Final Contract Year (CY) 2020 Marketing Guidance for Texas Medicare-Medicaid Plans

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Table of Contents

Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the Contract Year (CY) 2019 Medicare Communications and Marketing Guidelines (MCMG), posted at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html, and the August 6, 2019, Health Plan Management System (HPMS) guidance memorandum, "Medicare Communications and Marketing Guidelines," apply to Medicare-Medicaid plans (MMPs) participating in the Texas capitated financial alignment model demonstration, except as noted or modified in this guidance document.[1]

This guidance document provides information only about those sections of the MCMG that are not applicable or that are different for MMPs in Texas; therefore, this guidance document should be considered an addendum to the CY 2019 MCMG. This MMP guidance is applicable to all marketing done for CY 2020 benefits.

Use of Independent Agents and Brokers

We clarify that Texas MMPs may compensate independent agents/brokers for certain opt-in enrollments as detailed in section 110 of this guidance. The requirements applicable to independent agents/brokers throughout the MCMG are, therefore, applicable to Texas MMPs in the scenarios described in section 110 of this guidance.

Compliance with Section 1557 of the Affordable Care Act of 2010

MMPs are subject to the disclosure requirements under Section 1557 of the Affordable Care Act. For more information, MMPs should refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557/.

Formulary and Formulary Change Notice Requirements

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

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

- Formulary change notices must be sent for any negative formulary change (as described in section 30.3.3, "Midyear Formulary Changes," and section 30.3.4, "Provision of Notice Regarding Formulary Changes," of Chapter 6 of the Prescription Drug Benefit Manual),

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

regardless of whether or not the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan.

- Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on Texas MMP websites.

Section 20 - Communications and Marketing Definitions

MMPs are subject to marketing and beneficiary communications applicable to Medicare Advantage plans in 42 CFR Parts 422 and 423, as well as those applicable to Medicaid managed care organizations in 42 CFR Part 438. CMS developed a joint review process (JRP) for MMP beneficiary materials under each Financial Alignment Initiative capitated model demonstration that combines state and CMS review requirements and parameters. Given these differences, CMS continues to consider all CY 2020 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F.[2] As a result, this section of the MCMG and its subsections do not apply to MMPs. We provide additional detail about materials subject to HPMS submission in the guidance related to section 90.1.1 of the MCMG in this document. In addition, for any other references to communications throughout the MCMG, the previous definition of marketing materials applies.

We note that the definitions of "communications" and "marketing" materials in the MCMG include both terms as defined by Texas and as encompassed within the term "marketing, outreach, and member materials" in the three-way contract.

In addition, we clarify that the following materials, while not subject to review by CMS, are subject to review by the state:

- Materials in the Critical Elements chapter of the Uniform Managed Care Manual
- Health risk assessment forms
- Member surveys
- Flexible benefits and rewards and incentives materials
- Press releases that include Medicare/Texas Medicaid/STAR+PLUS program references and name recognition, regardless of whether they contain plan-specific information
- LTSS non-acute service documents, along with the original corresponding STAR+PLUS documents and HHSC approval forms
- MMP apps that are not health related

[2] "Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program," which may be found in the Federal Register published April 16, 2018 (see https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare).

MMPs will submit these materials to the state via HPMS. The state adopts the same timeframes for review of these materials as applies to marketing materials ten (10) days for a model review and 45 days for a non-model review). MMPs will submit provider materials to the state at Dual_Demo_Pilot@hhsc.state.tx.us.

Section 30.2 - Standardization of Plan Name Type

As is the case for other Medicare health plans, MMPs are required to include the plan type in each plan's name using standard terminology consistent with the guidance provided in this section. CMS created the standardized plan type label "Medicare-Medicaid Plan" to refer generically to all plans participating in a capitated financial alignment model demonstration. MMPs must use the "Medicare-Medicaid Plan" plan type terminology following their plan name at least once on the front page or beginning of each marketing piece, excluding envelopes, consistent with the requirements of section 30.2 of the MCMG.

CMS is unable to create state-specific plan type labels in HPMS for each state's demonstration plans; therefore, all MMPs are referred to by the standardized plan name type "Medicare-Medicaid Plan" in CMS' external communications – e.g., the Medicare & You handbook and the Medicare Plan Finder tool on www.medicare.gov. The state also refers to MMPs as STAR+PLUS Medicare-Medicaid Plans and has provided additional guidance on branding for the demonstration. MMPs are required to use the STAR+PLUS MMP program logo on all marketing materials, including the Member ID Card.

To reduce beneficiary confusion, we also clarify that MMPs in Texas that offer Medicare Advantage products, including SNPs, in the same service area as their MMPs may not use the same plan marketing name for both those products. Thus, for example, an organization offering both a SNP and an MMP in the same service area could not use the same name – e.g., Acme Duals Care (HMO SNP) – for its SNP product as for its MMP product – e.g., Acme Duals Care (Medicare-Medicaid Plan).

Section 30.3 - Non-English Speaking Population

The standard articulated in this section for translation of marketing materials into non-English languages will be superseded to the extent that Texas' standard for translation of marketing materials is more stringent. Guidance regarding the translation requirements for all plans, including MMPs, is released annually each fall. The required languages for translation for each MMP are also updated annually, as needed, in the HPMS Marketing Module. We expect the standard for CY 2020 will remain unchanged relative to the standard for CY 2019 and that Texas MMPs must translate all required marketing materials into Spanish for all service areas.

