DRAFT CY 2015 Marketing Guidance for Texas Medicare-Medicaid Plans

Released for Comment: December 5, 2014

Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the CY 2015 Medicare Marketing Guidelines (MMG), posted at http://www.cms.gov/ManagedCareMarketing, apply to Medicare-Medicaid plans (MMPs) participating in the Texas 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 Texas; 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 Texas 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 10 - Introduction	Clarifies guidance on marketing start dates for CY 2015 and adds guidance on materials subject to State review.
Section 20 – Materials Not Subject to Review	Adds guidance on materials not subject to CMS or state review and clarifies that "general health promotion materials" has the same meaning as "health-related materials" in the three-way contract.
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 30.9 – Enrollee Referral Programs	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.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 30.10 – Star Ratings Information from CMS	Clarifies that the requirements of this section are not applicable to MMPs.
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 40.1 – Marketing Material Identification	Clarifies the terminology in this section and add requirements regarding placement of the marketing material identification number.
Section 40.4 – Prohibited Terminology/Statements	Adds new requirements for MMPs to current MMG requirements of this section.
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 organizations offering both MMPs and non-MMP Medicare health plans may only send current members information about their MMP product.
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 its administrative services contractor. Clarifies that this section applies only with respect to marketing materials from third parties that provide non-benefit/non-health services only when they are specifically general health promotion/health related materials.
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.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
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	Replaces current disclaimer in this section with a new disclaimer for 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.
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.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 70.1 – Promotional Activities	Replaces current guidance in this section with new guidance for MMPs.
Section 70.1.1 – Nominal Gifts	Adds new requirements for MMPs to current MMG requirements of this section.
Section 70.2 – Rewards and Incentives	Adds new requirements for MMPs to current MMG requirements of this section.
Section 70.5 – Marketing Through Unsolicited Contacts	Adds a new requirement on marketing through unsolicited contacts by conventional mail and other print media.
Section 70.6 – Telephonic Contact	Clarifies that MMPs may not call current MMP enrollees to promote other Medicare plan types. Similarly, organizations that offer non-MMP and MMP products may call their current non-MMP members (for example, those in Medicaid managed care products) to promote their MMP offerings. Adds a new prohibition on contacting individuals who submit enrollment applications to conduct quality control and agent oversight activities. Also clarifies that MMPs may not contact members who have been involuntarily disenrolled to resolve eligibility issues.
Section 70.7 – Outbound Enrollment and Verification Requirements	Clarifies that the requirements of this section are not applicable to MMPs.
Section 70.8 – Prospective Enrollee Educational Events	Adds new requirements for MMPs to current MMG requirements of this section.
Section 70.9 - Marketing/Sales Events and Appointments	Adds new requirements for MMPs to current MMG requirements of this section.
Section 70.9.2 – Personal/Individual Marketing Appointments	Adds new requirements for MMPs to current MMG requirements of this section.
Section 70.11 – Marketing in the Health Care Setting	Replaces current guidance in this section with new guidance for MMPs.
Section 70.11.1 – Provider Based Activities	Adds new requirements for MMPs to current MMG requirements of this section.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
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 administrative services contractor.
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 – Plan/Part D Sponsor Websites and Social/Electronic Media	Clarifies requirements regarding social and electronic media and requests MMP comments on social media policy.
Section 100.1 – General Website Requirements	Adds new requirements for MMPs to current MMG requirements of this section.
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.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
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.
Section 120.3 – Agent/Broker Training and Testing	Clarifies that the state will not provide annual specifications for training and testing criteria and documentation requirements.
Section 150 – Use of Medicare Mark for Part D Sponsors	Clarifies the requirements of this section for MMPs.
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 are inapplicable to MMPs in Texas, because the use of independent agents/brokers is not permitted and all MMP enrollment transactions must be processed by the State's administrative services contractor.

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 section 2.3.6.5 of the three-way contract. Available model materials reflect acceptable reading levels. Current Part D models are acceptable for use as currently provided. 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.

- MMP-specific model materials tailored to MMPs in Texas, including an Annual Notice of Change (ANOC), Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated formulary, combined provider/pharmacy directory, ID card, welcome letter for passively enrolled individuals, and the welcome letter for individuals who voluntarily enrolled: 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 Texas will be added to this 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://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.

