Final Contract Year (CY) 2019 Marketing Guidance for the 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) 2019 Medicare Communications and Marketing Guidelines (MCMG), posted at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html, apply to the Medicare-Medicaid plan (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 MCMG 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 2019 MCMG. This MMP guidance is applicable to all marketing done for CY 2019 benefits.

Use of Independent Agents and Brokers

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

Compliance with Section 1557 of the Affordable Care Act of 2010

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

Formulary and Formulary Change Notice Requirements

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

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

- Formulary change notices must be sent for any negative formulary change (as described in section 30.3.3, "Midyear Formulary Changes," and section 30.3.4, "Provision of Notice Regarding Formulary Changes," of Chapter 6 of the Prescription Drug Benefit Manual), regardless of whether or not the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan.

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

- Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on the Rhode Island MMP website.

Additional Guidance for Rhode Island MMPs

Beyond the specific modifications to the MCMG that follow, we clarify that the MMP may only market its MMP product in its MMP materials.

Section 20 - Communications and Marketing Definitions

MMPs are subject to marketing and beneficiary communications applicable to Medicare Advantage plans in 42 CFR Parts 422 and 423, as well as those applicable to Medicaid managed care organizations in 42 CFR Part 438. CMS has developed a joint review process for MMP beneficiary materials under each Financial Alignment Initiative capitated model demonstration that combines state and CMS review requirements and parameters. Given these differences, CMS will continue to consider all CY 2019 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F.[2] As a result, this section of the MCMG and its subsections do not apply to MMPs. We provide additional detail about materials subject to HPMS submission in the guidance related to section 90.1.1 of the MCMG in this document. In addition, for any other references to communications throughout the MCMG, the previous definition of marketing materials will apply.

Section 30.2 - Standardization of Plan Name Type

As is the case for other Medicare health plans, MMPs are required to include the plan type in each plan's name using standard terminology consistent with the guidance provided in this section. CMS created the standardized plan type label "Medicare-Medicaid Plan" to refer generically to all plans participating in a capitated financial alignment model demonstration. 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 30.2 of the MCMG.

Section 30.3 - Non-English Speaking Population

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 translation 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 each MMP are also updated annually, as needed, in the HPMS Marketing Module.

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

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

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.

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

Section 30.4 - Hours of Operation Requirements for Materials

In addition to the requirements of this section, the MMP must also provide the phone and TTY/TDD numbers and days 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 40.2 - Marketing Through Unsolicited Contacts

Section 40.2 of the MCMG provides examples of unsolicited direct contact with current and prospective enrollees. We reiterate that marketing via conventional mail and other print media (e.g., advertisements, direct mail) is not considered unsolicited contact and, therefore, is permissible. We also clarify, both here and in section 40.3 of this guidance, that MMP marketing to current non-MMP enrollees (including those enrolled in other product lines such as their Medicaid managed care product) to promote an MMP offering is not considered unsolicited direct contact and, therefore, is permissible.

Section 40.3 - Marketing Through Telephonic Contact

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

- Consistent with section 40.3 of the MCMG, calls made by the MMP to current members (including those enrolled in other product lines) are not considered unsolicited direct contact and are therefore permissible. 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 the 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

[3] CMS makes 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 https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html. CMS makes available a Spanish and Chinese translation of the Part D transition letter to all Medicare health plans at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html.

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 40.6 - Marketing Star Ratings

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 MCMG. Therefore, this section does not apply to the MMP.

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

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

Section 40.8 - Marketing of Rewards and Incentives Programs

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

- 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 50.2 - Marketing/Sales Events

In addition to requirements in this section of the MCMG, 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 50.3 - 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 50.3 of the MCMG.

Section 60.1 - Provider-Initiated Activities

We clarify that the guidance in this section about referring patients to other sources of information such as the "State Medicaid office" also applies to materials produced and/or distributed by the State's enrollment broker. The remainder of section 60.1 of the MCMG applies to the MMP.

Section 70.1.2 - Documents to be Posted on Website

The requirements of this section apply with the following modifications:

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

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

Section 70.1.3 - 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 80.2 - Customer Service Call Center Hours of Operations

We clarify that 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. Customer service call center hours and days must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. MMPs may use alternative technologies on Saturdays, Sundays, and State and/or Federal holidays 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 in section 80.1 of the MCMG, and/or allow a beneficiary to leave a message in a voice mail box. A customer service representative must then return the call in a timely manner, no more than one business day later. All other guidance in section 80.2 of the MCMG applies to the MMP.

Section 80.3 - Informational Scripts

We clarify that informational calls to plan call centers that become enrollment calls at the proactive request of the beneficiary must be transferred to the State's enrollment broker. The MMP should refer to section 80.7 of this guidance, as well as section 80.7 of the MCMG, for clarification of the types of activities conducted by a plan customer service representative that

do not require the use of State-licensed marketing representatives. The MMP must use a State-licensed (and, when required, appointed) marketing agent for any activity that meets the definition of marketing in section 20 of this guidance.