CMS and the state have designated materials that are vital and, therefore, must be translated into the non-English languages specified in this section.[3] This information is located in section 100.4 of this document.

MMPs are also required to make required materials available in alternate formats upon request (e.g., large print, braille, audio).

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

For additional information regarding notice and tagline requirements, refer to Appendix A and Appendix B to Part 92 of Section 1557 of the Patient Protection and Affordable Care Act.

Section 30.4 - Hours of Operation Requirements for Materials

In addition to the requirements of this section, MMPs must also provide the phone and TTY numbers and days and hours of operation information for the state's administrative services contractor at least once in any marketing materials detailed in section 100.4 of this guidance, as well as any materials that are provided prior to the time of enrollment and where an MMP's customer service number is provided for enrollees to call.

Section 30.6 - Electronic Communication Policy

In addition to restrictions on electronic communication included in this section of the MCMG, we clarify that Texas MMPs are prohibited from initiating contact via email to prospective enrollees.

Section 30.7 - Prohibited Terminology/Statements

In addition to the requirements of this section of the MCMG, MMPs may not claim to be endorsed by Texas Medicaid or use the terms, "Medicaid-approved" or "Medicare-Medicaid approved."

Section 30.8 - Product Endorsements/Testimonials

In addition to the requirements of this section of the MCMG, Texas MMPs must also adhere to the following requirements:

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

- An endorsement or testimonial by an individual cannot use any quotes by physicians or other health care providers.

- A contracted or employed physician or health care provider cannot provide an endorsement or testimonial.

Section 40.2 - Marketing Through Unsolicited Contacts

In addition to the existing restrictions on marketing through unsolicited contact, Texas MMPs are prohibited from marketing through unsolicited contacts by conventional mail and other print media and by email. Potential members must initiate contact with the MMP and give permission to be called or contacted.

For purposes of this section, enrollment materials sent to passively enrolled individuals are not considered marketing through unsolicited contact.

Section 40.3 - Marketing Through Telephonic Contact

The requirements of section 40.3 of the MCMG apply with the following clarifications and modifications:

- MMPs may not contact individuals who submit enrollment applications to conduct quality control and agent oversight activities.

- MMPs may not contact members who have been involuntarily disenrolled to resolve eligibility issues.

- Consistent with section 40.3 of the MCMG, calls made by MMPs to current members (including those enrolled in other product lines) are not considered unsolicited direct contact and are, therefore, permissible. Organizations that offer non-MMP and MMP products may call their current non-MMP members (e.g., those in Texas Medicaid managed care products), including individuals who have previously opted out of passive enrollment into an MMP, to promote their MMP offerings.

- Plans may use reasonable efforts to contact current non-MMP enrollees who are eligible for MMP enrollment to provide information about their MMP products. Callers with questions about other Medicare program options should be transferred to 1-800-MEDICARE or to the State Health Insurance Assistance Program (SHIP) (known as the Health Information Counseling & Advocacy Program of Texas, or HICAP in Texas) for information and assistance.

Section 40.4 - Nominal Gifts

In addition to the requirements of this section, we clarify that any nominal gifts offered by MMPs:

- May not be provided to providers for the purpose of distributing to prospective or current members;

- May be provided to encourage prospective or current member attendance at MMP events; and

- May be provided to encourage current enrollees to participate in periodic surveys.

MMPs are allowed to accept promotional items from third-party sources and distribute to prospective or current enrollees as nominal gifts subject to the dollar limits stated in section 40.4 of the MCMG. In accordance with the other requirements of this section, MMPs may adhere their plan sticker to promotional items provided by third-party sources that MMPs distribute to prospective or current enrollees as nominal gifts.

Section 40.5 - Exclusion of Meals as a Nominal Gift

In addition to the requirements of this section of the MCMG, we clarify that MMPs must not provide meals at any event at which a prospective enrollee will be in attendance, including CMS-defined educational events and other events that would fall under the definition of communications.

Section 40.6 - Marketing Star Ratings

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs are not subject to the Star Ratings requirements in the MCMG. Therefore, this section does not apply to MMPs.

Section 40.6.1 - Marketing Plans/Part D Sponsors with an Overall 5-Star Rating

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs are not subject to the Star Ratings requirements in the MCMG. Therefore, this section does not apply to MMPs.

Section 40.8 - Marketing of Rewards and Incentives Programs

MMPs may market rewards and incentives to current enrollees, as provided in section 40.8 of the MCMG. Any rewards and incentives programs must be consistent with section 100 of Chapter 4 of the Medicare Managed Care Manual.

Section 50.1 - Educational Events

In addition to the guidance in this section, the following requirements apply to MMP educational events:

- Events may only focus on health and program education.

- Events may be hosted by MMPs but must be held in public venues. Events must be physically accessible to all current or potential enrollees, including persons with disabilities and persons using public transportation.

- Events cannot be held at in-home or one-on-one settings, in or around public assistance offices, or in the common areas of provider offices.

- MMPs may not charge members for goods or services distributed at educational events.

- MMPs may offer free health screenings to potential members at educational events as long as they are **not** conditioned upon enrollment into the MMP. The health screenings cannot be used to identify and discourage less healthy potential members from enrolling in the MMP.

