pharmacy counter areas.

(b) *Where marketing is permitted.* Marketing activities and materials are permitted in common areas within the health care setting, including the following:

- (1) Common entryways.
- (2) Vestibules.
- (3) Waiting rooms.
- (4) Hospital or nursing home cafeterias.
- (5) Community, recreational, or conference rooms.

(c) *Provider-initiated activities.* Provider-initiated activities are activities conducted by a provider at the request of the patient, or as a matter of a course of treatment, and occur when meeting with the patient as part of the professional relationship between the provider and patient. Provider-initiated activities do not include activities conducted at the request of the MA organization or pursuant to the network participation agreement between the MA organization and the provider. Provider-initiated activities that meet the definition in this paragraph (c) fall

outside of the definition of marketing in § 422.2260. Permissible provider-initiated activities include:

(1) Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare & You” handbook, or “Medicare Options Compare” (from <https://www.medicare.gov>), including in areas where care is delivered.

(2) Providing the names of MA organizations with which they contract or participate or both.

(3) Answering questions or discussing the merits of a MA plan or plans, including cost sharing and benefit information, including in areas where care is delivered.

(4) Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, CMS’ website at <https://www.medicare.gov>, or 1-800-MEDICARE.

(5) Referring patients to MA plan marketing materials available in common areas;

(6) Providing information and assistance in applying for the LIS.

(7) Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.

(d) *Plan-initiated provider activities.* Plan-initiated provider activities are those activities conducted by a provider at the request of an MA organization. During a plan-initiated provider activity, the provider is acting on behalf of the MA organization. For the purpose of plan-initiated activities, the MA organization is responsible for compliance with all applicable regulatory requirements.

(1) During plan-initiated provider activities, MA organizations must ensure that the provider does not:

(i) Accept or collect Scope of Appointment forms.

(ii) Accept Medicare enrollment applications.

(iii) Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.

(iv) Mail marketing materials on behalf of the MA organization.

(v) Offer inducements to persuade patients to enroll in a particular MA plan or organization.

(vi) Conduct health screenings as a marketing activity.

(vii) Distribute marketing materials or enrollment forms in areas where care is being delivered.

(viii) Offer anything of value to induce enrollees to select the provider.

(ix) Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.

(2) During plan-initiated provider activities, the provider may do any of the following:

(i) Make available, distribute, and display communications materials, including in areas where care is being delivered.

(ii) Provide or make available marketing materials and enrollment forms in common areas.

(e) *MA organization activities in the health care setting.* MA organization activities in the health care setting are those activities, including marketing activities that are conducted by MA organization staff or on behalf of the MA organization, or by any downstream entity, but not by a provider. All marketing must comply with the requirements in paragraphs (a) and (b) of this section. However, during MA organization activities, the following is permitted:

(1) Accepting and collect Scope of Appointment forms.

(2) Accepting enrollment forms.

(3) Making available, distributing, and displaying communications materials, including in areas where care is being delivered.

(f) *Activities of Institutional Special Needs Plans (I-SNPs) Serving Long-Term Care Facility Residents* (1) Depending on the context of a given situation, I-SNP contracted with a long-term care facility can be viewed as both a provider and a plan.

(2) I-SNPs may use staff operating in a social worker capacity to provide information, including marketing materials (excluding enrollment forms), to residents of a long term care facility.

(3) Social workers of the I-SNP (whether employees, agents, or contracted providers) may not accept or collect a scope of appointment or enrollment form on behalf of the I-SNP.

(4) Unless the beneficiary or the beneficiary's authorized representative initiates additional contact with or by the plan, all other marketing and outreach activities in the beneficiary's room must follow the requirements for beneficiary contact under § 422.2264.

(5) All other activities with healthcare providers or in the healthcare setting must comply with §§ 422.2266(a), (b), (c), (d), and (e).

[86 FR 6108, Jan. 19, 2021]

§ 422.2267 Required materials and content.

For information CMS deems to be vital to the beneficiary, including information related to enrollment, benefits, health, and rights, the agency may develop materials or content that are either standardized or provided in a model form. Such materials and content are collectively referred to as required.

(a) *Standards for required materials and content.* All required materials and content, regardless of categorization as standardized in paragraph (b) of this section or model in paragraph (c) of this section, must meet the following:

(1) Be in a 12pt font, Times New Roman or equivalent.

(2) For markets with a significant non-English speaking population, be in the language of these individuals. Specifically, MA organizations must translate required materials into any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package (PBP) service area.

(3) Be provided to enrollees on a standing basis in any non-English language identified in paragraphs (a)(2) and (4) of this section or accessible format upon receiving a request for the materials in a non-English language or accessible format or when otherwise learning of the enrollee's primary language or need for an accessible format. This requirement also applies to the individualized plans of care described in § 422.101(f)(1)(ii) for special needs plan enrollees.

(4) For any fully integrated dual eligible special needs plan or highly integrated dual eligible special needs plan, as defined at § 422.2, or applicable integrated plan, as defined at § 422.561, be translated into the language(s) required by the Medicaid translation standard as specified through their capitated Medicaid managed care contract in addition to the language(s) required by the Medicare translation standard in paragraph (a)(2) of this section.

(5) Be provided to the beneficiary within CMS's specified timeframes.

(b) *Standardized materials.* Standardized materials and content are required materials and content that must be used in the form and manner provided by CMS.

(1) When CMS issues standardized material or content, an MA organization must use the document without alteration except for the following:

(i) Populating variable fields.

(ii) Correcting grammatical errors.

(iii) Adding customer service phone numbers.

(iv) Adding plan name, logo, or both.

(v) Deleting content that does not pertain to the plan type (for example, removing Part D language for a MA-only plan).

(vi) Adding the SMID.

