Final CY 2015 Marketing Guidance for Illinois Medicare-Medicaid Plans

Released: July 25, 2014

Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the CY 2015 Medicare Marketing Guidelines (MMG) (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual), posted at http://www.cms.gov/ManagedCareMarketing, apply to Medicare-Medicaid plans (MMPs) participating in the Illinois Capitated Financial Alignment Demonstration, except as noted or modified in this guidance document.[1]

This guidance document provides information only about those sections of the MMG that are not applicable or that would be different for MMPs in Illinois; therefore, this guidance document should be considered an addendum to the CY 2015 MMG. This MMP guidance will be applicable to all marketing done for CY 2015 benefits. The table below summarizes those sections of the CY 2015 MMG that are clarified, modified, or replaced for Illinois MMPs in this guidance.

Table 1: Summary of Clarifications, Modifications, or Replacements of MMG Guidance

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 30.5 – Requirements Pertaining to Non-English Speaking Populations	Clarifies the requirements of this section for MMPs.
Section 30.6 – Required Materials with an Enrollment Form	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter	Replaces current guidance in the MMG with new guidance for MMPs.
Section 30.10 – Star Ratings Information from CMS	Clarifies that the requirements of this section are not applicable to MMPs.

[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 MMG do not apply unless specifically noted in this guidance.

Section 30.10.1 – Referencing Star Ratings in Marketing Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.10.2 – Plans with an Overall 5-Star Rating	Clarifies that the requirements of this section are not applicable to MMPs.
Section 40.6 – Hours of Operation Requirements for Marketing Materials	Adds new requirements for MMPs to current MMG requirements of this section.
Section 40.8 – Marketing of Multiple Lines of Business	Clarifies that organizations offering both MMP and non-MMP products in a service area may not market the non-MMP products in MMP marketing materials.
Section 40.8.1 – Multiple Lines of Business – General Information	Clarifies that MMPs may not send marketing materials to current 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.
Section 40.8.3 – Marketing Materials from Third Parties that Provide Non-Benefit/Non-Health Services	Clarifies that the requirements of this section do not apply to materials produced by the State and the State's enrollment broker. Adds a new prohibition on the use of materials developed by third parties that provide non-benefit/non-health service materials for MMPs.
Section 40.10 – Standardization of Plan Name Type	Clarifies the requirements of this section for MMPs.
Section 50.1 – Federal Contracting Disclaimer	Replaces current disclaimer in this section with a new Federal-State disclaimer for MMPs.
Section 50.2 – Disclaimers When Benefits Are Mentioned	Replaces current disclaimers in this section with new disclaimers for MMPs.
Section 50.3 – Disclaimers When Plan Premiums Are Mentioned	Clarifies that the requirements of this section are not applicable to MMPs.
Section 50.4 – Disclaimer on Availability of Non-English Translations	Replaces current disclaimer in this section with a new disclaimer for MMPs.
Section 50.5 – Disclaimer on SNP Materials	Clarifies that MMPs must include a disclaimer regarding the NCQA approval of their model of care and replaces current disclaimer in this section with a new disclaimer for MMPs.