In addition to the guidance in this section of the MCMG, we note that, as provided under the three-way contract, the state may request that Texas MMPs provide current schedules of all educational events conducted for current or prospective enrollees.

Section 50.2 - Marketing/Sales Events

In addition to the requirements of this section, MMPs may not:

- Maintain sign-in sheets;
- Assist individuals with completing enrollment forms; and
- Charge members for goods or services distributed at events.

Section 50.3 - Personal/Individual Marketing Appointments

The provisions of this section apply to MMPs, with the following modifications:

- MMP representatives are not permitted to conduct unsolicited personal/individual appointments. An individual appointment must only be set up at the request of a beneficiary or his/her authorized representative. An MMP can offer an individual appointment to a beneficiary who has contacted the MMP to request assistance or information. However, MMPs are prohibited from making unsolicited offers of individual appointments.
- An MMP must make reasonable efforts to conduct an appointment in the beneficiary's preferred location. An MMP cannot require that an individual appointment occur in a beneficiary's home.
- MMP representatives may not assist individuals with completing enrollment forms.

Section 60.1 - Provider-Initiated Activities

In addition to the requirements of this section, we clarify that MMPs must ensure that contracted providers are aware that they are not to assist beneficiaries with enrollment decisions. Providers may only inform beneficiaries of benefits, services, and specialty care services offered through the plans with which they contract. Providers must follow the Texas Provider Marketing Guidelines that became effective in July 2014 per SB 8 (refer to http://www.tmhp.com/Pages/Topics/Marketing.aspx). Contracted providers also may not:

- Make any oral or written statements that any MMP is endorsed by CMS, a federal or state governmental agency, or similar entity.
- Display marketing materials for any MMP anywhere in the provider office, including common areas.

- Recommend one (1) MMP over another or assist a beneficiary in deciding to select a specific MMP.

- Induce or accept a current or prospective member's enrollment in or disenrollment from an MMP.

- Assist an enrollee with enrollment forms.

- Portray any MMP in a negative manner.

- Provide nominal gifts on behalf of an MMP to current or prospective members, or condition nominal gifts on enrollment with an MMP.

- Use terms that would influence, mislead, or cause prospective members to contact the MMP, rather than the state's administrative services contractor, for enrollment in the MMP.

- Discriminate against current or prospective member based on race, creed, age, color, religion, national origin, ancestry, marital status, sexual orientation, physical or mental disability, health status, or existing need for medical care.

- Use telephone number "2-1-1" for enrollment purposes to promote enrollment in an MMP.

We clarify that the guidance in this section about referring patients to other sources of information such as the "state Medicaid office" also applies to materials produced by the state and/or distributed by its administrative services contractor.

Section 60.2 - Plan-Initiated Provider Activities in the Healthcare Setting

In addition to the requirements of this section, we clarify that MMPs may have agreements with providers in connection with plan activities and should ensure that those agreements address marketing activity in a manner consistent with Medicare and Texas Medicaid regulations. These requirements are discussed throughout this section. MMPs may not cobrand or conduct plan marketing activities in health care settings.

MMPs may not use providers to make available, distribute, and/or display plan marketing materials, communications, and/or enrollment forms. Providers may distribute or display general health promotion materials/health-related materials for all contracted MMPs. Providers are not required to distribute or display all general health promotion materials provided by each MMP with whom they contract. Providers can choose which items to distribute or display, as long as they distribute/display one (1) or more items from each contracted MMP without giving the appearance of supporting one (1) MMP over another. Providers that choose to display MMP stickers must display a sticker for each plan that provides one (1), or the provider may choose to display none at all. MMPs may provide health-related display posters and materials for providers to display in common areas, subject to the following requirements:

- Health-related posters cannot be larger than 16" x 24".

- Materials may include the MMP's name, logo, and contact information.

- MMP stickers may not be larger than 5" x 7" and may not indicate anything more than MMP is accepted or welcomed here.

Providers may choose whether to display items such as pens or pencils provided by each contracted MMP. Providers can choose which items to display as long as they display one (1) or more from each contracted MMP. Items may only be placed in common areas.

Providers are not expected to proactively contact all participating MMPs; rather, if a provider agrees to make available and/or distribute materials, they should do so as long as they accept future requests from other MMPs with which they participate.

We also clarify that there are no distinctions between provider types with respect to applicability of these requirements.

Section 60.4 - Plan/Part D Sponsor Activities in the Healthcare Setting

In addition to the requirements of this section, we clarify that MMPs may not conduct sales activities, including sales presentations and the distribution and collection of enrollment forms, in common areas of a health care setting.

Section 70.1.1 - General Website Requirements

In addition to the requirements of this section, MMP websites must:

- Remain HIPAA-compliant with respect to member eligibility or identification, including any member or provider portal.

- Include STAR+PLUS MMP program logos.

- Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention.

Section 70.1.2 - Documents to be Posted on Website

The requirements of this section apply with the following modifications:

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

- Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs are not subject to the Star Ratings requirements in the MCMG. Therefore, MMPs are not required to post a CMS Star Ratings document on their websites.

Section 70.1.3 - Required Content

In addition to the requirements outlined in this section, MMPs must also include on their websites:

- A direct link to the state's administrative services contractor.