(vii) A Notice of Privacy Practices as required under the HIPAA Privacy Rule (45 CFR 164.520).

(2) The MA organization may develop accompanying language for standardized material or content, provided that language does not conflict with the standardized material or content. For example, CMS may issue standardized content associated with an appeal notification and MA organizations may draft a letter that includes the standardized content in the body of the letter; the remaining language in the letter is at the plan's discretion, provided it does not conflict with the standardized content or other regulatory standards.

(c) *Model materials.* Model materials and content are those required materials and content created by CMS as an example of how to convey beneficiary information. When drafting required materials or content based on CMS models, MA organizations:

(1) Must accurately convey the vital information in the required material or content to the beneficiary, although the MA organization is not required to use CMS model materials or content verbatim; and

(2) Must follow CMS's specified order of content, when specified.

(d) *Delivery of required materials.* MA organizations must mail required materials in hard copy or provide them electronically, following the requirements in paragraphs (d)(1) and (2) of this section.

(1) For hard copy mailed materials, each enrollee must receive his or her own copy, except in cases of non-beneficiary-specific material(s) where the MA organization has determined multiple enrollees are living in the same household and it has reason to believe the enrollees are related. In that case, the MA organization may mail one copy to the household. The MA organization must provide all enrollees an opt-out process so the enrollees can each receive his or her own copy, instead of a copy to the household. Materials specific to an individual beneficiary must always be mailed to that individual.

(2) Materials may be delivered electronically following the requirements in paragraphs (d)(2)(i) and (ii) of this section.

(i) Without prior authorization from the enrollee, MA organizations may mail new and current enrollees a notice informing enrollees how to electronically access the following required materials: the Evidence of Coverage, Provider and Pharmacy Directories, and Formulary. The following requirements apply:

(A) The MA organization may mail one notice for all materials or multiple notices.

(B) Notices for prospective year materials may not be mailed prior to September 1 of each year, but must be sent in time for an enrollee to access the specified materials by October 15 of each year.

(C) The MA organization may send the notice throughout the year to new enrollees.

(D) The notice must include the website address to access the materials, the date the materials will be

available if not currently available, and a phone number to request that hard-copy materials be mailed.

(E) The notice must provide the enrollee with the option to request hardcopy materials. Requests may be material specific, and must have the option of a one-time request or a permanent request that must stay in place until the enrollee chooses to receive electronic materials again.

(F) Hard copies of requested materials must be sent within three business days of the request.

(ii) With prior authorization from the enrollee, MA organizations may provide any required material or content electronically. To do so, MA organizations must:

(A) Obtain prior consent from the enrollee. The consent must specify both the media type and the specific materials being provided in that media type.

(B) Provide instructions on how and when enrollees can access the materials.

(C) Have a process through which an enrollee can request hard copies be mailed, providing the beneficiary with the option of a one-time request or a permanent request (which must stay in place until the enrollee chooses to receive electronic materials again), and with the option of requesting hard copies for all or a subset of materials. Hard copies must be mailed within three business days of the request.

(D) Have a process for automatic mailing of hard copies when electronic versions or the chosen media type is undeliverable.

(e) *CMS required materials and content.* The following are required materials that must be provided to current and prospective enrollees, as applicable, in the form and manner outlined in this section. Unless otherwise noted or instructed by CMS and subject to § 422.2263(a) of this chapter, required materials may be sent once a fully executed contract is in place, but no later than the due dates listed for each material in this section.

(1) *Evidence of Coverage (EOC).* The EOC is a standardized communications material through which certain required information (under § 422.111(b)) must be provided annually and must be provided:

(i) To current enrollees of the plan by October 15, prior to the year to which the EOC applies.

(ii) To new enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.

(2) *Part C explanation of benefits (EOB)*. The EOB is a model communications material through which plans must provide the information required under § 422.111(k). MA organizations may send this monthly or per claim with a quarterly summary.

(3) *Annual notice of change (ANOC)*. The ANOC is a standardized marketing material through which plans must provide the information required under § 422.111(d)(2) annually.

(i) Must send for enrollee receipt no later than September 30 of each year.

(ii) Enrollees with an October 1, November 1, or December 1 effective date must receive within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.

(4) *Pre-Enrollment checklist (PECL)*. The PECL is a standardized communications material that plans must provide to prospective enrollees with the enrollment form, so that the enrollees understand important plan benefits and rules. For telephonic enrollments, the contents of the PECL must be reviewed with the prospective enrollee prior to the completion of the enrollment. It references information on the following:

- (i) The EOC.
- (ii) Provider directory.
- (iii) Pharmacy directory.
- (iv) Formulary.
- (v) Premiums/copayments/coinsurance.
- (vi) Emergency/urgent coverage.
- (vii) Plan-type rules.
- (viii) Effect on current coverage.

(5) *Summary of Benefits (SB)*. MA organizations must disseminate a summary of highly utilized coverage that include benefits and cost sharing to prospective enrollees, known as the SB. The SB is a model marketing material. It must be in a clear and accurate form.

(i) The SB must be provided with an enrollment form as follows:

(A) In hard copy with a paper enrollment form.

(B) For online enrollment, the SB must be made available electronically (for example, via a link) prior to the completion and submission of enrollment request.

(C) For telephonic enrollment, the beneficiary must be verbally told where the SB can be accessed.

(ii) The SB must include the following information:

(A) Information on the following medical benefits, starting in the top half of the first page and in the order as identified in paragraphs (A)(1) through (A)(10), including—

- (1) Monthly Plan Premium.
- (2) Deductible/Out-of-pocket limits.
- (3) Inpatient/Outpatient Hospital coverage.
- (4) Ambulatory Surgical Center (ASC).
- (5) Doctor Visits (Primary Care Providers and Specialists).
- (6) Preventive Care.
- (7) Emergency Care/Urgently Needed Services.
- (8) Diagnostic Services/Labs/Imaging.
- (9) Hearing Services/Dental Services/Vision Services.
- (10) Mental Health Services.