Section 50.6 – Disclaimer when Cost-Sharing is Mentioned on D-SNP Materials Targeting Potential Enrollees	Replaces current disclaimer in this section with a new disclaimer for MMP materials that include Part D benefit information.
Section 50.12 – Disclaimer for Plans Accepting Online Enrollment Requests	Clarifies that the requirements of this section are not applicable to MMPs.
Section 50.13 – Disclaimer When Using Third Party Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 50.14 – Disclaimer When Referencing Star Ratings Information	Clarifies that the requirements of this section are not applicable to MMPs.
Section 60.1 – Summary of Benefits (SB)	Replaces current guidance in this section with new guidance for MMPs.
Section 60.2 – ID Card Requirements	Clarifies the requirements of this section for MMPs.
Section 60.4 – Directories	Clarifies the requirements of this section for MMPs and provides additional flexibility regarding the requirements for providing MMP directories to enrollees at the time of enrollment and thereafter.
Section 60.5 – Formulary and Formulary Change Notice Requirements	Clarifies the requirements of this section for MMPs. Extends the requirements for formulary change notifications to Medicaid-covered drugs.
Section 60.7 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)	Replaces current guidance in this section with new guidance for MMPs.
Section 60.8 – Other Mid-Year Changes Requiring Enrollee Notification	Extends the requirements of this section to mid-year changes in Medicaid benefits.
Section 70.1.1 – Nominal Gifts	Clarifies that nominal gifts may not be provided to prospective enrollees.
Section 70.5 – Marketing Through Unsolicited Contacts	Clarifies that, in addition to the requirements of this section, the State's enrollment broker information should be included on marketing materials under certain circumstances.
Section 70.7 – Outbound Enrollment and Verification Requirements	Clarifies that the requirements of this section are not applicable to MMPs.
Section 70.9.2 – Personal/Individual Marketing Appointments	Clarifies that the requirements of this section do not apply to MMPs.

Section 70.11 – Marketing in the Health Care Setting	Extends the requirements of this section to MMPs in long-term care facilities.
Section 70.11.5 – Comparative and Descriptive Plan Information Provided by a Non-Benefit/Non-Health Service-Providing Third Party	Clarifies that the requirements of this section vis-à-vis State agencies also apply to the State's enrollment broker.
Section 80.1 – Customer Service Call Center Requirements	Replaces current guidance in this section regarding permissible use of alternate call center technologies on weekends and holidays with new guidance for MMPs.
Section 80.2 – Requirements for Informational Scripts	Clarifies requirements in this section for MMPs.
Section 90 – The Marketing Review Process	Clarifies that references in this section (and subsections) to CMS in its role in marketing reviews also apply to the State.
Section 90.2.3 – Submission of Multi-Plan Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 90.3 – HPMS Material Statuses Section 90.5 – Time Frames for Marketing Review	Clarifies the requirements of these sections with respect to the lack of "deeming" for jointly reviewed materials.
Section 90.6 – File & Use Process	Clarifies the File & Use certification process for MMPs.
Section 90.6.1 – Restriction on the Manual Review of File & Use Eligible Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.2 – Required Content	Adds new requirements for MMPs to current MMG requirements of this section.
Section 100.2.1 – Required Documents for All Plans/Part D Sponsors	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.2.2 – Required Documents for Part D Sponsors	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.3 – Electronic Enrollment	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.5 – Online Formulary, Utilization Management (UM), and Notice Requirements	Extends the formulary change notice requirements of this section to non-Part D drug formulary changes.

Section 120 – Marketing and Sales Oversight and Responsibilities	Clarifies that the requirements of this section (and subsections) are not applicable to MMPs with respect to independent agents and brokers.
Section 150 – Use of Medicare Mark for Part D Sponsors	Clarifies the requirements of this section for MMPs.
Section 160.1 – When Prior Authorization from the Beneficiary is Not Required	Clarifies that MMPs may not send marketing materials to current 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.
Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received	Replaces current disclaimer in this section with a new disclaimer for MMPs.

In addition, we clarify that all requirements applicable to independent agents/brokers throughout the MMG will be inapplicable to MMPs in Illinois, because the use of independent agents/brokers will not be permitted and all MMP enrollment transactions must be processed by the State's enrollment broker.

We refer MMPs to the following available model materials. We note that materials created by MMPs 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 will be acceptable for use as currently provided, and MMPs must add required disclaimers in section 50 of this guidance, as appropriate. Adding required MMP disclaimers to Part D models will not render the documents non-model when submitted for review or accepted as File & Use materials.

