Final Contract Year (CY) 2018 Marketing Guidance for Rhode Island Medicare-Medicaid Plan

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Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the Contract Year (CY) 2018 Medicare Marketing Guidelines (MMG), posted at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html, apply to the Medicare-Medicaid plan (the MMP) participating in the Rhode Island capitated financial alignment model demonstration, except as noted or modified in this guidance document.[1]

This guidance document provides information only about those sections of the MMG that are not applicable or that are different for the MMP in Rhode Island; therefore, this guidance document should be considered an addendum to the CY 2018 MMG. This MMP guidance is applicable to all marketing done for CY 2018 benefits. The table below summarizes those sections of the CY 2018 MMG that are clarified, modified, or replaced in this guidance for the Rhode Island MMP.

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

Medicare Marketing Guidelines (MMG) Section	Change in This Guidance Document
Section 10 – Introduction	Adds requirements for an annual marketing plan submission.
Section 20 – Materials Not Subject to Marketing Review	Provides one exception to the list of materials not subject to marketing review and submission processes in this section of the MMG.
Section 30.5 – Requirements Pertaining to Non-English Speaking Populations	Clarifies the requirements of this section for the MMP.
Section 30.6 – Required Materials with an Enrollment Form	Clarifies that the requirements of this section are not applicable to the MMP.
Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter	Replaces current guidance in the MMG with guidance for the MMP.
Section 30.8 – Enrollment Verification Requirements	Clarifies that the requirements of this section are not applicable to the MMP.
Section 30.10 – Star Ratings Information from CMS	Clarifies that the requirements of this section are not applicable to the MMP.

[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 30.10.1 – Referencing Star Ratings in Marketing Materials	Clarifies that the requirements of this section are not applicable to the MMP.
Section 30.10.2 – Plans with an Overall 5-Star Rating	Clarifies that the requirements of this section are not applicable to the MMP.
Section 40.6 – Hours of Operation Requirements for Marketing Materials	Adds requirements for the MMP to current MMG requirements of this section.
Section 40.8 – Marketing of Multiple Lines of Business	Clarifies that the MMP may only market its MMP product in its MMP materials.
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 vendors. Adds a prohibition on the use of materials developed by third parties that provide non- benefit/non-health service materials for the MMP.
Section 40.10 – Standardization of Plan Name Type	Clarifies the requirements of this section for the MMP.
Section 60.1 – Summary of Benefits (SB)	Replaces current guidance in this section with guidance for the MMP.
Section 60.2 – ID Card Requirements	Clarifies the requirements of this section for the MMP.
Section 60.4 – Formulary and Formulary Change Notice Requirements	Clarifies the requirements of this section for the MMP. Extends the requirements for formulary change notifications to Medicaid-covered drugs. Adds an option for the MMP to send a distinct and separate notice alerting enrollees how to access or receive the formulary.
Section 60.6 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)	Replaces current guidance in this section with guidance for the MMP.
Section 60.7 – 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 70.2 – Marketing through Unsolicited Contacts	Reiterates MMG guidance on unsolicited contact. Clarifies that marketing via conventional mail and other print media and marketing of the MMP to current enrollees is not considered unsolicited direct contact and is therefore permissible.
Section 70.4 – Marketing/Sales Events and Appointments	Adds requirements for the MMP to current MMG requirements of this section.
Section 70.4.2 – Personal/Individual Marketing Appointments	Clarifies that the requirements of this section for the MMP.
Section 70.5.4 – 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 guidance for the MMP.
Section 80.2 –Informational Scripts	Clarifies requirements in this section for the MMP.
Section 80.3 – Enrollment Scripts/Calls	Clarifies that the requirements of this section are not applicable to the MMP.
Section 80.4.1 – Telephonic Contact	Clarifies telephonic contact requirements for the MMP.
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 90.2.1 – Submission of Non-English and Alternate Format Materials	Clarifies that the MMP has state-specific MMP errata codes.
Section 90.2.3 – Submission of Multi-Plan Materials	Clarifies that the requirements of this section are not applicable to the MMP.