(B) Information on prescription drug expenses, including:

- (1) Deductible, the initial coverage phase, coverage gap, and catastrophic coverage.
- (2) A statement that costs may differ based on pharmacy type or status (for example, preferred/non-preferred, mail order, long-term care (LTC) or home infusion, and 30-or 90-day supply), when applicable.

(C) For Medicare Medical Savings Account Plans (MSAs), the SB must include the following:

- (1) The amount Medicare deposits into the beneficiaries MSA account.
- (2) A statement that the beneficiary pays nothing once the deductible is met.

(D) For dual eligible special needs plan (D-SNP)s, the SB must identify or describe the Medicaid benefits to prospective enrollees. This may be done by either of the following:

- (1) Including the Medicaid benefits in the SB.

(2) Providing a separate document identifying the Medicaid benefits that accompanies the SB.

(E) For D–SNPs open to dually eligible enrollees with differing levels of cost, the SB must:

(1) State how cost sharing and benefits differ depending on the level of Medicaid eligibility.

(2) Describe the Medicaid benefits, if any, provided by the plan.

(F) Fully integrated dual eligible SNPs (FIDE SNPs) and highly integrated D–SNPs, as defined in § 422.2, that provide Medicaid benefits have the option to display integrated Medicare and Medicaid benefits in the SB.

(G) MA organizations may describe or identify other health related benefits in the SB.

(6) *Enrollment/Election form*. This is a model communications material through which plans must provide the information required under § 422.60(c).

(7) *Enrollment Notice*. This is a model communications material through which plans must provide the information required under § 422.60(e)(3).

(8) *Disenrollment Notice*. This is a model communications material through which plans must provide the information required under § 422.74(b).

(9) *Mid-Year Change Notification*. This is a model communications material through which plans must provide a notice to enrollees when there is a mid-year change in benefits or plan rules, under the following timelines:

(i) Notices of changes in plan rules, unless otherwise addressed elsewhere in this part, must be provided 30 days in advance.

(ii) For National Coverage Determination (NCD) changes announced or finalized less than 30 days before their effective date, a notification is required as soon as possible.

(iii) Mid-year NCD or legislative changes must be provided no later than 30 days after the NCD is announced or the legislative change is effective.

(A) Plans may include the change in next plan mass mailing (for example, newsletter), provided it is within 30 days.

(B) The notice must also appear on the MA organization's website.

(10) *Non-renewal Notice*. This is a standardized communications material

through which plans must provide the information required under § 422.506.

(i) The Non-renewal Notice must be provided at least 90 calendar days before the date on which the nonrenewal is effective. For contracts ending on December 31, the notice must be dated October 2 to ensure national consistency in the application of Medigap Guaranteed Issue (GI) rights to all enrollees, except for those enrollees in special needs plans (SNPs). Information about non-renewals or service area reductions may not be released to the public, including the Non-renewal Notice, until CMS provides notification to the plan.

(ii) The Non-renewal Notice must do all of the following:

(A) Inform the enrollee that the plan will no longer be offered and the date the plan will end.

(B) Provide information about any applicable open enrollment periods or special election periods or both (for example, Medicare open enrollment, non-renewal special election period), including the last day the enrollee has to make a Medicare health plan selection.

(C) Explain what the enrollee must do to continue receiving Medicare coverage and what will happen if the enrollee chooses to do nothing.

(D) As required under § 422.506(a)(2)(ii)(A), provide a CMS-approved written description of alternative MA plan, MA–PD plan, and PDP options available for obtaining qualified Medicare services within the beneficiary's region in the enrollee's notice.

(E) Specify when coverage will start after a new Medicare plan is chosen.

(F) List 1–800–MEDICARE contact information together with other organizations that may be able to assist with comparing plans (for example, SHIPs).

(G) Explain Medigap to applicable enrollees and the special right to buy a Medigap policy, and include a Medigap fact sheet with the non-renewal notice that explains Medigap coverage, policy, options to compare Medigap policies, and options to buy a Medigap policy.

(H) Include the MA organization's call center telephone number, TTY number, and hours and days of operation.

(11) *Provider Directory*. This is a model communications material through which plans must provide the information under § 422.111(b)(3). The Provider Directory must:

(i) Be provided to current enrollees of the plan by October 15 of the year prior to the applicable year.

(ii) Be provided to new enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later.

(iii) Be provided to current enrollees upon request, within three business days of the request.

(iv) Be updated any time the MA organization becomes aware of changes.

(A) Updates to the online provider directories must be completed within 30 days of receiving information requiring update.

(B)(1) Updates to hardcopy provider directories must be completed within 30 days.

(2) Hard copy directories that include separate updates via addenda are considered up-to-date.

(12) *Provider Termination Notice*. This is a model communications material through which plans must provide the information required under § 422.111(e).

(i) The written Provider Termination Notice must be provided in hard copy via U.S. mail (first class postage is recommended, but not required).

(ii) The written Provider Termination Notice must do all of the following:

(A) Inform the enrollee that the provider will no longer be in the network and the date the provider will leave the network.

(B) Include names and phone numbers of in-network providers that the enrollee may access for continued care (this information may be supplemented with information for accessing a current provider directory, including both online and direct mail options).

(C) Explain how the enrollee may request a continuation of ongoing medical treatment or therapies with their current provider.

(D) Provide information about the annual coordinated election period and the MA open enrollment period, as well as explain that an enrollee who is impacted by the provider termination

may contact 1-800-MEDICARE to request assistance in identifying and switching to other coverage, or to request consideration for a special election period, as specified in § 422.62(b)(26), based on the individual's unique circumstances and consistent with existing parameters for this SEP.