- MMP-specific model materials tailored to MMPs in Illinois, including an Annual Notice of Change (ANOC), Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated formulary, combined provider/pharmacy directory, ID card, and welcome letter for passively enrolled individuals: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

  CY 2015 MMP-specific model materials tailored to MMPs in Illinois will be added to the website and will also be disseminated via the Health Plan Management System (HPMS).

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

- Part D appeals and grievances models in Chapter 18 of the Prescription Drug Benefit Manual: http://cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.html.

- Part C appeals and grievances models in Chapter 13 of the Medicare Managed Care Manual: http://cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html.

- ANOC/EOC (Member Handbook) errata model: http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html.

- The CMS Multi-Language insert model (Appendix 3 of the MMG): http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.html.

Following are the Illinois MMP-specific modifications to the MMG for CY 2015.

Section 30.5 – Requirements Pertaining to Non-English Speaking Populations

The standard articulated in this section for translation of marketing materials into non-English language will be superseded to the extent that Illinois' standard for translation of marketing materials is more stringent. The Illinois translation standard – which requires translation of materials into "prevalent languages" (i.e., Spanish and any language that is the primary language of 5% or more of the plan's service area population) – exceeded the Medicare standard for translation in Illinois MMP service areas for CY 2015.[2] Guidance regarding the CY 2015 translation requirements will be released later in 2014, and the required languages for translation for each MMP will be updated as necessary in the HPMS Marketing Module. We expect the Illinois standard for translation will likely be the more stringent (and, therefore, applicable) standard for Illinois MMPs for CY 2015. Therefore, for CY 2015, Illinois' standard requires translation of required marketing materials into Spanish. Required materials are (the Summary of Benefits (SB), ANOC/EOC (Member Handbook), formulary (List of Covered Drugs), provider/pharmacy directory (Provider and Pharmacy Network Directory), and the Part D transition letter.[3]

Section 30.6 – Required Materials with an Enrollment Form

Because MMPs will be too new to measure under the CMS plan (star) rating system, they will not be required to include the Star Ratings Information document when a beneficiary is provided with pre-enrollment information. We further clarify that the responsibility for sending enrollment and disenrollment notices to enrollees will be delegated to Illinois or its enrollment broker.

Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter

This section is replaced with the following revised guidance:

> **Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter**
>
> 42 CFR 422.111(c)(1), 423.128(c)(1), 422.2264(a), 423.2264(a)

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[2] Guidance on the CY 2014 translation requirements for all plans, including MMPs, was issued via HPMS and entitled, "Contract Year 2014 Translated Marketing Materials Requirements and Methodology" on September 18, 2013 and is located at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014MMPTranslationHPMSMemo.pdf. For additional information, refer to the April 10, 2013 HPMS memorandum, "Translation Requirements for CY 2013 Medicare-Medicaid Plans (MMPs)" at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CY2013MMPTranslationHPMSMemoFinal041013.pdf.

[3] CMS will make available Spanish translations of the Illinois MMP Summary of Benefits (SB), formulary, provider/pharmacy directory, and ANOC/EOC (Member Handbook). CMS makes available a Spanish translation of the Part D transition letter to all Medicare health plans at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html.

The following materials must be provided to enrollees at the time of enrollment and annually thereafter:

- Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) (Member Handbook), or simply an Evidence of Coverage (EOC) (Member Handbook), as applicable and described in the replacement guidance below for section 60.7 of the MMG.

- A comprehensive integrated formulary (List of Covered Drugs) that includes Medicare and Medicaid outpatient prescription drugs and over-the-counter pharmacy drugs or products provided under the MMP.

- A combined provider and pharmacy directory (Provider and Pharmacy Network Directory) that includes all providers of Medicare, Medicaid, and additional benefits, or information about how to access or receive the pharmacy/provider directory (required at the time of enrollment; see section 60.4 for additional information about provision of a directory post-enrollment).

- A single identification (ID) card for accessing all covered services under the plan (required at the time of enrollment and as needed or required by the MMP post-enrollment).