Medicare Marketing Guidelines (MMG) Section	Change in This Guidance Document
Section 90.3 – HPMS Material Statuses Section 90.5 – Timeframes 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 the MMP.
Section 100.2 – Required Content	Adds requirements for the MMP to current MMG requirements of this section.
Section 100.2.2 – Required Documents for All Plans/Part D Sponsors	Modifies the requirements of this section for the MMP.
Section 100.3 – Electronic Enrollment	Clarifies that the requirements of this section are not applicable to the MMP.
Section 100.4 – 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 110.2 – Marketing of Rewards and Incentives Programs	Adds requirements to those in CMS guidance regarding the offering of rewards and incentives to current enrollees by the MMP.
Section 120 – Marketing and Sales Oversight and Responsibilities	Clarifies that the requirements of this section (and subsections) are not applicable to the MMP with respect to independent agents and brokers. Clarifies that MMP staff conducting marketing activity of any kind must be licensed in the State (and, when required, appointed) as an insurance broker/agent.
Section 120.6 – Activities That Do Not Require the Use of State-Licensed Marketing Representatives	Clarifies that the requirements of this section are applicable to the MMP.
Section 150 – Use of Medicare Mark for Part D Sponsors	Clarifies the requirements of this section for the MMP.
Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received	Replaces current disclaimer in this section with a disclaimer for the MMP.

Medicare Marketing Guidelines (MMG) Section	Change in This Guidance Document
Appendix 5 – Disclaimers	Modifies and clarifies disclaimer requirements for MMPs.

Use of Independent Agents and Brokers

We clarify that all requirements applicable to independent agents/brokers throughout the MMG are inapplicable to the MMP because the use of independent agents/brokers is not permitted. The State's enrollment broker must process all MMP enrollment transactions.

Model Materials

We note that materials the MMP creates should take into account the reading level requirements established in the three-way contract. Available model materials reflect acceptable reading levels. Current Part D models are acceptable for use as currently provided, and the MMP must add required disclaimers in Appendix 5 of this guidance and Appendix 5 of the MMG, as appropriate. Adding required MMP disclaimers to Part D models does not render the documents non-model when submitted for review or accepted as File & Use materials.

We refer the MMP to the following available model materials:

- MMP-specific model materials tailored to the MMP in Rhode Island, including a Summary of Benefits (SB), Annual Notice of Change (ANOC), Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated formulary (List of Covered Drugs), combined Provider and Pharmacy Directory, single Member ID Card, integrated denial notice, and welcome letters for opt-in and passively enrolled individuals: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

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

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

- MMP-specific ANOC/EOC errata model: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. This MMP errata model, based on the Medicare Advantage errata model, may be helpful to the MMP in creating its own errata notices.

Provider and Pharmacy Directory Requirements

Guidance related to Provider and Pharmacy Directories is no longer included in the MMG and is, instead, available in Chapter 4 of the Medicare Managed Care Manual , the January 17, 2017 HPMS memorandum entitled, "Provider Directory Policy Updates," Chapter 5 of the Prescription Drug Benefit Manual, and the August 16, 2016 HPMS memorandum entitled "Pharmacy Directories and Disclaimers." This guidance on general, update, dissemination and timing, online directories, disclaimers, and submission requirements for directories applies to the MMP's directory with the following modifications:

- The MMP is required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. However, as provided in section 110.2.1 of Chapter 4 of the Medicare Managed Care Manual, the MMP may print separate directories for PCPs and specialists provided both directories are made available to enrollees at the time of enrollment**.**

- The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits.

- The MMP must use the model Provider and Pharmacy Directory document provided by CMS and the State. The model will be consistent with directory requirements in the three-way contract. A non-model directory is not permitted.

- For multi-county service areas, the combined Provider and Pharmacy Directory may be provided for all providers by county, provided the directory includes a disclaimer that the directory only includes providers in that particular county (or counties), that a complete directory is available on the plan's website, and that the enrollee may contact the plan's customer service call center to request assistance with locating providers in other counties or to request a complete hard copy Provider and Pharmacy Directory.