(E) Include the MA organization's call center telephone number, TTY number, and hours and days of operation.

(iii) The telephonic Provider Termination Notice specified in § 422.111(e)(1)(i) must relay the same information as the written Provider Termination Notice as described in paragraph (e)(12)(ii) of this section.

(13) *Star Ratings Document*. This is a standardized marketing material through which Star Ratings information is conveyed to prospective enrollees.

(i) The Star Ratings Document is generated through HPMS.

(ii) The Star Ratings Document must be provided with an enrollment form, as follows:

(A) In hard copy with a paper enrollment form.

(B) For online enrollment, made available electronically (for example, via a link) prior to the completion and submission of enrollment request.

(C) For telephonic enrollment, the beneficiary must be verbally told where they can access the Star Ratings Document.

(iii) New MA organizations that have no Star Ratings are not required to provide the Star Ratings Document until the following contract year.

(iv) Updated Star Ratings must be used within 21 calendar days of release of updated information on Medicare Plan Finder.

(v) Updated Star Ratings must not be used until CMS releases Star Ratings on Medicare Plan Finder.

(14) *Organization Determination Notice*. This is a model communications material through which plans must provide the information under § 422.568.

(15) *Excluded Provider Notice*. This is a model communications material through which plans must notify enrollees when a provider they visit or consult has been excluded from participating in the Medicare program based

on an OIG exclusion or the CMS preclusion list.

(16) *Notice of Denial of Medical Coverage or Payment (NDMCP) (also known as the Integrated Denial Notice (IDN))*. This is a standardized communications material used to convey beneficiary appeal rights when a plan has denied a service as non-covered or excluded from benefits.

(17) *Notice of Medicare Non-Coverage (NOMNC)*. This is a standardized communications material used to convey beneficiary appeal rights when a plan is terminating previously-approved coverage in a Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), or Home Health setting (HHA).

(18) *Detailed Explanation of Non-Coverage (DENC)*. This is a standardized communications material used to convey to a beneficiary why their current Medicare covered SNF, CORF or HHA services should end.

(19) *Appointment of Representative (AOR)*. This is a standardized communications material used to authorize or appoint an individual to act on behalf of a beneficiary for the purpose of a specific appeal, grievance, or organization determination.

(20) *An Important Message From Medicare About Your Rights (IM)*. This is a standardized communications material used to convey a beneficiary's rights as a hospital inpatient and appeal rights when their covered inpatient hospital stay is ending.

(21) *Detailed Notice of Discharge Form (DND)*. This is a standardized communications material, as required under § 422.622(e), used to convey to a beneficiary why their current Medicare covered inpatient hospital stay should end.

(22) *Medicare Outpatient Observation Notice (MOON)*. This is a standardized communications material used to inform a beneficiary that he or she is an outpatient receiving observation services.

(23) *Appeal and Grievance Data Form*. This is a standardized communications material used to convey organization-specific grievance and appeals data.

(24) *Request for Administrative Law Judge (ALJ) Hearing*. This is a standardized communications material used to

formally request a reconsideration of the independent review entity's determination.

(25) *Attorney Adjudicator Review in Lieu of ALJ Hearing*. This is a standardized communications material used to request that an attorney adjudicator review a previously determined decision rather than having an ALJ do so.

(26) *Notice of Right to an Expedited Grievance*. This is a model communications material used to convey a Medicare enrollee's rights to request that a decision be made on a grievance or appeal within a shorter timeframe.

(27) *Waiver of Liability Statement*. This is a model communications material used by non-contracted providers to waive beneficiary liability for payment for denied services while utilizing the enrollee appeals process under subpart M of part 422.

(28) *Notice of Appeal Status*. This is a model communications material used to inform a beneficiary of the denial of an appeal and additional appeal rights.

(29) *Notice of Dismissal of Appeal*. This is a model communications material used to convey the rationale by an MA organization to dismiss beneficiary's appeal.

(30) *Member ID card*. The member ID card is a model communications material that plans must provide to enrollees as required under § 422.111(i). The member ID card—

(i) Must be provided to new enrollees within ten calendars days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the plan effective date, whichever is later;

(ii) Must include the plan's—

(A) Website address;

(B) Customer service number (the member ID card is excluded from the hours of operations requirement under § 422.2262(c)(1)(i)); and

(C) Contract/PBP number;

(iii) Must include, if issued for a PPO and PFFS plan, the phrase “Medicare limiting charges apply.”;

(iv) May not use a member's Social Security number (SSN), in whole or in part;

(v) Must be updated whenever information on a member's existing card changes; in such cases an updated card must be provided to the member;

(vi) Is excluded from the translation requirement under paragraphs (a)(2) through (4) of this section; and

(vii) Is excluded from the 12-point font size requirement under paragraph (a)(1) of this section.

(31) *Notice of availability of language assistance services and auxiliary aids and services (Notice of Availability).*

(i) Prior to contract year 2026 marketing on September 30, 2025, the notice is referred to as the *Multi-language insert (MLI)*. This is a standardized communications material which states, “We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1-xxx-xxx-xxxx]. Someone who speaks [language] can help you. This is a free service.” in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese.

(A) Additional languages that meet the 5 percent service area threshold, as required under paragraph (a)(2) of this section, must be added to the MLI used in that service area. A plan may also opt to include in the MLI any additional language that do not meet the 5 percent service area threshold, where it determines that this inclusion would be appropriate.

(B) Except where otherwise provided in paragraph (e)(31)(i)(G) of this section, the MLI must be provided with all required materials under paragraph (e) of this section.

(C) The MLI may be included as a part of the required material or as a standalone material in conjunction with the required material.