- Information on the potential for contract termination, as required under 42 CFR 422.111(f)(4).

- Information that materials are published in alternate formats (e.g., large print, braille, audio).

- General information about the program, including how to access the MMP's call center(s).

Section 70.3 - Social Media

In addition to the requirements of this section, we clarify that MMP use of electronic media is permitted. For Texas MMPs, electronic media refers to television, radio, and MMP-specific apps. MMPs may use both social and electronic media to disseminate health-related material, but MMPs may not use social media to disseminate plan or program-specific information.

Section 70.4 - Mobile Applications

In addition to the requirements in this section of the MCMG, we clarify that MMPs must notify CMS and the state of any intent to implement an MMP-specific app. Any apps that are not health related, regardless of whether they are targeted to current or potential enrollees, must be submitted as state-only marketing materials in HPMS (see section 20 of this guidance).

Section 80.1 - Customer Service Call Center Requirements and Standards

In addition to the guidance in this section of the MCMG, call centers must meet the following operating standards:

- Have a process to measure the time from which the telephone is answered to the point at which the caller reaches a customer service representative capable of responding to the caller's question in a manner sensitive to the caller's language and cultural needs.

- Ensure that ninety-nine (99) percent of calls are answered by the fourth ring by a customer service representative or an automated call pick-up system.

- Ensure that no more than one (1) percent of incoming calls receive a busy signal.

We clarify that hold time messages that include marketing content must be submitted in HPMS, and Texas MMPs must use marketing material code 17263 for this purpose. All other guidance in section 80.1 of the MCMG applies to MMPs.

Section 80.1.1 - Customer Service Call Center Hours of Operations

We clarify that MMPs must operate a toll-free call center during usual business hours. In light of the scope and nature of the services and benefits provided by MMPs, CMS interprets usual business hours for customer service call centers for both current and prospective enrollees as meaning at least the following: seven (7) days a week, at least from 8 a.m. to 8 p.m. CT,

except as provided below. Customer service call center hours and days must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. MMPs may use alternative technologies on Saturdays, Sundays, and all federal and/or state holidays except New Year's Day, as specified in the three-way contract, in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide the required information listed in section 80.1 of the MCMG, and/or allow a beneficiary to leave a message in a voice mail box. A customer service representative must then return the call in a timely manner, no more than one (1) business day later. All other guidance in section 80.1.1 of the MCMG applies to MMPs.

Section 80.2 - Hours of Operation for Telephone Lines Solely Designated For Sales and Enrollment

Since Texas MMPs are not allowed to market directly to individual potential enrollees and all enrollments into MMPs are submitted by the state's enrollment broker, this section does not apply.

Section 80.3 - Informational Scripts

We clarify that informational calls to plan call centers that become enrollment calls at the proactive request of the beneficiary must be transferred to the state's administrative services contractor.

MMPs should refer to section 80.7 of this guidance, as well as section 80.7 of the MCMG, for clarification of the types of activities conducted by a plan customer service representative that do not require the use of state-licensed marketing representatives. MMPs must use a state-licensed (and, when required, appointed) marketing agent for any activity that meets the definition of marketing in section 20 of this guidance.

Section 80.4 - Telesales and Enrollment Scripts

Telesales scripts are considered marketing and must be submitted to CMS as outlined in section 90 of this guidance. The remainder of the guidance in this section on enrollment scripts does not apply to MMPs because enrollment requests must be transferred to the state's administrative services contractor.

Section 80.7 - Activities That Do Not Require the Use of State-Licensed Marketing Representatives

Consistent with section 80.7 of the MCMG, we clarify that in order to provide more than factual information, MMP outbound callers must be state-licensed (and, when required, appointed) marketing agents. The MMP must use state-licensed (and, when required, appointed) marketing agents for any activity that meets the definition of marketing in section 20 of this guidance.

Section 90 - Tracking, Submission, and Review Process

Any references in this section of the MCMG, and in all subsections thereunder, to CMS in its role in reviewing marketing materials are also references to the state for purposes of MMP marketing material review.

Section 90.1 - Material Identification

The second paragraph of this section of the MCMG is modified as follows for MMPs:

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

In addition, when a third party, such as a pharmacy benefit manager (PBM) creates and distributes member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization for materials the third party provides to MMP enrollees. The material must be submitted in HPMS using a separate material ID for the MMP, and that material ID must be included on the material. The remainder of section 90.1 of the MCMG applies to MMPs, including the requirement that non-English and alternate format materials based on previously created materials may have the same material ID as the material on which they are based.

In addition to the requirements of this section, we clarify that the material ID is equivalent to the "Form Number" terminology used by the state, and that, at a minimum, it must be placed on the first page of a material and in the bottom corner. We also clarify that Multi-Contract Entities (MCE) are not applicable to Texas MMPs.

Section 90.1.1 - Materials Subject to Submission

CMS has developed a JRP for MMP beneficiary materials under each Financial Alignment Initiative capitated model demonstration that combines state and CMS review requirements and parameters. Given these differences, CMS will continue to consider all CY 2019 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F in CY 2019.[4]

Section 90.4 - Submission of Websites and Webpages for Review

MMPs must submit in HPMS all required website content listed in section 70 of the MCMG for review in HPMS under the Internet Web Page marketing code for Texas for prospective state-only review.

