Final Contract Year (CY) 2019 Marketing Guidance for Michigan Medicare-Medicaid Plans

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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, apply to Medicare-Medicaid plans (MMPs) participating in the Michigan 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 Michigan; 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 2019 benefits.

Use of Independent Agents and Brokers

We clarify that all requirements applicable to independent agents/brokers throughout the MCMG are inapplicable to MMPs in Michigan because the use of independent agents/brokers is not permitted. All MMP enrollment transactions must be processed by the State's enrollment broker.

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

Michigan 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 Michigan 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), 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 Michigan MMP websites.

[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.

Additional Guidance for Michigan MMPs

The following are additional Michigan MMP-specific modifications to the MCMG for CY 2019 beyond those that modify the MCMG:

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

- We clarify that MMPs may not send marketing materials to current MMP members about other Medicare products they offer, and they may not send information requesting members' prior authorization to receive materials about other Medicare products they offer. MMPs may not prompt current members to contact the MMP regarding other Medicare products. Such materials may only be sent when a current enrollee proactively makes a request for information about other Medicare products.

For purposes of the Michigan demonstration, we add the following guidance for use of the MI Health Link logo (the logo) by MMPs:

- All use of the MI Health Link logo must meet the following requirements:

    - The MI Health Link logo will not be used to imply sponsorship or endorsement on materials distributed by the MMP.

    - The MI Health Link logo will not be used in any manner that may possibly disparage, bring into disrepute, or negatively reflect on MI Health Link or in connection with any products or services that may possibly diminish or damage the goodwill of the MI Health Link program or the Michigan Department of Health and Human Services.

    - When the MI Health Link logo is used on materials – with the exception of materials related to rewards, incentives, promotional items, materials described in Table 1 of section 100.4 of this guidance, and other materials subject to marketing review – the MMP will include the following disclaimer:

        "The Michigan Department of Health and Human Services, MI Health Link program has not reviewed or endorsed this information."

    - All materials referred to in Table 1 of section 100.4 of this guidance must contain the MI Health Link logo.

    - MMPs may not include the MI Health Link logo on educational materials.

    - MMPs may not use the MI Health Link logo on business cards.

    - The MI Health Link logo appearance must not be altered. The MI Health Link logo must stand by itself so as to avoid unintended associations with any other objects, including, but not limited to, text, photographs, illustrations, borders, and edges.

- The width of the blank space surrounding the logo must be equal to 1/3 of the size of the symbol that is displayed (e.g., if the symbol is 30 pixels across, it must have 10 pixels of blank space above, below and on each side). The logo and the MMP's logo should retain their natural proportional size and should not appear stretched, distorted, or pixelated.

- The MI Health Link logo must not be used as a feature or design element, or be incorporated into any other service mark/logo.

- All materials that contain the MI Health Link logo, except the Member ID Card, must use the MI Health Link logo that includes the slogan "Linking Medicare and Medicaid for you." Furthermore, the Member ID Card must display the MI Health Link logo in the card's top right corner.

- Envelopes may, but are not required to, include the MI Health Link logo; however, consistent with Appendix 2 of the MCMG, envelopes are required to include the MMP's name or logo.

- Use of the MI Health Link logos is limited to the two versions (color and black/white – or reverse). The MI Health Link logo provided by the State to MMPs cannot be altered without the express permission of the Michigan Department of Health and Human Services.

- The MMP's logo must be displayed whenever the MI Health Link logo will appear on the MMP document(s) or material.

- The MI Health Link logo and the MMP's logo should appear next to each other wherever possible.

- The MI Health Link logo must appear in color whenever the ICO's logo is displayed in color on the same document or material.

- MMPs must submit materials that contain the MI Health Link logo for State review in HPMS under code 17053 unless the material has its own specified code (e.g., Member Handbook, Formulary, envelopes, etc.)

- MMPs' downstream contractors and related entities may not use the MI Health Link logo unless the document meets all of the guidelines set forth in this document and has been approved through HPMS or the State approved process.

- The State of Michigan, through the Michigan Department of Health and Human Services, retains the right to change these guidelines at any time.

In addition, all marketing, advertising, and member education materials the MMP sends must include the MMP's Member Services toll-free and TTY/TDD numbers.

All marketing, advertising, and member education materials must use the term "care coordinator(s)" when discussing the individual who coordinates members' care. Terms such as care manager, case manager, or any other term used by the MMP to discuss the care coordinator are prohibited.

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 has developed a joint review process 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.[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 will apply.

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.