(D) When used as a standalone material, the MLI may include organization name and logo.

(E) When mailing multiple required materials together, only one MLI is required.

(F) The MLI may be provided electronically when a required material is provided electronically as permitted under paragraph (d)(2) of this section.

(G) At plan option for CY 2025 marketing and communications beginning September 30, 2024, the plan may use the model notice described in § 422.2267(e)(31)(ii) to satisfy the MLI re-

quirements set forth in paragraph (e)(31)(i) of this section.

(ii) For CY 2026 marketing and communications beginning September 30, 2025, the required notice is referred to as the Notice of availability of language assistance services and auxiliary aids and services (Notice of Availability). This is a model communications material through which MA organizations must provide a notice of availability of language assistance services and auxiliary aids and services that, at a minimum, states that the MA organization provides language assistance services and appropriate auxiliary aids and services free of charge.

(A) This notice of availability of language assistance services and auxiliary aids and services must be provided in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency of the relevant State or States associated with the plan’s service area and must be provided in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.

(B) If there are additional languages in a particular service area that meet the 5 percent service area threshold, described in paragraph (a)(2) of this section, beyond the languages described in paragraph (e)(31)(i) of this section, the notice of availability of language assistance services and auxiliary aids and services must also be translated into those languages. MA organizations may also opt to translate the notice in any additional languages that do not meet the 5 percent service area threshold, where the MA organization determines that this inclusion would be appropriate.

(C) The notice must be provided with all required materials under paragraph (e) of this section.

(D) The notice may be included as a part of the required material or as a standalone material in conjunction with the required material.

(E) When used as a standalone material, the notice may include organization name and logo.

(F) When mailing multiple required materials together, only one notice is required.

(G) The notice may be provided electronically when a required material is provided electronically as permitted under paragraph (d)(2) of this section.

(32) *Federal Contracting Statement.* This is model content through which plans must convey that they have a contract with Medicare and that enrollment in the plan depends on contract renewal.

(i) The Federal Contracting Statement must include all of the following:

(A) Legal or marketing name of the organization.

(B) Type of plan (for example, HMO, HMO SNP, PPO, PFFS, PDP).

(C) A statement that the organization has a contract with Medicare (when applicable, MA organizations may incorporate a statement that the organization has a contract with the state/Medicaid program).

(D) A statement that enrollment depends on contract renewal.

(ii) MA organizations must include the Federal Contracting Statement on all marketing materials with the exception of the following:

(A) Banners and banner-like advertisements.

(B) Outdoor advertisements.

(C) Text messages.

(D) Social media.

(E) Envelopes.

(33) *Star Ratings Disclaimer.* This is model content through which plans must:

(i) Convey that MA organizations are evaluated yearly by Medicare.

(ii) Convey that the ratings are based on a 5-star rating system.

(iii) Include the model content in disclaimer form or within the material whenever Star Ratings are mentioned in marketing materials, with the exception of when Star Ratings are published on small objects (that is, a giveaway items such as a pens or rulers).

(34) *SSBCI disclaimer.* This is model content and must be used by MA organizations that offer CMS-approved SSBCI as specified in § 422.102(f). In the SSBCI disclaimer, MA organizations must include the information required in paragraphs (i) through (iii) of this section. MA organizations must do all of the following:

(i) Convey the benefits mentioned are a part of special supplemental benefits.

(ii) List the chronic condition(s) the enrollee must have to be eligible for the SSBCI offered by the applicable MA plan(s), in accordance with the following requirements.

(A) The following applies when only one type of SSBCI is mentioned:

(1) If the number of condition(s) is five or fewer, then list all condition(s).

(2) If the number of conditions is more than five, then list the top five conditions, as determined by the MA organization, and convey that there are other eligible conditions not listed.

(B) The following applies when multiple types of SSBCI are mentioned:

(1) If the number of condition(s) is five or fewer, then list all condition(s), and if relevant, state that these conditions may not apply to all types of SSBCI mentioned.

(2) If the number of conditions is more than five, then list the top five conditions, as determined by the MA organization, for which one or more listed SSBCI is available, and convey that there are other eligible conditions not listed.

(iii) Convey that even if the enrollee has a listed chronic condition, the enrollee will not necessarily receive the benefit because coverage of the item or service depends on the enrollee being a “chronically ill enrollee” as defined in § 422.102(f)(1)(i)(A) and on the applicable MA plan’s coverage criteria for a specific SSBCI required by § 422.102(f)(4).

(iv) Meet the following requirements for the SSBCI disclaimer in ads:

(A) For television, online, social media, radio, or other voice-based ads, either read the disclaimer at the same pace as, or display the disclaimer in the same font size as, the advertised phone number or other contact information.

(B) For outdoor advertising (as defined in § 422.2260), display the disclaimer in the same font size as the advertised phone number or other contact information.

(v) Include the SSBCI disclaimer in all marketing and communications materials that mention SSBCI.

(35) *Accommodations Disclaimer.* This is model content through which MA organizations must:

(i) Convey that accommodations for persons with special needs are available.

(ii) Provide a telephone number and TTY number.

(iii) Include the model content in disclaimer form or within the body of the material on any advertisement of invitation to all events described under § 422.2264(c).

(36) *Mailing Statements.* This is standardized content. It consists of statements on envelopes that MA organizations must include when mailing information to current members, as follows:

(i) MA organizations must include the following statement when mailing information about the enrollee's current plan: "Important [Insert Plan Name] information."

(ii) MA organizations must include the following statement when mailing health and wellness information: "Health and wellness or prevention information."

(iii) The MA organization must include the plan name; however, if the plan name is elsewhere on the envelope, the plan name does not need to be repeated in the disclaimer.