Section 90.4.1 – Submission of CMS Required Websites with Marketing Content

MMPs should submit their websites via links on a document. State reviewers should be able to review the information as it will be displayed on the website. The link may provide access to a live website or a test website, provided that the test site displays information as it will appear to the beneficiary/consumer. Submitting screen shots or text on a document is not acceptable. If

[4] "Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program," which may be found in the Federal Register published April 16, 2018 (see https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare).

the option to view online is not feasible, the MMP should contact their marketing reviewers prior to submission to receive permission to submit information in a manner other than a live link.

Once an MMP's website is reviewed and approved in its entirety, the MMP may update specific pages of the same website by submitting only the pages to be changed via links on a document in HPMS. Any updates to pages should be submitted with their own unique material ID and date stamped accordingly. MMPs must resubmit webpages for review when changes are made to plan benefits, premiums, or cost-sharing.

MMPs may make the website available for public use during the state review period; however, MMPs must indicate that the website is pending review until the state has either approved or disapproved the website. If the website or portions of the website are disapproved, MMPs must submit the revision to HPMS within 20 days.

MMPs are not required to resubmit materials that have received prior approval for posting on their website. Any documents that require submission to HPMS should not be posted on the website until they are approved by the state.

See section 70 of the MCMG for required website content.

Section 90.5 - Submission of Multi-Plan Materials

This section does not apply to MMPs.

Section 90.6 - Status of HPMS Material

We clarify that, for purposes of MMP materials, there is no "deeming" of materials requiring either a dual review by CMS and the state or a one-sided state review, and materials remain in a "pending" status until the state and CMS reviewer dispositions match. However, CMS and state marketing reviewers have standard operating procedures for ensuring materials are reviewed in a timely manner and differences in dispositions are resolved expeditiously. Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MMPs may obtain more information about the specific review parameters and timeframes for marketing materials under the Texas capitated financial alignment model demonstration in the Marketing Code Lookup functionality in the HPMS Marketing Module.

In addition, we note that the "non-marketing" status is not available for JRP marketing codes in HPMS for CY 2020. All other guidance in this section of the MCMG applies.

Section 90.8 - File & Use Process

We clarify that MMPs become certified for File & Use through the three-way contract. All other guidance in section 90.8 of the MCMG applies.

Section 100 - Required Materials

We clarify that CMS will continue to consider all CY 2020 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F.[5] As a result, all marketing materials must be submitted in HPMS. All other portions of this section apply to MMPs.

Section 100.4 - List of Required Materials

This section is replaced with the following revised guidance:

> **Section 100.4 - List of Required Materials**
> 42 CFR Parts 417, 422, 423, 438
>
> **Model Materials**
>
> We note that materials MMPs create should take into account the reading level requirements established in the three-way contract. Available model materials reflect acceptable reading levels. Current Part D models are acceptable for use as currently provided, and MMPs must add required disclaimers in Appendix 2 of this guidance, as appropriate. Adding required MMP disclaimers to Part D models does not render the documents non-model when submitted for review or accepted as File & Use materials.
>
> We refer MMPs to the following available model materials:
>
> - MMP-specific model materials tailored to MMPs in Texas, including a Summary of Benefits (SB), Annual Notice of Change (ANOC), Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated Formulary (List of Covered Drugs), combined Provider and Pharmacy Directory, single Member ID Card, integrated denial notice, welcome letter for passively enrolled individuals, and welcome letter for individuals who voluntarily enrolled: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.
>
> - Required Part D models, including the Excluded Provider Letter, Prescription Transfer Letter, and Transition Letter: http://cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html.
>
> - Required Drug-Only Explanation of Benefits (EOB) as either (1) the Part D EOB: http://cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html or (2) the MMP Drug-Only EOB: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. Texas MMPs will have the option to use either model to meet the requirement to send a Part D EOB.

[5] "Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program," which may be found in the Federal Register published April 16, 2018 (see https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare).

- Part D appeals and grievances models and notices (including those in the Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance): https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html, https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html, and https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.html.

- Part C appeals and grievances models and notices (including those in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance): http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Guidance.html and https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html.

- MMP-specific ANOC/EOC errata model: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Required Materials and Instructions for MMPs

Below is a list of required materials for Texas MMPs. In addition, we provide high-level information for each material. Guidance (as noted) should be reviewed as applicable. Additionally, MMPs should consult the HPMS Marketing Code Lookup functionality for specific codes and instructions for uploading required materials.

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

Annual Notice of Changes (ANOC)	
To Whom Required:	Must be provided to current enrollees of plan, including those with October 1, November 1, and December 1 effective dates.
Timing:	• MMPs must send for enrollee receipt no later than September 30 of each year. (**Note**: ANOC must be posted on MMP website by October 15.) • Enrollees with October 1, November 1, and December 1 enrollment effective dates must receive the ANOC for the upcoming year by one (1) month after the effective date of enrollment but not later than December 15.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	• Code 17209. • Must be submitted prior to mailing ANOCs.
Format Specification:	• TX MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• Actual Mail Dates (AMDs) and number of recipients (not the number of ANOCs mailed) must be entered into HPMS within 15 days of mailing. This includes mail dates for alternate materials. MMPs that mail in waves should enter the AMD for each wave. MMPs may enter up to ten (10) waves of mailings. For instructions on meeting this requirement, refer to the *Update AMD/Beneficiary Link/Function* section of the Marketing Review Users Guide in HPMS. • **Note**: For a single mailing to multiple recipients, as allowed under section 100.1 of the MCMG, MMPs should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed. • Plans may include the following with the ANOC: o Summary of Benefits (SB). o Provider and Pharmacy Directory o EOC (Member Handbook). o Formulary (List of Covered Drugs). o Notification of Electronic Documents. o No additional plan communications unless otherwise directed.
Translation Required:	Yes.