- For individuals enrolled through passive enrollment, a demonstration plan-specific Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including co-pays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. Because the EOC (Member Handbook) may not be provided until just prior to the effective date of a passive enrollment, the SB must be provided to individuals enrolled through passive enrollment prior to receipt of the EOC (Member Handbook) to ensure that they have sufficient information about plan benefits to make an informed decision prior to the passive enrollment effective date. Refer to the revised guidance for section 60.7 contained in this document for more information about when an MMP must send an SB to current enrollees post-enrollment.

MMPs must provide enrollees who self-select into the demonstration the following materials no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever occurs later. We clarify that this group of enrollees who self-select 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. For late-month enrollment transactions (those for which CMS confirmation of enrollment is received less than ten (10) calendar days before the end of the month prior to the effective date), MMPs must send these materials no later than ten (10) calendar days from receipt of CMS confirmation of enrollment. 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.

- A welcome letter consistent with a model developed jointly by CMS and the State

- A comprehensive integrated formulary
- A combined pharmacy/provider directory, or information about how to access or receive the pharmacy/provider directory, consistent with section 60.4 of this guidance
- A single ID card

MMPs must provide enrollees who are passively enrolled the following materials no later than 30 calendar days prior to the effective date of enrollment:

- A welcome letter consistent with a model developed jointly by CMS and the State
- A comprehensive integrated formulary
- A combined pharmacy/provider directory, or information about how to access or receive the pharmacy/provider directory, consistent with section 60.4 of this guidance
- A Summary of Benefits (SB)

We clarify that individuals eligible for passive enrollment who select a different MMP or initiate an earlier enrollment date than their passive enrollment effective date must receive the materials listed above (and on the same timeline) as enrollees who self-select into the demonstration. Additional materials may not be included in this mailing, unless the MMP chooses to mail the EOC (Member Handbook) and ID card early along with the materials in this mailing.

In addition, MMPs must provide enrollees who are passively enrolled a single ID card for receipt by the end of the month preceding the month the enrollment will take effect (e.g., the ID card must be received by a beneficiary by March 31 for an April 1 effective enrollment date).

After the time of initial enrollment for both enrollees who are passively enrolled and enrollees who self-select into the demonstration, the Annual Notice of Change (ANOC) and EOC (Member Handbook) must also be provided annually consistent with the replacement guidance below for section 60.7 of the MMG.

The following tables summarize the requirements of this section.

Table 2: Required Materials for New Members

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Passive enrollment	• Welcome letter • Formulary • Pharmacy/provider directory, (or information about how to access or receive the directory) • SB	30 calendar days prior to the effective date of enrollment
	• ID card • EOC (Member Handbook)	No later than the day prior to the effective date of enrollment
Self-selected enrollment (with enrollment confirmation received more than 10 calendar days before the end of the month)	• Welcome letter • Formulary • Pharmacy/provider directory, (or information about how to access or receive the directory) • ID card • EOC (Member Handbook)	No later than the last day of the month prior to the effective date
Self-selected enrollment (with enrollment confirmation received less than 10 calendar days before the end of the month)	• Welcome letter • Formulary • Pharmacy/provider directory, (or information about how to access or receive the directory) • ID card • EOC (Member Handbook)	No later than 10 calendar days from receipt of the CMS confirmation of enrollment

Table 3: Required Materials for Renewing Members

Required Materials for Renewing Members	Timing of Beneficiary Receipt
• ANOC/EOC (Member Handbook) • Formulary	September 30
• ID card	As needed
• Pharmacy/provider directory (or information about how to access or receive the directory)	At least every three years, with change pages for major network changes as needed. The plan website's directory must be kept up-to-date consistent with section 100.4.

Section 30.10 – Star Ratings Information from CMS

Because MMPs will be too new to measure under the CMS plan (star) rating system, this section does not apply to MMPs.

Section 30.10.1 – Referencing Star Ratings in Marketing Materials

Because MMPs will be too new to measure under the CMS plan (star) rating system, this section does not apply to MMPs.