(iv) Delegated or sub-contracted entities and downstream entities that conduct mailings on behalf of a multiple MA organizations must also comply with this requirement; however, they do not have to include a plan name.

(37) *Promotional Give-Away Disclaimer.* This is model content. The disclaimer consists of a statement that must make clear that there is no obligation to enroll in a plan, and must be included when offering a promotional give-away such as a drawing, prizes, or a free gift.

(38) *Provider Co-branded Material Disclaimer.* This is model content through which MA organizations must:

(i) Convey, as applicable, that other pharmacies, physicians or providers are available in the plan's network.

(ii) Include the model content in disclaimer form or within the material whenever co-branding relationships with network provider are mentioned, unless the co-branding is with a provider network or health system that represents 90 percent or more of the network as a whole.

(39) *Out of Network Non-Contracted Provider Disclaimer.* This is standardized content. The disclaimer consists of the statement: "Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services," and must be included whenever materials reference out-of-network/non-contracted providers.

(40) *NCQA SNP Approval Statement.* This is model content and must be used by SNPs who have received NCQA approval. MA organizations must:

(i) Convey that MA organization has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP).

(ii) Include the last contract year of NCQA approval.

(iii) Convey that the approval is based on a review of [insert Plan Name's] Model of Care.

(iv) Not include numeric SNP approval scores.

(41) *Third-party marketing organization disclaimer.* This is standardized content. If a TPMO does not sell for all MA organizations in the service area the disclaimer consists of the statement: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact *Medicare.gov*, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options." If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact *Medicare.gov*, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices." The MA organization must ensure that the disclaimer is as follows:

(i) Used by any TPMO, as defined under § 422.2260, that sells plans on behalf of more than one MA organization.

(ii) Verbally conveyed within the first minute of a sales call.

(iii) Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.

(iv) Prominently displayed on TPMO websites.

(v) Included in any marketing materials, including print materials and television advertisements, developed, used or distributed by the TPMO.

(42) *Mid-year supplemental benefits notice.* This is a model communications material through which plans must inform each enrollee of the availability of any item or service covered as a supplemental benefit that the enrollee has not begun to use by June 30 of the plan year.

(i) The notice must be sent on an annual basis, no earlier than June 30 of the plan year, and no later than July 31 of the plan year.

(ii) The notice must include the following content:

(A) *Mandatory supplemental benefits.* For each mandatory supplemental benefit an enrollee has not used, the MA organization must include the same information about the benefit that is provided in the Evidence of Coverage.

(B) *Optional supplemental benefits.* For each optional supplemental benefit an enrollee has not used, the MA organization must include the same information about the benefit that is provided in the Evidence of Coverage.

(C) *SSBCI.* For plans that include SSBCI—

(1) The MA organization must include an explanation of SSBCI available under the plan (including eligibility criteria and limitations and scope of the covered items and services) and must include point-of-contact information for eligibility assessments, including providing point-of-contact information (which can be the customer service line or a separate dedicated line), with trained staff that enrollees can contact to inquire about or begin the SSBCI eligibility determination process and to address any other questions the enrollee may have about the availability of SSBCI under their plan;

(2) When an enrollee has been determined eligible for SSBCI but has not

used SSBCI, the MA organization must include a description of the unused SSBCI for which the enrollee is eligible, and must include a description of any limitations on the benefit; and

(3) The disclaimer specified at paragraph (e)(34) of this section.

(D) The information about all supplemental benefits listed in the notice must include all of the following:

(1) Scope of benefit.

(2) Applicable cost-sharing.

(3) Instructions on how to access the benefit.

(4) Any applicable network information.

(E) Supplemental benefits listed consistent with the format of the EOC.

(F) A customer service number, and required TTY number, to call for additional help.

[86 FR 6108, Jan. 19, 2021, as amended at 87 FR 27898, May 9, 2022; 88 FR 22336, Apr. 12, 2023; 88 FR 34780, May 31, 2023; 89 FR 30827, Apr. 23, 2024; 89 FR 63827, Aug. 6, 2024]

§ 422.2272 Licensing of marketing representatives and confirmation of marketing resources.

In its marketing, the MA organization must:

(a) Demonstrate to CMS' satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.

(b) Establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in the MA plan, and understand the rules applicable under the plan.

(c) Employ as marketing representatives only individuals who are licensed by the State to conduct marketing activities (as defined in the Medicare Marketing Guidelines) in that State, and whom the organization has informed that State it has appointed, consistent with the appointment process provided for under State law.

(d) Report to the State in which the MAO appoints an agent or broker, the termination of any such agent or broker, including the reasons for such termination if State law requires that the reasons for the termination be reported.

(e) Establish and implement an oversight plan that monitors agent and

broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS.

[73 FR 54220, Sept. 18, 2008, as amended at 73 FR 54250, Sept. 18, 2008; 76 FR 21569, Apr. 15, 2011; 83 FR 16735, Apr. 16, 2018; 88 FR 22337, Apr. 12, 2023]

§ 422.2274 Agent, broker, and other third-party requirements.

If an MA organization uses agents and brokers to sell its Medicare plans, the requirements in paragraphs (a) through (e) of this section are applicable. If an MA organization makes payments to third parties, the requirements in paragraph (f) of this section are applicable.

(a) *Definitions.* For purposes of this section, the following definitions are applicable:

Compensation. (i) Includes monetary or non-monetary remuneration of any kind relating to the sale, renewal, or services related to a plan or product offered by an MA organization including, but not limited to the following:

- (A) Commissions.
- (B) Bonuses.
- (C) Gifts.
- (D) Prizes or awards.

(E) Beginning with contract year 2025, payment of fees to comply with state appointment laws, training, certification, and testing costs.

(F) Beginning with contract year 2025, reimbursement for mileage to, and from, appointments with beneficiaries.