ANOC and EOC (Member Handbook) Errata	
To Whom Required:	Must be provided when plan errors are found in the ANOC or EOC (Member Handbook) and sent to current enrollees.
Timing:	Must send to enrollees immediately following CMS approval.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	• Code 17206 for ANOC Errata. • Code 17262 for EOC (Member Handbook) Errata. • ANOC errata must be submitted by October 15. • EOC (Member Handbook) errata must be submitted by November 15.
Format Specification:	Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	MMPs must use an errata notice to notify enrollees of plan errors in their original documents. We clarify that errata notices should only be used to notify enrollees of plan errors in plan materials. **Note:** Any mid-year changes, including but not limited to mid-year legislative benefit additions or removals and changes in enrollment policies, should be communicated to current enrollees consistent with the "Mid-Year Change Notification" guidance in this section. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to plan error. Instead, plans should use the HPMS Marketing Module replacement function for these changes.
Translation Required:	Yes.

Coverage/Organization Determination, Discharge, Appeals and Grievance Notices	
To Whom Required:	• Must be provided to enrollees who have requested an appeal or have had an appeal requested on their behalf. • Grievances may be responded to electronically, orally, or in writing.
Timing:	Provided to enrollees (generally by mail) on an ad hoc basis, based on required timeframes in the three-way contract.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Various codes for CMS required notices. Refer to HPMS Marketing Code Lookup functionality for TX MMP codes.
Format Specification:	Other CMS models; modifications permitted.
Guidance and Other Needed Information:	Three-way contract, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
Translation Required:	Yes.

Evidence of Coverage (EOC) / Member Handbook	
To Whom Required:	Must be provided to all enrollees of plan.
Timing:	• Must send to current enrollees of plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current contract year, as well as an EOC (Member Handbook) document for the upcoming contract year. We clarify that, for these members, the ANOC may be included in the EOC (Member Handbook) or provided separately, as well as the Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary), and the Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) for the upcoming year, must be received by one (1) month after the effective date of enrollment, but not later than December 15.
Method of Delivery:	Hard copy EOC (Member Handbook) or via Notification of Electronic Documents (consistent with section 100.2.1 of the MCMG) or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	• Code 17208. • Submitted prior to October 15 of each year.
Format Specification:	• TX MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	No additional information.
Translation Required:	Yes.

Excluded Provider Letter	
To Whom Required:	Provided to enrollees when a sponsor has excluded a prescriber or pharmacy participating in the Medicare program based on an Office of Inspector General (OIG) exclusion.
Timing:	Provided to enrollees on an ad hoc basis.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17237.
Format Specification	Model provided; modifications permitted.
Guidance and Other Needed Information:	https://oig.hhs.gov/fraud/exclusions.asp
Translation Required:	Yes.

Explanation of Benefits (EOB) – Part D	
To Whom Required:	Must be provided anytime an enrollee utilizes their prescription drug benefit.
Timing:	Sent at the end of the month following the month when the benefit was utilized.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	• Code 17236 when using the Part D EOB model, or • Code 17255 when using the MMP Rx-only EOB model.
Format Specification:	• Part D EOB model - modifications permitted or • TX MMP specific model - standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	Three-way contract and Medicare Prescription Drug Benefit Manual, Chapters 5 and 6, and HPMS code usage instructions.
Translation Required:	Yes.

Formulary (List of Covered Drugs)	
To Whom Required:	Must be provided to all enrollees of plan.
Timing:	• Must be sent to current enrollees of plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.
Method of Delivery:	Hard copy, or via Notification of Electronic Documents (consistent with section 100.2.1 of the MCMG), or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17203.
Format Specification:	Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• MMPs must make available a comprehensive integrated Formulary (List of Covered Drugs) that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the plan. • OTC items and/or supplemental benefits that are in excess of Medicaid requirements may not be included in this document. • MMPs are only permitted to make available a comprehensive, not abridged, Formulary (List of Covered Drugs).
Translation Required:	Yes.

Integrated Denial Notice	
To Whom Required:	Any enrollee with an adverse benefit determination.
Timing:	Provided to enrollees (generally by mail) on an ad hoc basis, at least ten (10) days in advance of any adverse benefit determination.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17221.
Format Specification:	• TX MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	Three-way contract.
Translation Required:	Yes.

Member ID Card	
To Whom Required:	Must be provided to all plan enrollees.
Timing:	• Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • Must also be provided to all enrollees if information on existing card changes.
Method of Delivery:	Must be provided in hard copy. In addition to the hard copy, plans may also provide a digital version (e.g., app).
HPMS Timing and Submission:	Code 17211.
Format Specification:	Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	MMPs must issue a single Member ID Card meeting these requirements for all services offered under the plan. Separate pharmacy and health benefits Member ID cards are not permitted.
Translation Required:	No.