MMPs may also use any State-specific plan type terminology in their marketing materials (e.g., a plan can state that Medicare-Medicaid Plans are also known as Integrated Care Organizations (ICOs) in Michigan), provided they comply with the guidance regarding use of the CMS standardized plan type in section 30.2 of the MCMG.

To reduce beneficiary confusion, we also clarify that MMPs in Michigan 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 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

Marketing materials must be available in languages appropriate to the beneficiaries being served within the demonstration region. All material must be culturally appropriate and available in alternative formats in accordance with the Americans with Disabilities Act. The standard articulated in this section of the MCMG regarding translation of marketing materials into non-English languages will be superseded to the extent that Michigan's standard for translation of marketing materials is more stringent. Guidance on the translation requirements for all plans,

[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).

including MMPs, is released annually each fall. Required languages for translation for the MMP are also updated annually, as needed, in the HPMS Marketing Module.

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 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.

For additional information regarding notice and tagline requirements, please 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/TDD numbers and days and hours of operation information for Michigan's enrollment broker at least once in any marketing materials that are provided prior to the time of enrollment and where a customer service number is provided for current and prospective enrollees to call.

Section 40.2 - Marketing Through Unsolicited Contacts

Section 40.2 of the MCMG provides examples of unsolicited direct contact with current and prospective enrollees. We reiterate that marketing via conventional mail and other print media (e.g., advertisements, direct mail) is not considered unsolicited contact and, therefore, is permissible.

In addition to the requirements of section 40.2 of the MCMG, MMPs conducting permitted unsolicited marketing activities, such as through e-mail (provided that they include an opt-out function), conventional mail and other print media, are required to include the following disclaimer on all materials used for that purpose:

> "For information on <plan name> and other options for your health care, call Michigan ENROLLS at 1-800-975-7630 (TTY: 1-888-263-5897). Office hours are Monday through Friday, 8 AM to 7 PM."

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

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[3] CMS makes available Spanish translations of the Michigan 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.

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 call current MMP enrollees to promote other Medicare plan types. Information about other Medicare plan types can only be provided at the proactive request of a current MMP enrollee.

- Consistent with section 40.3 of the MCMG, calls made by the MMP 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 (for example, those in 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 warm transferred to 1-800-MEDICARE or to the State Health Insurance Assistance Program (known in Michigan as the Michigan Medicare/Medicaid Assistance Program, or MMAP) for information and assistance.

Section 40.4 - Nominal Gifts

Under the Michigan demonstration, MMPs may not offer financial or other incentives, including private insurance, to induce enrollees or potential enrollees to enroll with the MMP or to refer a friend, neighbor, or other person to enroll with the plan. We clarify, however, that nominal gifts are permitted consistent with section 40.4 of the MCMG.

MMPs may offer a nominal gift to the general population in the community, provided that such promotion and distribution of materials are directed at the entire population of the MMP's approved demonstration region and are not given in connection with enrollment.

Rewards and incentives programs are permitted consistent with section 40.8 of this guidance and Chapter 4 of the Medicare Managed Care Manual.

Section 40.6 - Marketing Star Ratings

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be 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 will not be 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 for current members must be consistent with section 100 of Chapter 4 of the Medicare Managed Care Manual with the following modifications:

- The State has the authority to impose limitations or deny an incentive that seems inappropriate for health prevention and promotion behaviors.

- Reward and incentive items cannot be items that are considered a health benefit (e.g., a free checkup) or be offered in the form of cash or other monetary rebates.

Section 50.2 - Marketing/Sales Events

Under the Michigan demonstration, MMPs may hold marketing events to persuade enrollees or potential enrollees to enroll with the MMP; however, the MMP may not discuss enrollment, disenrollment, or Medicaid eligibility. The MMP must refer all such inquiries to the State's enrollment broker. Advertisement of a health fair must be directed at the general population. An MMP's name may be used in health fair advertisements only if the State has approved the advertisement.

Section 50.3 - Personal/Individual Marketing Appointments

Since Michigan MMPs will not be allowed to market directly to individual potential enrollees, the requirements of this section do not apply.

Section 60.1 - Provider-Initiated Activities

We clarify that the guidance in this section 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 enrollment broker.

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 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 will not be 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 website the contact information for the State's enrollment broker and must use the following language:

> "If you have questions about enrollment or disenrollment in MI Health Link, please call Michigan ENROLLS toll-free at 1-800-975-7630. Persons with hearing and speech disabilities may call the TTY number at 1-888-263-5897. The office hours are Monday through Friday, 8 AM to 7 PM."