(G) Beginning with contract year 2025, reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

(H) Beginning with contract year 2025, any other payments made to an agent or broker that are tied to enrollment, related to an enrollment in an MA plan or product, or for services conducted as a part of the relationship associated with the enrollment into an MA plan or product.

Fair market value (FMV) means, for purposes of evaluating agent or broker compensation under the requirements of this section only, the amount that CMS determines could reasonably be expected to be paid for an enrollment or continued enrollment into an MA

plan. Beginning January 1, 2021, the national FMV is \$539, the FMV for Connecticut, Pennsylvania, and the District of Columbia is \$607, the FMV for California and New Jersey is \$672, and the FMV for Puerto Rico and the U.S. Virgin Islands is \$370. For contract year 2025, there will be a one-time increase of \$100 to the FMV to account for administrative payments included under the compensation rate. For subsequent years, FMV is calculated by adding the current year FMV and the product of the current year FMV and MA growth percentage for aged and disabled beneficiaries, which is published for each year in the rate announcement issued under § 422.312.

Initial enrollment year means the first year that a beneficiary is enrolled in a plan versus subsequent years (c.f., *renewal year*) that a beneficiary remains enrolled in a plan.

Like plan type means one of the following:

- (i) PDP replaced with another PDP.
- (ii) MA or MA-PD replaced with another MA or MA-PD.
- (iii) Cost plan replaced with another cost plan.

Plan year and *enrollment year* mean the year beginning January 1 and ending December 31.

Renewal year means all years following the initial enrollment year in the same plan or in different plan that is a like plan type.

Unlike plan type means one of the following:

- (i) An MA or, MA-PD plan to a PDP or Section 1876 Cost Plan.
- (ii) A PDP to a Section 1876 Cost Plan or an MA or MA-PD plan.
- (iii) A Section 1876 Cost Plan to an MA or MA-PD plan or PDP.

(b) *Agent/broker requirements.* Agents and brokers who represent MA organizations must follow the requirements in paragraphs (b)(1) through (3) of this section. Representation includes selling products (including Medicare Advantage plans, Medicare Advantage-Prescription Drug plans, Medicare Prescription Drug plans, and section 1876 Cost plans) as well as outreach to existing or potential beneficiaries and answering or potentially answering questions from existing or potential beneficiaries.

(1) Be licensed and appointed under State law (if required under applicable State law).

(2) Be trained and tested annually as required under paragraph (c)(4) of this section, and achieve an 85 percent or higher on all forms of testing.

(3) Secure and document a Scope of Appointment prior to meeting with potential enrollees.

(c) *MA organization oversight.* MA organizations must oversee first tier, downstream, and related entities that represent the MA organization to ensure agents and brokers abide by all applicable State and Federal laws, regulations, and requirements. MA organizations must do all of the following:

(1) As required under applicable State law, employ as marketing representatives only individuals who are licensed by the State to conduct marketing (as defined in this subpart) of health insurance in that State, and whom the MA organization has informed that State it has appointed, consistent with the appointment process for agents and brokers provided for under State law.

(2) As required under applicable State law, report the termination of an agent or broker to the State and the reason for termination.

(3) Report to CMS all enrollments made by unlicensed agents or brokers and for-cause terminations of agents or brokers.

(4) On an annual basis, provide training and testing to agents and brokers on Medicare rules and regulations, the plan products that agents and brokers will sell, including any details specific to each plan product, and relevant State and Federal requirements.

(5) On an annual basis for plan years through 2024, by the last Friday in July, report to CMS whether the MA organization intends to use employed, captive, or independent agents or brokers in the upcoming plan year and the specific rates or range of rates the plan will pay independent agents and brokers. Following the reporting deadline, MA organizations may not change their decisions related to agent or broker type, or their compensation rates and ranges, until the next plan year.

(6) On an annual basis by October 1, have in place full compensation struc-

tures for the following plan year. The structure must include details on compensation dissemination, including specifying payment amounts for initial enrollment year and renewal year compensation.

(7) Submit agent or broker marketing materials to CMS through HPMS prior to use, following the requirements for marketing materials in this subpart.

(8) Ensure beneficiaries are not charged marketing consulting fees when considering enrollment in MA plans.

(9) Establish and maintain a system for confirming that:

(i) Beneficiaries enrolled by agents or brokers understand the product, including the rules applicable under the plan.

(ii) Agents and brokers appropriately complete Scope of Appointment records for all marketing appointments (including telephonic and walk-in).

(10) Demonstrate that marketing resources are allocated to marketing to the disabled Medicare population as well as to Medicare beneficiaries age 65 and over.

(11) Must comply with State requests for information about the performance of a licensed agent or broker as part of a state investigation into the individual's conduct. CMS will establish and maintain a memorandum of understanding (MOU) to share compliance and oversight information with States that agree to the MOU.

(12) Ensure that, prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether or not the beneficiary's current providers are in the plan's network), regarding pharmacies (that is, whether or not the beneficiary's current pharmacy is in the plan's network), prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.

(13) Beginning with contract year 2025, ensure that no provision of a contract with an agent, broker, or other

TPMO has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary.

(d) *Compensation requirements.* MA organizations must ensure they meet the requirements in paragraphs (d)(1) through (5) of this section in order to pay compensation. These compensation requirements only apply to independent agents and brokers.

(1) *General rules.* (i) MA organizations may only pay agents or brokers who meet the requirements in paragraph (b) of this section.

(ii) For contract years through contract year 2024, MA organizations may determine, through their contracts, the amount of compensation to be paid, provided it does not exceed limitations outlined in this section. Beginning with contract year 2025, MA organizations are limited to the compensation amounts outlined in this section.

(iii) MA organizations may determine their payment schedule (for example, monthly or quarterly). Payments (including payments for AEP enrollments) must be made during the year of the beneficiary's enrollment.