Mid-Year Change Notification to Enrollees	
To Whom Required:	Must be provided to all applicable enrollees when there is a mid-year change in benefits, plan rules, formulary, provider network, or pharmacy network.
Timing:	Ad hoc, based on specific requirements for each issue.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG. If the mid-year change affects a document that the MMP has not sent to the member in hard copy (e.g., the EOC (Member Handbook)), the MMP is not required to send a hard copy mid-year change notification.
HPMS Timing and Submission:	Various codes. Refer to HPMS Marketing Code Lookup functionality for TX MMP codes.
Format Specification:	Model not available; must include required content.
Guidance and Other Needed Information:	• Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until model notice is received from CMS. • MMPs may elect to share Non-Renewal and Service Area Reduction (NR/SAR) information only with first tier, downstream, and related entities (FDRs) or anyone that the MAO does business with (i.e., contracted providers). • Additional NR/SAR notice information can be found in the annual “Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models” HPMS memo. • If a non-model document is created, the document must contain all the elements in the model.
Translation Required:	Yes.

Non-Renewal and Termination Notices	
To Whom Required:	Must be provided to each affected enrollee after MMP decides to non-renew or reduce its plan's service area or before the termination effective date.
Timing:	At least 90 days before the end of the current contract period.
Method of Delivery:	Notices must be hard copy and sent via U.S. mail. First class postage is recommended.
HPMS Timing and Submission:	Code 17212 for both notices.
Format Specification:	TX MMP model required for current contract year. Modifications permitted per instructions.
Guidance and Other Needed Information:	• Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until notice is received from CMS and the state. • MMPs may elect to share Non-Renewal and Service Area Reduction (NR/SAR) information only with first tier, downstream, and related entities (FDRs) or anyone that the MMP does business with (i.e., contracted providers). • Additional NR/SAR notice information can be found in the annual "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models" HPMS memo. • For terminations, relevant notice requirements are provided in 42 CFR 422.506, 422.508, and 422.512.
Translation Required:	Yes.

Part D Transition Letter	
To Whom Required:	Must be provided when a beneficiary receives a transition fill for a non-formulary drug.
Timing:	Must be sent within three (3) days of adjudication of temporary transition fill.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17240.
Format Specification:	Model provided; modifications permitted.
Guidance and Other Needed Information:	Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4.10.
Translation Required:	Yes.

Prescription Transfer Letter	
To Whom Required:	When a Part D sponsor requests permission from an enrollee to fill a prescription at a different network pharmacy than the one currently being used by enrollee.
Timing:	Ad hoc.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17238.
Format Specification:	Part D model provided; modifications permitted.
Guidance and Other Needed Information:	The model notice should only be used when the transfer of the prescription is not initiated by the beneficiary (or someone on his or her behalf).
Translation Required:	Yes.

Provider and Pharmacy Directory	
To Whom Required:	Must be provided to all current enrollees of the plan.
Timing:	• Must be sent to current enrollees of Plan for receipt by October 15 of each year. Must be posted to plan website by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be provided to current enrollees upon request, within three (3) business days of the request. • Must update directory information any time they become aware of changes. All updates to the online provider and pharmacy directories are expected to be completed within 30 days of receiving information. Updates to hard copy provider and pharmacy directories must be completed within 30 days; however, hard copy directories that include separate updates via addenda are considered up-to-date.
Method of Delivery:	Hard copy or via Notification of Electronic Documents (consistent with section 100.2.1 of the MCMG) or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17204.
Format Specification:	• TX MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.

Provider and Pharmacy Directory	
Guidance and Other Needed Information:	• MMPs are required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. MMPs may print separate directories for primary care physicians (PCPs) and specialists provided both directories are made available to enrollees at the time of enrollment. • The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits. • For MMPs with multi-county service areas, the combined Provider and Pharmacy Directory may be provided for all providers by county, provided the directory includes a disclaimer that the directory only includes providers in that particular county (or counties), that a complete directory is available on the plan's website, and that the enrollee may contact the plan's customer service call center to request assistance with locating providers in other counties or to request a complete hard copy Provider and Pharmacy Directory. • Texas MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the Texas MMP Provider and Pharmacy Directory marketing code. • As applicable, refer to the language and guidelines issued in the August 16, 2018, HPMS memorandum, "Pharmacy Directories and Disclaimers" for the pharmacy portion of the combined directory.
Translation Required:	Yes.

Scope of Appointment (SOA)	
To Whom Required:	Must be documented for all marketing activities, in-person, telephonically, including walk-ins to MMP or agent offices.
Timing:	Prior to the appointment.
Method of Delivery:	Beneficiary signed hard copy, telephonic recording, or electronically signed.
HPMS Timing and Submission:	Code 17248.
Format Specification:	No model required, must include required content.

Guidance and Other Needed Information:	• The following requirements must be on the scope of appointment (SOA) form or on the recorded call:
	  ○ Product types to be discussed
	  ○ Date of appointment
	  ○ Beneficiary and agent contact information
	  ○ Statement stating there is no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur.
	• A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon.

Translation Required:	Yes.