- The MMP Provider and Pharmacy Directory is considered a marketing material and must be submitted in the HPMS marketing module. The MMP may obtain more information about the specific review parameters and timeframes for the Provider and Pharmacy Directory under the Rhode Island capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. In addition, we note that the guidance on HPMS submission and material IDs in section 110.2.6 of Chapter 4 of the Medicare Managed Care Manual does not apply to the MMP with respect to the submission of updates and/or addenda pages. The MMP must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the Rhode Island MMP Provider and Pharmacy Directory marketing code.

Compliance with Section 1557 of the Affordable Care Act of 2010

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

Following are the Rhode Island MMP-specific modifications to the MMG for CY 2018.

Section 10 – Introduction

Annually, the MMP must submit a marketing plan to the State for review and approval. For CY 2018, the MMP must submit the marketing plan to the State prior to conducting any marketing activity. If there are substantial/material changes, the MMP must submit the revised marketing plan to the State for review and approval. Marketing plans should be submitted to the State via RI EOHHS' usual (non-MMP) process for managed care plans to submit marketing materials for review.

Section 20 – Materials Not Subject to Marketing Review

The requirements of section 20 of the MMG apply to the MMP with the following modification:

- The MMP Provider and Pharmacy Directory is considered a marketing material and must be submitted in the HPMS marketing module. The MMP may obtain more information about the specific review parameters and timeframes for the Provider and Pharmacy Directory under the Rhode Island capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module.

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 Rhode Island's standard for translation of marketing materials is more stringent. The Rhode Island standard requires translation if fifty (50) or more enrollees speak a single language other than English as a primary language. Guidance on the translation requirements for all plans, including the Rhode Island MMP, is released via HPMS annually each fall. Required languages for translation for the MMP are also updated annually, as needed, in the HPMS Marketing Module.

For CY 2018, it is our expectation that the Rhode Island MMP will translate the following required materials into Spanish, as well as any additional languages that meet the aforementioned translation standard: the Summary of Benefits (SB), ANOC/EOC (Member Handbook), formulary (List of Covered Drugs), Provider and Pharmacy Directory, the distinct and separate notice alerting enrollees how to access or receive the Provider and Pharmacy Directory described in Chapter 4 of the Medicare Managed Care Manual, the integrated denial notice, and the Part D transition letter.[2]

The MMP must have a process for ensuring that enrollees can make a standing request to receive the materials identified in this section, in alternate formats and in all non-English languages identified in this section and in the HPMS Marketing Module, at the time of request and on an ongoing basis thereafter.

Final populated translations of all marketing materials must be submitted in HPMS (see section 90.2 of the MMG for more information about the material submission process).

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

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

Section 30.6 – Required Materials with an Enrollment Form

Because the Medicare-Medicaid Coordination Office (MMCO) is in the process of developing a Star Ratings system for MMP performance, the MMP will not be subject to the Star Ratings requirements in the MMG. Therefore, the MMP will not be required to include the Star Ratings Information document when a beneficiary is provided with any enrollment information. We further clarify that the responsibility for sending enrollment and disenrollment notices to enrollees will be delegated to Rhode Island or its designated vendor, with the exception of any notices delegated to the MMP, as described in Appendix 5 of the MMP Enrollment and Disenrollment Guidance (see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html).

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:
>
> - ANOC/EOC (Member Handbook), or a standalone EOC (Member Handbook), as applicable and described in the replacement guidance for section 60.6 of the MMG contained in this document.
>
> - 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, or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs.
>
> - A combined Provider and Pharmacy Directory that includes all providers of Medicare, Medicaid, and additional benefits, or distinct and separate notice alerting enrollees how to access or receive the directory (required at the time of enrollment and annually thereafter).
>
> - A single Member 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 SB containing a concise description of the important aspects of enrolling

in the plan, as well as the benefits offered under the plan, including copays, 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 60.6 of the MMG contained in this document for more information about when the MMP must send an SB to current enrollees post-enrollment.