(iv) MA organizations may only pay compensation for the number of months a member is enrolled.

(2) *Initial enrollment year compensation.* For each enrollment in an initial enrollment year for contract years through contract year 2024, MA organizations may pay compensation at or below FMV.

(i) MA organizations may pay either a full or pro-rated initial enrollment year compensation for:

(A) A beneficiary's first year of enrollment in any plan; or

(B) A beneficiary's move from an employer group plan to a non-employer group plan (either within the same parent organization or between parent organizations).

(ii) MA organizations must pay pro-rated initial enrollment year compensation for:

(A) A beneficiary's plan change(s) during their initial enrollment year.

(B) A beneficiary's selection of an "unlike plan type" change. In that case, the new plan would only pay the

months that the beneficiary is enrolled, and the previous plan would recoup the months that the beneficiary was not in the plan.

(3) *Renewal compensation.* For each enrollment in a renewal year for contract years through contract year 2024, MA plans may pay compensation at a rate of up to 50 percent of FMV. For contract years beginning with contract year 2025, for each enrollment in a renewal year, MA organizations may pay compensation at 50 percent of FMV.

(i) MA plans may pay compensation for a renewal year:

(A) In any year following the initial enrollment year the beneficiary remains in the same plan; or

(B) When a beneficiary enrolls in a new "like plan type".

(ii) [Reserved]

(4) *Other compensation scenarios.* (i) When a beneficiary enrolls in an MA-PD, MA organizations may pay only the MA compensation (and not compensation for Part D enrollment under § 423.2274 of this chapter).

(ii) When a beneficiary enrolls in both a section 1876 Cost Plan and a stand-alone PDP, the 1876 Cost Plan sponsor may pay compensation for the cost plan enrollment and the Part D sponsor must pay compensation for the Part D enrollment.

(iii) When a beneficiary enrolls in a MA-only plan and a PDP plan, the MA plan sponsor may pay for the MA plan enrollment and the Part D plan may pay for the PDP plan enrollment.

(iv) When a beneficiary changes from two plans (for example, a MA plan and a stand-alone PDP) (dual enrollments) to one plan (MA-PD), the MA organization may only pay compensation at the renewal rate for the MA-PD product.

(5) *Additional compensation, payment, and compensation recovery requirements (Charge-backs).* (i) MA organizations must retroactively pay or recoup funds for retroactive beneficiary changes for the current and previous calendar years. MA organizations may choose to recoup or pay compensation for years prior to the previous calendar year, but they must do both (recoup amounts owed and pay amounts due) during the same year.

(ii) Compensation recovery is required when:

(A) A beneficiary makes any plan change (regardless of the parent organization) within the first three months of enrollment (known as rapid disenrollment), except as provided in paragraph (d)(5)(iii) of this section.

(B) Any other time period a beneficiary is not enrolled in a plan, but the plan paid compensation based on that time period.

(iii) Rapid disenrollment compensation recovery does not apply when:

(A) A beneficiary enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1.

(B) A beneficiary's enrollment change is not in the best interests of the Medicare program, including for the following reasons:

(1) Other creditable coverage (for example, an employer plan).

(2) Moving into or out of an institution.

(3) Gain or loss of employer/union sponsored coverage.

(4) Plan termination, non-renewal, or CMS imposed sanction.

(5) To coordinate with Part D enrollment periods or the State Pharmaceutical Assistance Program.

(6) Becoming LIS or dually eligible for Medicare and Medicaid.

(7) Qualifying for another plan based on special needs.

(8) Due to an auto, facilitated, or passive enrollment.

(9) Death.

(10) Moving out of the service area.

(11) Non-payment of premium.

(12) Loss of entitlement or retroactive notice of entitlement.

(13) Moving into a 5-star plan.

(14) Moving from an LPI plan into a plan with three or more stars.

(iv)(A) When rapid disenrollment compensation recovery applies, the entire compensation must be recovered.

(B) For other compensation recovery, plans must recover a pro-rated amount of compensation (whether paid for an initial enrollment year or renewal year) from an agent or broker equal to the number of months not enrolled.

(1) If a plan has paid full initial compensation, and the enrollee disenrolls prior to the end of the enrollment year, the total number of months not en-

rolled (including months prior to the effective date of enrollment) must be recovered from the agent or broker.

(2) Example: A beneficiary enrolls upon turning 65 effective April 1 and disenrolls September 30 of the same year. The plan paid full initial enrollment year compensation. Recovery is equal to 6/12ths of the initial enrollment year compensation (for January through March and October through December).

(e) *Payments other than compensation (administrative payments).* (1) For contract years through contract year 2024, payments made for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments) must not exceed the value of those services in the marketplace.

(2) Beginning with contract year 2025, administrative payments are included in the calculation of enrollment-based compensation.

(f) *Payments for referrals.* Payments may be made to individuals for the referral (including a recommendation, provision, or other means of referring beneficiaries) to an agent, broker or other entity for potential enrollment into a plan. The payment may not exceed \$100 for a referral into an MA or MA-PD plan and \$25 for a referral into a PDP plan.

(g) *TPMO oversight.* In addition to any applicable FDR requirements under § 422.504(i), when doing business with a TPMP, either directly or indirectly through a downstream entity, MA plans must implement the following as a part of their oversight of TPMOs:

(1) When a TPMP is not otherwise an FDR, the MA organization is responsible for ensuring that the TPMP adheres to any requirements that apply to the MA plan.

(2) Contracts, written arrangements, and agreements between the TPMP and an MA plan, or between the TPMP and an MA plan's FDR, must ensure the TPMP:

(i) Discloses to the MA organization any subcontracted relationships used for marketing, lead generation, and enrollment.