Section 30.10.2 – Plans with an Overall 5-Star Rating

Because MMPs will be too new to measure under the CMS plan (star) rating system, this section does not apply to MMPs.

Section 40.6 – Hours of Operation Requirements for Marketing Materials

In addition to the requirements of this section, MMPs must also provide the phone number and hours of operation information for the State'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 40.8 – Marketing of Multiple Lines of Business

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.

Section 40.8.1 – Multiple Lines of Business – General Information

We clarify that MMPs may not send marketing materials to current 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. Such materials may only be sent when a current enrollee proactively makes a request for information about other Medicare products.

Section 40.8.3 – Marketing Materials from Third Parties that Provide Non-Benefit/Non-Health Services

In addition to the guidance in this section, CMS and the State clarify that materials produced by the State and its enrollment broker do not constitute non-benefit/non-health service-providing third party marketing materials. Therefore, such materials do not need to be submitted to the plan sponsor for review prior to their use. As indicated in the CMS "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 2, 2012, the CMS MMG do not apply to communications by State governments, and materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials.

In addition, we clarify that Illinois MMPs may not distribute materials from non-benefit/non-health service providing third party entities.

Section 40.10 – 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 Demonstration. MMPs must use the "Medicare-Medicaid Plan" terminology consistent with the requirements of section 40.10 of the MMG, which include a requirement that an MMP use the "(Medicare-Medicaid Plan)" standardized plan type label following the plan name at least once on the front page or beginning of each marketing piece. Illinois also refers to MMPs as Medicare-Medicaid Plans and has provided additional information about branding for the demonstration.

In addition, we clarify that MMPs in Illinois 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 in order to reduce beneficiary confusion. 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 50.1 – Federal Contracting Disclaimer

This section is replaced with the following revised guidance:

> **Section 50.1 – Federal and State Contracting Disclaimer**
>
> 42 CFR 422.2264, 423.2264
>
> All marketing materials must include the statement that the MMP contracts with both the Federal and the State government. The following statement must be used:

"<Plan's legal or marketing name> is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees."

NOTE: Radio and television and Internet banner ads do not need to include the Federal and State contracting disclaimer.

Section 50.2 – Disclaimers When Benefits Are Mentioned

This section is replaced with the following revised guidance:

Section 50.2 – Disclaimers When Benefits Are Mentioned

42 CFR 422.111(a), 422.111(b), 422.111(f), 423.128(b)

The following disclaimers must be used when benefit information is included in marketing materials:

Only for summary documents like the Summary of Benefits (SB): "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 Member Handbook."

"Limitations [, copays,] and restrictions may apply. For more information, call <plan name> <Member Services> or read the <plan name> Member Handbook."

"Benefits, List of Covered Drugs, pharmacy and provider networks [and/or copayments] may change from time to time throughout the year and on January 1 of each year."

Section 50.3 – Disclaimers When Plan Premiums Are Mentioned

This section does not apply to MMPs, as MMPs are not permitted to assess plan premiums, and States will pay Medicare Part B premiums on behalf of Medicare-Medicaid enrollees in MMPs.

Section 50.4 – Disclaimer on Availability of Non-English Translations

This section is replaced with the following revised guidance:

Section 50.4 – Disclaimer on Availability of Non-English Translations

42 CFR 422.2264(e), 423.2264(e)

Plan sponsors that meet either: (1) Medicare's five (5) percent threshold for language translation (refer to section 30.7) or (2) the relevant Medicaid translation standard must place the following alternate language disclaimer on all materials as required in section 30.7.

"You can get this document in Spanish, or speak with someone about this information in other languages for free. Call <toll-free number>. The call is free."

The alternate language disclaimer must be provided in both English and Spanish. The Spanish disclaimer must be placed below the English version and in the same font size as the English version.

NOTE: ID cards are excluded from this requirement.