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

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

Section 10 – Introduction

The prohibition on marketing for an upcoming year prior to October 1 will only apply when the upcoming plan year begins on January 1. Given the anticipated demonstration start in Texas for CY 2015, MMPs may not begin marketing activity prior to February 1, 2015, or once the MMP has entered into a three-way contract with CMS and the State, has passed the CMS/State readiness review, and is connected to CMS enrollment and payment systems such that the MMP is able to receive payment and enrollments, whichever is later. Marketing activity for CY 2016 may begin no earlier than October 1, 2015 and must be consistent with the CY 2016 MMG (which will be issued in final in late spring or early summer of 2015), with the exceptions articulated in Texas-specific guidance as appropriate.

We note that the definition of "marketing materials" in Appendix 1 of the MMG includes both "marketing" and "communications" as defined by Texas and as encompassed within the term "marketing, outreach, and member materials" in the three-way contract.

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

- Materials in the Critical Elements chapter of the Uniform Managed Care Manual
- Health risk assessment forms
- Member surveys
- Value-added services (VAS) and flexible benefit materials
- Press releases that include Medicare/Medicaid/STAR+PLUS program references and name recognition, regardless of whether they contain plan-specific information.

These materials may be submitted to the state via a resource mailbox to be provided when this guidance is finalized.

Section 20 – Materials Not Subject to Review

We clarify that "general health promotion materials," as described in section 20 of the MMG, has the same meaning as "health-related materials" in the three-way contract, and that these materials are not required to be submitted for review.

For Texas MMPs, the list of materials not subject to CMS or state review also includes:

- Press releases that do not include: (1) any plan-specific information; and (2) any Medicare/Medicaid/STAR+PLUS program references and name recognition.

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 Texas' standard for translation of marketing materials is more stringent. For CY 2015, CMS' and Texas' translation standards are equivalent.[2] MMPs must therefore

[2] Guidance on the CY 2015 translation requirements for all plans, including MMPs, "Contract Year 2015 Translated Marketing Materials Requirements and Methodology," is located at: http://cms.gov/Medicare-Medicaid-

translate all required marketing materials into Spanish for all service areas.[3] Required materials are the Summary of Benefits (SB), ANOC/EOC (Participant Handbook), formulary (List of Covered Drugs), provider/pharmacy directory (Provider and Pharmacy Network Directory), ID card, integrated denial notice, and the Part D transition letter).

Plans are also required to make required materials available in other languages, large print, Braille, and audio upon request.

Section 30.6 – Required Materials with an Enrollment Form

Because MMPs are too new to measure under the CMS plan (star) rating system, they are not 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 the State's administrative services contractor.

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)
>
> 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 (required at the time of enrollment; see section 60.4 for additional information about provision of a directory post-enrollment).

Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015MMPTranslationHPMSMemo091214.pdf.

[3] CMS will make available Spanish translations of the Texas MMP Summary of Benefits (SB), formulary, provider/pharmacy directory, and ANOC/EOC (Participant Handbook).

- 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 send enrollees who opt into the demonstration the following materials for receipt 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 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. 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 for receipt 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

- An Evidence of Coverage (EOC) (Member Handbook)

MMPs must send enrollees who are passively enrolled the following materials for receipt 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 opt 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 send 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 July 31 for an August 1 effective enrollment date).

For all current enrollees, both enrollees who are passively enrolled and enrollees who opt into the demonstration, the Annual Notice of Change (ANOC) and EOC (Member Handbook) must also be sent 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 Enrollees

Enrollment Mechanism	Required Materials for New Enrollees	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

Enrollment Mechanism	Required Materials for New Enrollees	Timing of Beneficiary Receipt
Opt-in 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
Opt-in 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 OR • ANOC • SB • Formulary	September 30
If only the ANOC, SB, and formulary are sent by September 30: • EOC (Member Handbook)	December 31
• ID Card	As needed

Required Materials for Renewing Members	Timing of Beneficiary Receipt
• 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 30.9 – Enrollee Referral Programs

Because Texas prohibits enrollee referral programs, this section does not apply to MMPs.

Section 30.10 – Star Ratings Information from CMS

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

Section 40.1 – Marketing Material Identification

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

Section 40.4 – Prohibited Terminology/Statements

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

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 administrative services contractor at least once in any marketing materials that are provided prior to the time of enrollment and where a plan 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

In addition to the requirements of this section, we clarify that organizations offering both MMPs and non-MMP Medicare health plans may only send current members information about their MMP product.