The MMP must send enrollees who opt in to the demonstration the following materials for receipt no later than eight (8) calendar days from receipt of 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 and 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 eight (8) calendar days before the end of the month prior to the effective date), the MMP must send enrollees these materials for receipt no later than eight (8) calendar days from receipt of confirmation of enrollment. The MMP should refer to the date of the Enrollment E-file to identify the start of the eight (8) calendar-day timeframe.

- A welcome letter, which must contain 4Rx information, consistent with a model developed jointly by CMS and the State

- A comprehensive integrated formulary (List of Covered Drugs), or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs)

- A combined Provider and Pharmacy Directory, or a distinct and separate notice alerting enrollees how to access or receive the directory, consistent with the requirements in Chapter 4 of the Medicare Managed Care Manual

- A single Member ID Card

- An EOC (Member Handbook)

The MMP 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, which must contain 4Rx information, consistent with a model developed jointly by CMS and the State

- A comprehensive integrated formulary (List of Covered Drugs), or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs)

- A combined Provider and Pharmacy Directory, or a distinct and separate notice alerting enrollees how to access or receive the directory, consistent with Chapter 4 of the Medicare Managed Care Manual.

- An SB

In addition, the MMP must provide enrollees who are passively enrolled an EOC (Member Handbook) and a single Member ID Card for receipt by the end of the month preceding the month the enrollment will take effect (e.g., the Member ID Card and EOC (Member Handbook) must be received by a beneficiary by January 31 for a February 1 effective enrollment date).

After the time of initial enrollment for both enrollees who are passively enrolled and enrollees who opt in to the demonstration, the ANOC and EOC (Member Handbook) must also be received annually consistent with the replacement guidance for section 60.6 of the MMG contained in this document.

Additional informational materials related to benefits or plan operations may be included in these required mailings to new and current enrollees – both at the time of enrollment and annually thereafter – consistent with the requirements of section 60.3 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 (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • SB	30 calendar days prior to the effective date of enrollment
Passive enrollment	• Member ID Card • EOC (Member Handbook)	No later than the day prior to the effective date of enrollment

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received more than 8 calendar days before the end of the month)	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook)	No later than the last day of the month prior to the effective date
Opt-in enrollment (with enrollment confirmation received less than 8 calendar days before the end of the month)	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook)	No later than 8 calendar days from receipt of the confirmation of enrollment

Table 3: Required Materials for Renewing Members

Required Materials for Renewing Members	Timing of Beneficiary Receipt
• ANOC/EOC (Member Handbook) • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) OR • ANOC • SB • Formulary (or a distinct and separate notice alerting enrollees how to access or receive the formulary)	September 30 The ANOC, SB, and List of Covered Drugs (Formulary) must be posted on plan websites by September 30. The EOC (Member Handbook) must only be posted by September 30 if it is sent with the ANOC.
If only the ANOC, SB, and formulary are sent by September 30: • EOC (Member Handbook)	December 31 The EOC (Member Handbook) must be posted on plan websites by December 31. The ANOC, SB, and formulary (List of Covered Drugs) must still be posted by September 30.
Member ID Card	As needed
Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory)	September 30. The plan website's directory must be kept up-to-date consistent with Chapter 4 of the Medicare Managed Care Manual. The Provider and Pharmacy Directory must be posted on plan websites by September 30.

Section 30.8 –Enrollment Verification Requirements

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

Section 30.10 – Star Ratings Information from CMS

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

Section 30.10.1 – Referencing Star Ratings in Marketing Materials

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

Section 30.10.2 – Plans with an Overall 5-Star Rating

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

Section 40.6 – Hours of Operation Requirements for Marketing Materials

In addition to the requirements of this section, the MMP must also provide the phone and TTY/TDD numbers 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 the MMP may only market its MMP product in its MMP materials.