Section 50.5 – Disclaimer on SNP Materials

We clarify that the prohibition on discussion of numeric Special Needs Plan (SNP) approval scores in marketing materials or press releases also applies to MMPs. MMPs may only include the following information related to their National Committee for Quality Assurance (NCQA) model of care approval:

"<Plan name> has a Model of Care approved by the National Committee for Quality Assurance (NCQA) and Illinois Medicaid until <last contract year of NCQA and State approval of model of care> based on a review of < plan name>'s Model of Care."

Section 50.6 – Disclaimer When Cost-Sharing is Mentioned on D-SNP Materials Targeting Potential Enrollees

This section is replaced with the following revised guidance:

Section 50.6 – MMP Materials Including Part D Benefit Information

42 CFR 422.2, 422.4(a)(1)(iv), 422.111(b)(2)(iii), 422.2264, 423.2264

The following disclaimer must be on any MMP materials that mention Part D benefits, unless the plan charges $0 copays for <u>all</u> Part D drugs:

"Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details."

Section 50.12 – Disclaimer for Plans Accepting Online Enrollment Requests

This section does not apply to MMPs, as the Online Enrollment Center on the Medicare Plan Finder website is not available to MMPs.

Section 50.13 – Disclaimer When Using Third Party Materials

This section does not apply to MMPs because they are not permitted to distribute materials developed by a non-benefit/non-health service providing third party entity that is not affiliated or contracted with the MMP.

Section 50.14 – Disclaimer When Referencing Star Ratings Information

Because MMPs are too new to measure under the CMS plan (star) rating system, this section does not apply to MMPs.

Section 60.1 – Summary of Benefits (SB)
This section is replaced with the following revised guidance:

> **Section 60.1 – Summary of Benefits (SB)**
>
> 42 CFR 422.111(b)(2), 422.111(f), 423.128(b)(2)
>
> MMPs must use the Summary of Benefits (SB) model document provided to Illinois MMPs by CMS and the State. 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 co-pays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.
>
> The Multi-Language Insert must be included with the SB.

Section 60.2 – ID Card Requirements

MMPs are required to meet the ID card content requirements in sections 60.2, 60.2.1, and 60.2.2. We clarify, however, that MMPs must issue a single ID card meeting these requirements for all services offered under the plan. Separate pharmacy and health benefits ID cards are not permitted. MMPs must use the model ID card document provided to Illinois MMPs by CMS and the State.

Section 60.4 – Directories

The pharmacy and provider directory requirements in sections 60.4, 60.4.1, 60.4.1.1, and 60.4.2 apply to MMPs with the following modifications:

- MMPs are required to make available a single, combined pharmacy/provider directory. Separate pharmacy and provider directories are not permitted;

- At the time of enrollment and then as required thereafter, MMPs have the option to mail either a pharmacy/provider directory or a document that provides enrollees with information about how to access the directory on the MMP website, as well as how to call the plan's customer service call center to request assistance with locating providers and request that a pharmacy/provider directory be mailed to them;

- The combined pharmacy/provider 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 pharmacy/provider 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) 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 pharmacy/provider directory; and

- MMPs must use the model pharmacy/provider directory document provided to Illinois MMPs by CMS and the State.

Section 60.5 – Formulary and Formulary Change Notice Requirements

The requirements of section 60.5, 60.5.1, 60.5.2, 60.5.3, 60.5.4, 60.5.5, and 60.5.6 apply to MMPs with the following modifications:

- MMPs must provide a comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the plan;

- MMPs are only permitted to provide comprehensive formularies, not abridged formularies;

- MMPs must use the model formulary document provided to Illinois MMPs by CMS and the State; and

- 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 the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan. Consistent with the guidance in the MMG, this notice must be provided to affected enrollees at least 60 calendar days prior to the change.