Summary of Benefits (SB)	
To Whom Required:	Enrollees who are passively enrolled. Optional with the ANOC and as requested for other enrollees.
Timing:	• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be available by October 15 of each year, but can be released as early as October 1 of each year. Must be posted on plan website by October 15 each year.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17201. Submitted prior to October 15 of each year.
Format Specification:	• TX MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• The SB must contain a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including applicable copays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. • Appendix 5 of the MCMG, Summary of Benefit Instructions, does not apply.
Translation Required:	Yes.

Welcome Letter	
To Whom Required:	Must be provided to all new enrollees of MMP.
Timing:	• Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17202.
Format Specification:	TX MMP model required for Contract Year.
Guidance and Other Needed Information:	• Must contain 4Rx information consistent with the model. • National Enrollment/Disenrollment Guidance for States & MMPs section 30.5.1.
Translation Required:	Yes.

Required Materials for New MMP Enrollees

The following table summarizes the required materials, and timing of receipt, for new MMP enrollees.

Table 1. Required Materials for New Enrollees

Enrollment Mechanism	Required Materials for New Enrollees	Timing of Beneficiary Receipt
Passive enrollment	• Welcome letter. • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary.) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory.) • SB.	30 calendar days prior to the effective date of enrollment.
Passive enrollment	• Member ID Card. • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to receive the EOC).	No later than the day prior to the effective date of enrollment.

Enrollment Mechanism	Required Materials for New Enrollees	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received more than ten (10) calendar days before the end of the month)[6]	• Welcome letter. • Formulary (List of Covered Drugs.) (or a distinct and separate notice alerting enrollees how to access or receive the formulary.) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory.) • Member ID Card. • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC.)	No later than the last day of the month prior to the effective date.
Opt-in enrollment (with enrollment confirmation received less than ten (10) calendar days before the end of the month)[6]	• Welcome letter. • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary.) • Provider and Pharmacy Directory (or separate notice alerting enrollees how to access or receive the directory.) • Member ID Card. • EOC (Member Handbook (or a distinct and separate notice alerting enrollees how to access or receive the EOC.)	No later than ten (10) calendar days from receipt of the CMS confirmation of enrollment.

Section 110 - Agent/Broker Activities, Oversight, and Compensation Requirements

All MMP enrollments continue to be processed by the state's administrative services contractor. However, we clarify that Texas MMPs are permitted to compensate independent agent/brokers in two scenarios, further detailed in the following table, in which individuals opt in to MMPs that are offered by the same parent organization as their previous coverage (for example, a Dual Eligible Special Needs Plan, or D-SNP), and that enrollment into the previous coverage was facilitated by an independent agent/broker. This situation can occur in the middle of the initial compensation year or in a subsequent year in which the agent/broker is receiving a renewal compensation for retention in that Medicare Advantage (MA) plan.

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

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

Table 2. Permissible Options for Compensating Independent Agents/Brokers when a Member Transitions from Compensation-eligible MA Product by Opting into a Texas MMP

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

Consistent with the guidance in section 110.6.5 et seq. of the MCMG, in the initial compensation scenario in the table above, the MA plan would be required to pro-rate the compensation paid to the agent for the months the enrollee was no longer enrolled in the MA plan.

In addition, we clarify that all other requirements applicable to independent agents/brokers throughout the MCMG, including section 110 of the MCMG, is applicable to Texas MMPs. We remind plans that all MMP enrollments will continue to be processed by the State's administrative services contractor.

We clarify that CMS does not regulate compensation of employed agents. We also clarify that MMP staff conducting marketing activity of any kind – as defined in section 20 of this guidance – must be licensed in the State (and, when required, appointed) as an insurance broker/agent.

Section 120.3 - Agent/Broker Training and Testing

In addition to the requirements of this section, we clarify that the state will not provide annual specifications for training and testing criteria and documentation requirements.

Appendix 2 - Disclaimers

The disclaimer language in the table below replaces the language in Appendix 2 of the MCMG.

Table 2. State-specific MMP Disclaimers

Note: Disclaimers are not required on the following material types: ID cards, call scripts, banners and banner-like ads, envelopes, outdoor advertising, text messages, and social media.

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Federal Contracting	<Plan's legal or marketing name> is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.	Required on materials except those specifically excluded above.
Benefits – "This is not a complete list…"	This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the <plan name> Member Handbook.	Required on the SB and all materials with ten (10) or more benefits except the EOC (Member Handbook).

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Availability of Non-English Translations	ATTENTION: If you speak <language of disclaimer>, language assistance services, free of charge, are available to you. Call <Member Services toll-free phone and TTY numbers, and days and hours of operation>. The call is free.	Required in applicable non-English languages on those model materials in section 100.4 for which the last row of the table indicates, "*Translation required:* Yes."
Non-plan and Non-health information	Neither Medicare nor Texas Medicaid has reviewed or endorsed this information.	Required on non-plan and non-health related information once prior authorization from the enrollee is granted to receive materials.

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

Appendix 3 - Pre-Enrollment Checklist

This appendix does not apply to MMPs since all enrollments are submitted by the State's administrative services contractor.

Appendix 7 - Use of Medicare Mark for Part D Sponsors

We clarify that MMPs have been required to sign a licensing agreement to use the official Medicare Mark as part of the three-way contract rather than through the HPMS contracting module. All other guidance in Appendix 7 of the MCMG applies.