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 vendors 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 for review prior to their use. As indicated in section 20 of the MMG, the MMG does 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 the Rhode Island MMP 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, the MMP is required to include the plan type in each plan's name using standard terminology consistent with the guidance provided in this section. CMS created the standardized plan type label "Medicare-Medicaid Plan" to refer generically to all plans participating in a capitated financial alignment model demonstration. The MMP must use the "Medicare-Medicaid Plan" plan type terminology following its plan name at least once on the front page or beginning of each marketing piece, excluding envelopes, consistent with the requirements of section 40.10 of the MMG.

Section 60.1 – Summary of Benefits (SB)

This section is replaced with the following revised guidance. We also note that Appendix 4 of the MMG does not apply to the MMP.

Section 60.1 – Summary of Benefits (SB)

42 CFR 422.111(b)(2), 423.128(b)(2)

The MMP must use the Summary of Benefits (SB) model document provided by CMS and the State. A non-model SB is not permitted. The SB must contain a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including applicable copays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.

Section 60.2 – ID Card Requirements

The MMP is required to meet the Member ID Card content requirements in sections 60.2, 60.2.1, and 60.2.2 of the MMG. We clarify, however, that the MMP must issue a single Member ID Card meeting these requirements for all services offered under the plan. Separate pharmacy and health benefits Member ID Cards are not permitted. The MMP must use the model Member ID Card document provided by CMS and the State. A non-model Member ID Card is not permitted.

Section 60.4 – Formulary and Formulary Change Notice Requirements

The requirements of section 60.4, 60.4.1, 60.4.2, 60.4.3, 60.4.4, 60.4.5, and 60.4.6 of the MMG apply to the MMP with the following modifications:

- The MMP must make available 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 plan;

- The MMP is only permitted to make available a comprehensive, not abridged, formulary (List of Covered Drugs);

- The MMP must use the model formulary (List of Covered Drugs) document provided by CMS and the State (a non-model formulary (List of Covered Drugs) is not permitted); 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.

We note that the new option available to all Part D sponsors in section 60.4 of the MMG to send either a hard copy formulary (List of Covered Drugs) or a distinct and separate notice (in hard copy) describing where enrollees can find the formulary (List of Covered Drugs) online and how enrollees can request a hard copy formulary also applies to the Rhode Island MMP starting with Contract Year 2018. MMPs should refer to section 60.4 of the MMG for additional detail about these requirements

Section 60.6– Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

This section is replaced with the following revised guidance:

Section 60.6 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) (Member Handbook)

42 CFR 417.427, 422.111(a)(3), 422.111(d)(2), 423.128(a)(3)

The MMP is required to send an 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.

The MMP 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:

- The MMP must send new enrollees (whether they opt in to 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 confirmation of enrollment is received less than eight (8) calendar days before the end of the month prior to the effective date), the MMP must send these materials for receipt no later than eight (8) calendar days from receipt of confirmation of enrollment.

- After the time of initial enrollment, the MMP must annually send an EOC (Member Handbook) for member receipt by December 31. If the MMP chooses this option (rather than a combined ANOC/EOC (Member Handbook) by September 30), it 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 (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) and the Provider and Pharmacy Directory (or distinct and separate notice alerting enrollees how to access or receive the directory) for the upcoming year, must be received by one month after the effective date of enrollment, but not later than December 15th.

Additional informational materials beyond the materials required to be sent with the ANOC/EOC (Member Handbook) or ANOC and EOC (Member Handbook) may be included with the ANOC, EOC (Member Handbook), or ANOC/EOC (Member Handbook) mailings consistent with the requirements of section 60.3 of the MMG.

We remind the MMP that it must upload in HPMS either (1) a standalone ANOC and a standalone EOC (Member Handbook), or (2) a combined ANOC/EOC (Member Handbook). The MMP should only use the combined ANOC/EOC (Member Handbook)

material code if it is sending enrollees a combined document. Otherwise, the MMP should use both the standalone EOC and the standalone ANOC codes. Submitting materials under both standalone and combined ANOC/EOC (Member Handbook) codes will impact CMS' ANOC and EOC (Member Handbook) timeliness and accuracy monitoring efforts and may subject the MMP to compliance action.