MMPs must also include information on the potential for contract termination (i.e., a statement that the MMP may terminate or non-renew its contract, or reduce its service area, and the effect any of those actions may have on MMP enrollees, as required under 42 CFR 422.111(f)(4)), and information that materials are available in alternate formats (e.g., large print, braille, audio).

Section 80.2 - Customer Service Call Center Hours of Operations

We clarify that MMPs must operate a toll-free call center for both current and prospective enrollees seven (7) days a week, at least from 8:00 a.m. to 8:00 p.m. ET, except as provided below. Customer service call center hours and days must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. MMPs may use alternative technologies on Saturdays, Sundays, and State and/or Federal holidays (except New Year's Day) in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide 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 business day later. All other guidance in section 80.2 of the MCMG applies to MMPs.

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 referred to Michigan's enrollment broker. We also clarify that MMPs may not ask callers if they would like to receive information about other Medicare lines of business they offer. Such information may only be provided at the proactive request of a member.

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 enrollment broker.

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 alpha numeric 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). Please note that MMPs should include an approved status only after the material is approved and not when submitting the material for review.

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.

Section 90.1.1 - Materials Subject to Submission

CMS has developed a joint review process 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

The requirements of this section apply without modification. We note, however, that MMPs should use state-specific MMP website codes. For more information about website codes, MMPs should consult the Marketing Code Look up functionality in the HPMS marketing module.

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[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).

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. 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 Michigan capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. In addition, we note that the "non-marketing" status is not available for joint review process (JRP) marketing codes in HPMS for CY 2019. All other guidance in this section of the MCMG applies.

Section 90.8 - File & Use Process

We clarify that the File & Use certification process for MMPs is included in 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 2019 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 and Appendix 2 of the MCMG, 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:

[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).

- MMP-specific model materials tailored to MMPs in Michigan, including an Annual Notice of Change (ANOC), Summary of Benefits, Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated formulary (List of Covered Drugs), combined provider/pharmacy directory (Provider and Pharmacy Directory), single Member ID Card, integrated denial notice, state-specific appeals notices, and welcome letters for opt-ins and passively enrolled individuals and other plan-delegated enrollment notices: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html.

- Required Part D models, including the Excluded Provider Letter, Prescription Transfer Letter, and Transition Letter: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html.

- Required MMP Drug-Only Explanation of Benefits (EOB): https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html.

- Part D appeals and grievances models and notices (including those in Chapter 18 of the Prescription Drug Benefit Manual): https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html and https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html.

- Part C appeals and grievances models and notices (including those in Chapter 13 of the Medicare Managed Care Manual): http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Guidance.html and http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html.

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

Required Materials and Instructions for MMPs

Below is a list of required materials for Michigan 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 Look-up 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 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 17009 • Must be submitted prior to mailing ANOCs.
Format Specification:	• MI 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 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 o Provider and Pharmacy Directory o EOC (Member Handbook) o Formulary (List of Covered Drugs) o Form allowing enrollees to “opt-in” to receiving their upcoming ANOC and EOC via e-mail. o No additional plan communications unless otherwise directed.
Translation Required (5% Threshold):	Yes.

ANOC and EOC (Member Handbook) Erratas	
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 17006 for ANOC errata. • Code 17062 for EOC 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 (5% Threshold):	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 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 other CMS required notices. Refer to HPMS Marketing Code Look-up functionality for IL MMP codes.

Coverage/Organization Determination, Discharge, Appeals and Grievance Notices	
Format Specification:	• MI MMP models - standardized model; a non-model document is not permitted. • Other CMS models - modifications permitted.
Guidance and Other Needed Information:	Three-way contract, Chapter 13 of the Medicare Managed Care Manual, and Chapter 18 of the Medicare Prescription Drug Benefit Manual.
Translation Required (5% Threshold):	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 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 month after the effective date of enrollment, but not later than December 15th.
Method of Delivery:	Hard copy EOC (Member Handbook) or via Electronic Notice of 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.

Evidence of Coverage (EOC) / Member Handbook	
HPMS Timing and Submission:	• Code 17008. • Submitted prior to October 15 of each year.
Format Specification:	• MI 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 (5% Threshold):	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 17037
Format Specification:	Model provided; modifications permitted.
Guidance and Other Needed Information:	https://oig.hhs.gov/fraud/exclusions.asp
Translation Required (5% Threshold):	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 17036
Format Specification:	• MI MMP specific model - standardized model; a non-model document is not permitted.