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

This section applies only with respect to marketing materials from third parties that provide non-benefit/non-health services only when they are specifically general health promotion/health related materials. Otherwise, materials produced by third parties that provide non-benefit/non-health services must be submitted for state review.

In addition to the guidance in this section, CMS and the State clarify that materials produced by the State and distributed by the State's administrative services contractor 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 communication 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.

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.

CMS is unable to create State-specific plan type labels in HPMS for each State's demonstration plans; therefore, all MMPs are referred to by the standardized plan name type "Medicare-Medicaid Plan" in CMS' external communications – e.g., the Medicare & You handbook and the Medicare Plan Finder tool on www.medicare.gov. MMPs may also use any State-specific plan type terminology in their marketing materials, provided they comply with the guidance regarding use of the CMS standardized plan type in section 40.10, under which the MMP must 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. The State will provide additional guidance on branding for the demonstration.

In addition, we clarify that MMPs in Texas that offer Medicare Advantage products, including SNPs, in the same service area as their MMPs, may not use the same plan marketing name for both those products 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 Texas 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, [and] 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 Medicare's five (5) percent threshold for language translation (refer to section 30.7) 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 Texas 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 relates to third party materials that are specifically not subject to review and applies to MMPs with the following modification to the disclaimer language:

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

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 Texas 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 Texas 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 either mail a pharmacy/provider directory or to mail 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 Texas 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; and

- MMPs must use the model formulary document provided to Texas MMPs by CMS and the State.

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.
>
> 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:

- MMPs must send new enrollees (whether they opt 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.

- For all current enrollees, MMPs must annually send an EOC (Member Handbook) for member receipt by December 31. MMPs choosing this option (rather than a combined ANOC/EOC (Member Handbook) by September 30) must also send an SB with the ANOC.

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.

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 – Promotional Activities

This section is replaced with the following revised guidance:

Section 70.1 - Promotional Activities

42 CFR 422.2268, 423.2268

Generally, promotional activities are designed to attract the attention of prospective enrollees and/or encourage retention of current enrollees. In addition to the guidance on nominal gifts, any promotional activities or items offered by MMPs:

- Must have only nominal value (must have a retail value of no more than $10) based on the fair marketing value of the item or less, with a maximum aggregate of $50 per person, per year.
- Must be offered to all people regardless of enrollment and without discrimination;
- Must not be items that are considered a health benefit (e.g., a free checkup);
- Must not be tied directly or indirectly to the provision of any other covered item or service;
- May not be provided to providers for the purpose of distributing to prospective or current members;
- May be provided to encourage prospective or current member attendance at MMP events; and
- May be provided to encourage current enrollees to participate in periodic surveys.
- MMPs are allowed to accept promotional items from third-party sources, and distribute to prospective or current enrollees subject to the dollar limits stated in this section. MMPs may adhere their plan sticker to promotional items provided by third-party sources.

NOTE: MMPs should track and document items given to current enrollees. MMPs should not track pre-enrollment promotional items on a per person basis; however, MMPs may not willfully structure pre-enrollment activities with the intent to give people more than $50 per year.

Section 70.1.1 – Nominal Gifts

In addition to the guidance in this section, we clarify that nominal gifts/giveaway items must have a total fair market value of less than $10 per individual.

Section 70.2 – Rewards and Incentives

In addition to the requirements of this section, rewards and incentives must have a retail value of no more than $10 based on the fair marketing value of the item.

Section 70.5 – Marketing Through Unsolicited Contacts

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

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

Section 70.6 – Telephonic Contact

In addition to the requirements of this section, MMPs may not contact individuals who submit enrollment applications to conduct quality control and agent oversight activities. MMPs may also not contact members who have been involuntarily disenrolled to resolve eligibility issues.

We clarify that MMPs may not call current members to promote other Medicare plan types. Information about other Medicare plan types can only be provided at the proactive request of a current member. However, consistent with section 70.6 of the MMG, organizations that offer non-MMP and MMP products may call their current non-MMP members (for example, those in Medicaid managed care products) to promote their MMP offerings. Callers with questions about other Medicare program options should be transferred to 1-800-Medicare or to the State Health Insurance Assistance Program for information and assistance.