To ensure timely mailing of its annual ANOC/EOC (Member Handbook), the MMP must indicate the actual mail date and the number of enrollees who were mailed the documents in HPMS within fifteen (15) calendar days of mailing. This includes mail dates for alternate materials. We remind the MMP that it should enter AMD information in HPMS for mailings to current members only. The MMP should not enter AMD information for October 1, November 1, or December 1 effective dates, or for January 1 effective dates for new members. If the MMP mails in waves, it should enter the actual mail date for each wave. The MMP may enter up to ten waves of mailings. If the MMP uses a standalone ANOC and a standalone EOC (Member Handbook, it must enter AMD information for one to ten mailing waves, as applicable, separately for both materials. If the MMP uses a combined ANOC/EOC (Member Handbook), it should enter AMD information for one to ten mailing waves, as applicable, only for the combined ANOC/EOC. For instructions on meeting this requirement, refer to the *Update AMD/Beneficiary Link/Function* section of the Marketing Review User Guide in HPMS.

Note: For a single mailing to multiple recipients, as allowed under section 30.7.1 of the MMG, the MMP should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed.

The MMP must use an errata notice to notify enrollees of certain errors in their original mailings. We clarify that errata notices should only be used to notify enrollees of plan errors in plan materials. Any mid-year changes, including but not limited to mid-year legislative benefit additions or removals and changes in enrollment policies, should be communicated to current enrollees consistent with section 60.7 of this guidance and section 60.7 of the MMG. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to plan error.

Section 60.7 – 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 affecting the MMP.

Section 70.2 – Marketing through Unsolicited Contacts

Section 70.2 of the MMG provides examples of unsolicited direct contact with current and prospective enrollees. We reiterate that marketing via conventional mail and other print media (e.g., advertisements, direct mail) is not considered unsolicited contact and, therefore, is permissible. We also clarify, both here and in section 80.4.1 of this guidance, that the MMP's marketing to current enrollees (including those enrolled in other product lines such as its Medicaid managed care product) is not considered unsolicited direct contact and, therefore, is permissible.

Section 70.4 - Marketing/Sales Events and Appointments

In addition to requirements in this section of the MMG, the MMP must convene all educational and marketing events at sites within the plan's service area that are physically accessible to all enrollees or potential MMP enrollees, including persons with disabilities and persons using public transportation.

Section 70.4.2 – Personal/Individual Marketing Appointments

Since the MMP is not allowed to market directly to individual, potential MMP enrollees, one-on-one appointments with potential MMP enrollees are generally not permitted. We clarify, however, that if a current or prospective MMP enrollee proactively requests a one-on-one appointment and the MMP has a documented incoming request for the one-on-one appointment, the MMP may meet with the enrollee subject to the requirements of sections 70.4.2 and 70.4.3 of the MMG.

Section 70.5.4 – 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 the State's 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)
>
> The MMP must operate a toll-free call center for both current and prospective enrollees seven (7) days a week, at least from 8:00 a.m. to 8:00 p.m. ET, except as provided below. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. The MMP may use alternative technologies on Saturdays, Sundays, and State and Federal holidays other than New Year's Day in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide the required information listed 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.
>
> The use of a call center and the provision of information through a call center are mandatory for the MMP.
>
> The call center must meet the following operating standards:
>
> - Provide information in response to inquiries outlined in sections 80.2 - 80.4 of the MMG. If callers are transferred to a third party for provision of the information listed in sections 80.2 and 80.4 of the MMG, all other requirements in this section apply to the services as performed by 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." Interpreters should be available within eight (8) minutes of reaching the CSR.

- Provide TTY service to all hearing impaired beneficiaries. CSRs through the TTY service should be available within seven (7) minutes of the time of answer.

- 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. A disconnected call is defined as a call that is unexpectedly dropped by the MMP.