Section 60.7 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

This section is replaced with the following revised guidance:

> **Section 60.7 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) (Member Handbook)**
>
> 42 CFR 422.111(a)(3), 422.111(d)(2), 423.128(a)(3)
>
> MMPs are required to send an Annual Notice of Change (ANOC) summarizing all major changes to the plan's covered benefits from one contract year to the next prior to the beginning of the second contract year of the demonstration and annually thereafter. The MMP may send the ANOC and EOC (Member Handbook) as a combined document or separately, as provided below.
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> MMPs must send the ANOC for member receipt by September 30 each year. The EOC (Member Handbook) may be sent as a standalone document as follows:
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> - MMPs must send new enrollees (whether they self-select into the demonstration or are passively enrolled) an EOC (Member Handbook) for member receipt by the end of the month preceding the month the enrollment will take effect (e.g., the document must be received by a beneficiary by June 30 for a July 1 effective enrollment date). For late-month enrollment transactions (those for which CMS confirmation of enrollment is received less than ten (10) calendar days before the

end of the month prior to the effective date), MMPs must send these materials no later than ten (10) calendar days from receipt of CMS confirmation of enrollment.

- After the time of initial enrollment, MMPs must annually send a combined ANOC/EOC (Member Handbook) for member receipt by September 30.

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 a combined ANOC/EOC (Member Handbook) document for the upcoming contract year. We clarify that, for these members, the combined ANOC/EOC (Member Handbook) for the upcoming year, as well as the formulary, and pharmacy/provider directory (or information about how to access the directory online or obtain a hard copy) for the upcoming year, must be received by one month after the effective date of enrollment, but not later than December 15th.

Additional materials beyond the materials required to be sent with the ANOC/EOC or ANOC and EOC may not be included with the ANOC, EOC, or ANOC/EOC mailing.

To ensure that MMPs are mailing their annual ANOC/EOC (Member Handbook) in a timely manner, plan sponsors must indicate the actual mail date in HPMS within fifteen (15) calendar days of mailing. This includes mail dates for alternate materials. MMPs that mail in waves should enter the actual date for each wave. For instructions on meeting this requirement, refer to the *Update Material Link/Function* section of the Marketing Review Users Guide in HPMS.

MMPs must use the ANOC/EOC (Member Handbook) errata model to notify enrollees of any errors in their original mailings.

Section 60.8 – Other Mid-Year Changes Requiring Enrollee Notification

The notification requirements for mid-year Medicare benefit changes described in this section are also applicable to mid-year Medicaid or required demonstration additional benefit changes.

Section 70.1.1 – Nominal Gifts

Under the Illinois 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. This includes nominal gifts offered at MMP-targeted educational events. Therefore, the guidance in section 70.1.1 does not apply, because MMPs are not permitted to offer nominal gifts. We clarify, however, that promotional activities, rewards, and incentives for current members are permitted consistent with sections 70.1 and 70.2 of the MMG.

Section 70.5 – Marketing Through Unsolicited Contacts

In addition to the requirements of section 70.5, MMPs conducting permitted unsolicited marketing activities such as 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 the Illinois Client Enrollment Services at 1-877-912-8880 (TTY: 1-866-565-8576) or visit http://enrollhfs.illinois.gov/."

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

Section 70.7 – Outbound Enrollment and Verification Requirements

Since all enrollments into MMPs will be submitted by the State's enrollment broker, the requirements of this section do not apply.

Section 70.9.2 – Personal/Individual Marketing Appointments

Since Illinois MMPs are not allowed to market directly to individual potential enrollees, the requirements of this section do not apply.

Section 70.11 – Marketing in the Health Care Setting

The flexibility provided in the last paragraph of this section for long-term care facility staff to provide residents meeting the eligibility criteria for an Institutional Special Needs Plan (I-SNP) with an explanatory brochure for each I-SNP with which the facility contracts is also applicable to MMPs.