Section 70.7 – Outbound Enrollment and Verification Requirements

Since all enrollments into MMPs are submitted by the State's administrative services contractor, the requirements of this section do not apply.

Section 70.8 – Prospective Enrollee Educational Events

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

- Events may only focus on health and program education.

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

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

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

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

In addition, MMPs must make available to CMS and the state, upon request, current schedules of all educational events.

Section 70.9 - Marketing/Sales Events and Appointments

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

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

Section 70.9.2 – Personal/Individual Marketing Appointments

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

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

Section 70.11 – Marketing in the Health Care Setting

This section is replaced with the following revised guidance:

Section 70.11 – Marketing in the Health Care Setting

42 CFR 422.2268(j) and (k), 423.2268 (j) and (k)

MMPs may have agreements with providers in connection with plan activities and expect those agreements to address marketing activity in a manner consistent with Medicare and Medicaid regulations. These requirements are discussed throughout this section. MMPs and providers with whom MMPs have a relationship (contractual or otherwise) who assist beneficiaries with plan selection should ensure that provider assistance results in plan selection that is always in the best interest of the beneficiary. MMPs may not cobrand or conduct plan marketing activities in health care settings.

MMPs may not use providers to make available and/or distribute plan marketing materials, with the exception of plan stickers. Providers may choose to distribute or display general health promotion materials/health-related materials and/or plan stickers for all contracted MMPs, or

may choose not to distribute or display for any contracted MMP. MMPs may provide health-related display posters and materials for providers to display in common areas, subject to the following requirements:

- Health-related posters cannot be larger than 16" x 24".
- Materials may include the MMP's name, logo, and contact information.
- MMP stickers may not be larger than 5"x7" and may not indicate anything more than MMP is accepted or welcomed here.

Providers are not required to distribute or display all general health promotion materials provided by each MMP with whom they contract. Providers can choose which items to distribute or display, as long as they distribute/display one or more items from each contracted MMP without giving the appearance of supporting one MMP over another.
Providers may choose whether to display items such as pens or pencils provided by each contracted MMP. Providers can choose which items to display as long as they display one or more from each contracted MMP. Items may only be placed in common areas.

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

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

Section 70.11.1 – Provider Based Activities

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

- Make any oral or written statements that the MMP is endorsed by CMS, a federal or state governmental agency, or similar entity.
- Market to persons currently enrolled in another MMP.
- Recommend one MMP over another or assist a beneficiary in deciding to select a specific MMP
- Induce or accept a current or prospective member's enrollment in or disenrollment from an MMP.
- Assist an enrollee with enrollment forms.

- Portray other plans in a negative manner.

- Provide promotional items or nominal gifts to a select MMP's current or prospective members or condition promotional or nominal gifts on enrollment with an MMP.

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

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

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

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 by the State and/or distributed by its administrative services contractor.

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 and State holidays as specified in the three-way contract, in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide the required information listed 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 service to all non-English speaking, limited English proficient and deaf or hard-of-hearing 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 administrative services contractor.

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 MMPs become certified for File & Use 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 – Plan/Part D Sponsor Websites and Social/Electronic Media

In addition to the requirements of this section, we clarify that the State is currently developing policy around use of social media sites by MMPs. We specifically request MMP comments on this issue. We also clarify that MMP use of electronic media (e.g., apps) is permitted. However, MMPs may only use electronic media for purposes of disseminating health-related material.

Section 100.1 – General Website Requirements

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

- Remain HIPAA-compliant with respect to member eligibility or identification, including any member or provider portal.
- Include STAR+PLUS MMP program logos
- Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention

MMPs must also notify CMS and the state of any intent to implement an MMP-specific app.

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 administrative services contractor at the following website: <website link>.
- Information on the potential for contract termination, and information that materials are published in alternate formats (e.g., large print, Braille, audio).
- General information about the program, including how to access the MMPs call center(s).

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

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

Section 100.2.2 – Required Documents for Part D Sponsors

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

Section 100.3 – Electronic Enrollment

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

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 is not permitted. All MMP enrollments are processed by the State's administrative services contractor. We clarify that CMS does not regulate compensation of employed agents.

Section 120.3 – Agent/Broker Training and Testing

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

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 160.4 – 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 Texas Medicaid has reviewed or endorsed this information."