Hold time messages (messages played when an enrollee or prospective enrollee is on hold when calling the plans) that promote the MMP or include benefit information must be submitted in HPMS for review as marketing materials (see section 90.2 of the MMG for more information about the material submission process). The MMP is prohibited from using hold time messages to sell other products.

For Pharmacy Technical Help or Coverage Determinations and Appeals Call Center requirements, refer to Appendix 3 in the MMG.

Section 80.2 – Informational Scripts

We clarify that informational calls to plan call centers that become enrollment calls at the proactive request of the beneficiary must be transferred to the State's enrollment broker. The MMP should refer to section 120.6 of this guidance, as well as section 120.6 of the MMG, for clarification of the types of activities conducted by a plan customer service representative that do not require the use of State-licensed marketing representatives. The MMP must use a State-licensed (and, when required, appointed) marketing agent for any activity that meets the definition of marketing in Appendix 1 of the MMG.

Section 80.3 – Enrollment Scripts/Calls

This section does not apply to the MMP because enrollment requests must be transferred to Rhode Island or its designated vendor.

Section 80.4.1 – Telephonic Contact

The requirements of section 80.4.1 of the MMG apply with the following clarifications:

- Consistent with section 80.4.1 of the MMG, calls made by the MMP to current members (including those enrolled in other product lines) are not considered unsolicited direct

contact and are therefore permissible. The MMP may call its current non-MMP enrollees (for example, those in Medicaid managed care products), including individuals who have previously opted out of passive enrollment into an MMP, to promote its MMP offering.

- The MMP may use reasonable efforts to contact current non-MMP enrollees who are eligible for MMP enrollment to provide information about its MMP product. Callers with questions about other Medicare program options should be warm transferred to 1-800-MEDICARE or to the State Health Insurance Assistance Program (The Point) for information and assistance.

Section 90 – The Marketing Review Process

Any references in this section of the MMG, 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 90.2.1 – Submission of Non-English and Alternate Format Materials

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

Section 90.2.3 – Submission of Multi-Plan Materials

This section does not apply to the MMP.

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. The MMP may obtain more information about the specific review parameters and timeframes for marketing materials under the Rhode Island capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. All other guidance in this section of the MMG and its subsections applies.

Section 90.5 – Timeframes 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. The MMP may obtain more information about the specific review parameters and timeframes for marketing materials under the Rhode Island capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. All other guidance in this section of the MMG and its subsections applies.

Section 90.6 – File & Use Process

We clarify that the File & Use certification for the MMP is included in the three-way contract. All other guidance in section 90.6 of the MMG and all its subsections applies.

Section 100.2 – Required Content

In addition to the requirements outlined in this section, the MMP must also include information on how to access the State's enrollment broker, including its website (if available), on its plan website. The MMP must also include information on the potential for contract termination (i.e., a statement that the MMP may terminate or non-renew its contract, or reduce its service area, and the effect any of those actions may have on MMP enrollees, as required under 42 CFR 422.111(f)(4)), and information that materials are published in alternate formats (e.g., large print, braille, audio).

Section 100.2.2 – Required Documents for All Plans/Part D Sponsors

The requirements of this section apply with the following modifications:

- The MMP will not be required to post the LIS Premium Summary Chart as this document will not be applicable to the MMP.

- Because MMCO is in the process of developing a Star Ratings system for MMP performance, the MMP will not be subject to the Star Ratings requirements in the MMG. Therefore, the MMP will not be required to post a CMS Star Ratings document on its website.

Section 100.3 – Electronic Enrollment

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

Section 100.4 – 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 the MMP's website as required in this section. All other guidance in this section applies without modification.

Section 110.2 – Marketing of Rewards and Incentives Programs

The MMP may market rewards and incentives programs to current enrollees as provided in section 110.2 of the MMG. Any rewards and incentives programs must be consistent with section 100 of Chapter 4 of the Medicare Managed Care Manual with the following modifications:

- MMP reward and incentives programs must promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings and PCP visits and wellness initiatives).