Section 70.11.5 – Comparative and Descriptive Plan Information Provided by a Non-Benefit/Non-Health Service-Providing Third Party

We clarify that the guidance in this section referring to materials provided by a "State agency" also applies to materials produced and/or distributed by Illinois' enrollment broker.

Section 80.1 – Customer Service Call Center Requirements

This section is replaced with the following revised guidance:

Section 80.1 – Customer Service Call Center Requirements

42 CFR 422.111(h)(1), 423.128(d)(1)

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. CT, except as provided below. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. For CY 2015, MMPs may use alternative technologies on Saturdays, Sundays, and Federal holidays 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 below, 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.

Call centers must meet the following operating standards:

- Provide information in response to inquiries outlined in sections 80.2 – 80.4. If callers are transferred to a third party for provision of the information listed in sections 80.2 and 80.4, all other requirements in section 80.1 apply to the third party.
- Follow an explicitly defined process for handling customer complaints.
- Provide interpreter services to all non-English speaking, limited English proficient, and hearing-impaired beneficiaries.
- Inform callers that interpreter services are "free."
- Limit average hold time to two (2) minutes. The average hold time is defined as the time spent on hold by the caller following the IVR system, touch-tone response system, or recorded greeting and before reaching a live person.
- Answer eighty (80) percent of incoming calls within thirty (30) seconds.
- Limit the disconnect rate of all incoming calls to five (5) percent.

For Pharmacy Technical Help or Coverage Determinations and Appeals Call Center requirements, refer to Appendix 4 in the MMG.

Section 80.2 – Requirements for Informational Scripts

We clarify that informational calls to plan call centers that become sales/enrollment calls at the proactive request of the beneficiary must be transferred to the State'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.

Section 90 – The Marketing Review Process

Any references in this section, 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 90.2.3 – Submission of Multi-Plan Materials

This section does not apply to MMPs.

Section 90.3 – HPMS Material Statuses

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. All other guidance in this section and its subsections applies.

Section 90.5 – Time Frames for Marketing Review

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. All other guidance in this section and its subsections applies.

Section 90.6 – File & Use Process

We clarify that the File & Use certification process for MMPs is to be handled through the three-way contract. All other guidance in section 90.6 and all its subsections applies.

Section 90.6.1 – Restriction on the Manual Review of File & Use Eligible Materials

This section does not apply to MMPs.

Section 100.2 – 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 enrollment broker website. MMPs must also include information on the potential for contract termination, and information that materials are published in alternate formats (e.g., large print, Braille, audio CD).

Section 100.2.1 – Required Documents for All Plans/Part D Sponsors

Because MMPs will be too new to measure under the CMS plan (star) rating system, MMPs will not be required to post a CMS plan ratings document on their websites.

Section 100.2.2 – Required Documents for Part D Sponsors

MMPs will not be required to post the LIS Premium Summary Chart, as this document will not be applicable to MMPs.

Section 100.3 – Electronic Enrollment

This section is not applicable to MMPs. The Online Enrollment Center will not be enabled for MMPs, and MMPs will not be permitted to directly enroll individuals through a secure Internet website. All enrollments will be processed via the State's enrollment broker.

Section 100.5 – Online Formulary, Utilization Management (UM), and Notice Requirements

Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on MMPs' websites as required in this section.

Section 120 – Marketing and Sales Oversight and Responsibilities

The provisions in this section and all its subsections applicable to independent agents/brokers do not apply to MMPs since the use of independent agents/brokers will not be permitted. All MMP enrollments will be processed by the State's enrollment broker. We clarify that CMS does not regulate compensation of employed agents.

Section 150 – 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 section 150 and all its subsections applies.

Section 160.1 – When Prior Authorization from the Beneficiary is Not Required

We clarify that MMPs may not send marketing materials to current 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. Such materials may only be sent when a current enrollee proactively makes a request for information about other Medicare products.

Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received

The disclaimer described in this section should be modified as follows:

> "Neither Medicare nor Illinois Medicaid has reviewed or endorsed this information."