Explanation of Benefits (EOB) – Part D	
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 (5% Threshold):	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 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 Electronic Notice of 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 17003
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 (5% Threshold):	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 10 days in advance of any adverse benefit determination.

Integrated Denial Notice	
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 17021
Format Specification:	• MI 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 (5% Threshold):	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 17011
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 (5% Threshold):	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.
HPMS Timing and Submission:	Various codes. Refer to HPMS Marketing Code Look-up functionality for MI 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 (5% Threshold):	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 17040
Format Specification:	Model provided; modifications permitted.
Guidance and Other Needed Information:	Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4.10.
Translation Required (5% Threshold):	Yes.

Plan Delegated Enrollment and Disenrollment Notices	
To Whom Required:	Must be provided as outlined in National Enrollment/Disenrollment Guidance for States & MMPs.
Timing:	Varies; must follow required timeframes as outlined in National Enrollment/Disenrollment Guidance for States & MMPs.
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:	Codes 17050.
Format Specification:	• MI MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• National Enrollment/Disenrollment Guidance for States & MMPs • MI Enrollment Guidance Appendix 5 • MMPs must use the Marketing Code Lookup functionality in the HPMS marketing module, along with the enrollment/disenrollment guidance, to determine the most appropriate code for their submissions.
Translation Required (5% Threshold):	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 17038
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 (5% Threshold):	Yes.

Provider and Pharmacy Directory	
To Whom Required:	Must be provided to all current enrollees of the plan.

Provider and Pharmacy Directory	
Timing:	• Must be sent to current enrollees of Plan for receipt 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 Electronic Notice of 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 17004
Format Specification:	• RI MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
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. • Michigan MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the Michigan MMP

Provider and Pharmacy Directory	
	Provider and Pharmacy Directory marketing code. • As applicable, refer to the language and guidelines issued in the August 16, 2018, HPMS memo, "Pharmacy Directories and Disclaimers" for the pharmacy portion of the combined directory.
Translation Required (5% Threshold):	• Yes.

Summary of Benefits	
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.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17001. Submitted prior to October 15 of each year.
Format Specification:	• MI 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 (5% Threshold):	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.

Welcome Letter	
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17002
Format Specification:	MI MMP model required for Contract Year.
Guidance and Other Needed Information:	• Must contain 4Rx information consistent with this model. • National Enrollment/Disenrollment Guidance for States & MMPs section 30.5.1
Translation Required (5% Threshold):	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 Members

Enrollment Mechanism	Required Materials for New Members	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 • Provider letter	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 access or receive the EOC)	No later than the day prior to the effective date of enrollment

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received more than 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) • Provider letter[7]	No later than the last day of the month prior to the effective date

[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.

[7] A provider letter is for enrollees to take with them when they go to appointments. It explains the enrollee's new benefit plan, continuity of care requirements, instructions for the provider to bill for services, and information on how to join the MMP's provider network. A model provider letter will be provided to MMPs by the State.

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received less than 10 calendar days before the end of the month)[8]	• 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) • Provider letter[9]	No later than 10 calendar days from receipt of the CMS confirmation of enrollment

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

The provisions in this section of the MCMG and all its subsections applicable to independent agents/brokers do not apply to MMPs since the use of independent agents/brokers is not permitted. All MMP enrollments will be processed by the State's enrollment broker. 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.

Appendix 2 - Disclaimers

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

[8] 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.

[9] A provider letter is for enrollees to take with them when they go to appointments. It explains the enrollee's new benefit plan, continuity of care requirements, instructions for the provider to bill for services, and information on how to join the MMP's provider network. A model provider letter will be provided to MMPs by the State.

Table 2: State-specific MMP Disclaimers

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 Michigan Medicaid to provide benefits of both programs to enrollees.	Required on materials as described in the "Applicable Documents and Notes" column in Appendix 2 of the MCMG.
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 10 or more benefits except the Member Handbook (EOC)
Availability of Non-English Translations	ATTENTION: If you speak <language of disclaimer>, language assistance services, free of charge, are available to you. Call <Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation>. The call is free.	Required on materials as described in the "Applicable Documents and Notes" column in Appendix 2 of the MCMG
Plan Online Enrollment Center	This disclaimer does not apply to MMPs.	N/A
Star Ratings	This disclaimer does not apply to MMPs.	N/A
Materials Developed by a Third Party	This disclaimer does not apply to MMPs.	N/A

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Non-plan and Non-health information	Neither Medicare nor Michigan 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.

Appendix 3 - Pre-Enrollment Checklist

This appendix does not apply to MMPs since all enrollments are submitted by the Michigan enrollment broker.

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.