- The MMP must take measures to monitor the effectiveness of such rewards and incentives programs and revise incentives as appropriate, with consideration of enrollee feedback.

- The MMP must submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented enrollee rewards and incentives programs and ensure that all such programs comply with all applicable CMS and State guidance and all relevant State and Federal laws.

Section 120 – Marketing and Sales Oversight and Responsibilities

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

We also clarify that MMP staff conducting marketing activity of any kind – as defined in Appendix 1 of the MMG – must be licensed in the State (and, when required, appointed) as an insurance broker/agent.

Section 120.6 – Activities That Do Not Require the Use of State-Licensed Marketing Representatives

Consistent with section 120.6 of the MMG, we clarify that in order to provide more than factual information, MMP outbound callers must be State-licensed (and, when required, appointed) marketing agents. The MMP must use State-licensed (and, when required, appointed) marketing agents for any activity that meets the definition of marketing in Appendix 1 of the MMG.

Section 150 – Use of Medicare Mark for Part D Sponsors

We clarify that the MMP is 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 of the MMG 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 Rhode Island Medicaid has reviewed or endorsed this information."

Appendix 5 – Disclaimers

The disclaimers in Appendix 5 of the MMG apply to MMPs except as modified or clarified below.

Federal Contracting Disclaimer

This disclaimer is replaced with the following revised MMP-specific disclaimer:

Federal and State Contracting Disclaimer

42 CFR 422.2264(c), 423.2264(c)

All marketing materials must include the statement that the MMP contracts with both the Federal and the State government. The MMP should include the contracting statement either in the text or at the end/bottom of the piece. The following statement must be used:

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

NOTE: In addition to the exceptions noted in section 50 of the MMG, radio, television, and internet banner ads do not need to include the Federal and State contracting disclaimer.

Benefits Are Mentioned

These disclaimers are replaced with the following revised MMP-specific disclaimers:

Benefits Are Mentioned

42 CFR 422.111(a) and (b), 422.2264, 423.128(a) and (b), 423.2264

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

> Only for summary documents like the 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 name> or read the Member Handbook."
>
> "Benefits [and/or copays] as well as the List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you."

Plan Premiums Are Mentioned

This disclaimer does not apply to the MMP, as the MMP is not permitted to assess plan premiums, and the State will pay Medicare Part B premiums on behalf of Medicare-Medicaid enrollees in the MMP.

Availability of Non-English Translations

This disclaimer is replaced with the following revised MMP-specific disclaimer:

> **Availability of Non-English Translations**
>
> 42 CFR 422.2264(e), 423.2264(e)
>
> The MMP must place the following non-English language disclaimer on the materials identified as required for translation into non-English languages in section 30.5 of this guidance:
>
> > "If you speak <language of disclaimer>, language assistance services, free of charge, are available to you. Call <Member Services at toll-free phone and TTY/TDD numbers, and days and hours of operation>. The call is free."
>
> The non-English language disclaimer must be included in Spanish and any other non-English languages that meet the standard described in section 30.5 of this guidance.

Referencing NCQA SNP Approval

We clarify that the prohibition on discussion of numeric Special Needs Plan (SNP) approval scores in marketing materials or press releases also applies to the MMP. The MMP 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 Rhode Island 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."

Mentioning Cost-Sharing Information on D-SNP Materials

This disclaimer is replaced with the following revised MMP-specific disclaimer:

> **Mentioning Cost-Sharing Information on MMP Materials**
>
> 42 CFR 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 get. Please contact the plan for more details."

Plans Accepting Online Enrollment Requests

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

Third Party Materials

This disclaimer does not apply to the MMP because it is 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.

Referencing Star Ratings Information

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

Pharmacy/Provider Network and Formulary

Because similar disclaimer language regarding formulary (List of Covered Drugs) and Provider and Pharmacy Directory changes is already included in the disclaimer requirements “Benefits Are Mentioned” guidance above, the disclaimer in this section of the MMG is not applicable to the MMP.