Section 80.4 - Telesales and Enrollment Scripts

Telesales scripts are considered marketing and must be submitted to CMS as outlined in section 90 of this guidance. The remainder of the guidance in this section on enrollment scripts does not apply to the MMP because enrollment requests must be transferred to Rhode Island or its designated vendor.

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

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

Section 90 - Tracking, Submission, and Review Process

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

Section 90.1 - Material Identification

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

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

The remainder of section 90.1 of the MCMG applies to MMPs, including the requirement that non-English and alternate format materials based on previously created materials may have the same material ID as the material on which they are based.

Section 90.1.1 - Materials Subject to Submission

CMS has developed a joint review process for MMP beneficiary materials under each Financial Alignment Initiative capitated model demonstration that combines state and CMS review requirements and parameters. Given these differences, CMS will continue to consider all CY

2019 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F in CY 2019.[4]

Section 90.4 - Submission of Websites and Webpages for Review

MMPs must submit in HPMS all required website content listed in section 70 of the MCMG for review in HPMS under the Internet Website marketing material code for Rhode Island for prospective state-only review. MMPs should submit their websites via links on a document. State reviewers should be able to review the information as it will be displayed on the website. The link may provide access to a live website or a test website, provided that the test site displays information as it will appear to the beneficiary/consumer. Submitting screen shots or text on a document is not acceptable. If the option to view online is not feasible, the MMP should contact its marketing reviewers prior to submission to receive permission to submit information in a manner other than a live link.

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

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

The MMP is not required to resubmit materials that have received prior approval for posting on its website. Any documents that require submission to HPMS should not be posted on the website until they are approved by the State.

See section 70 of the MCMG for required website content.

Section 90.5 - Submission of Multi-Plan Materials

This section does not apply to MMPs.

Section 90.6 - Status of HPMS Material

We clarify that, for purposes of MMP materials, there is no "deeming" of materials requiring either a dual review by CMS and the State or a one-sided State review, and materials remain in a "pending" status until the State and CMS reviewer dispositions match. 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. In addition, we note that the "non-

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

marketing" status is not available for joint review process (JRP) marketing codes in HPMS for CY 2019. All other guidance in this section of the MCMG applies.

Section 90.8 - File & Use Process

We clarify that the File & Use certification process for the MMP is included in the three-way contract. All other guidance in section 90.8 of the MCMG applies.

Section 100 - Required Materials

We clarify that CMS will continue to consider all CY 2019 MMP materials to be marketing materials as defined prior to the implementation of CMS-4182-F.[5] As a result all marketing materials must be submitted in HPMS. All other portions of this section apply to the MMP.

Section 100.4 - List of Required Materials

This section is replaced with the following revised guidance:

> **Section 100.4 - List of Required Materials**
> 42 CFR Parts 417, 422, 423, 438
>
> **Model Materials**
>
> We note that materials 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 2 of this guidance and Appendix 2 of the MCMG, as appropriate. Adding required MMP disclaimers to Part D models does not render the documents non-model when submitted for review or accepted as File & Use materials.
>
> We refer the MMP to the following available model materials:
>
> - MMP-specific model materials tailored to the MMP in Rhode Island, including an Annual Notice of Change (ANOC), Summary of Benefits, Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated formulary (List of Covered Drugs), combined provider/pharmacy directory (Provider and Pharmacy Directory), single Member ID Card, integrated denial notice, and welcome letters for opt in and passively enrolled individuals: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html.

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

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

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

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

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

Required Materials and Instructions for the MMP

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

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

Annual Notice of Changes (ANOC)	
To Whom Required:	• Must be provided to current enrollees of plan, including those with October 1, November 1, and December 1 effective dates.
Timing:	• The MMP must send for enrollee receipt no later than September 30 of each year. (**Note**: ANOC must be posted on MMP website by October 15.) • Enrollees with October 1, November 1, and December 1 enrollment effective dates must receive the ANOC for the upcoming year by one month after the effective date of enrollment but not later than December 15.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.

Annual Notice of Changes (ANOC)	
HPMS Timing and Submission:	• Code 17609 • Must be submitted prior to mailing ANOCs.
Format Specification:	• RI MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• Actual Mail Dates (AMDs) and number of recipients (not the number of ANOCs mailed) must be entered into HPMS within 15 days of mailing. This includes mail dates for alternate materials. An MMP that mails in waves should enter the AMD for each wave. An MMP may enter up to ten waves of mailings. For instructions on meeting this requirement, refer to the *Update AMD/Beneficiary Link/Function* section of the Marketing Review Users Guide in HPMS. • **Note:** For a single mailing to multiple recipients, as allowed under section 100.1 of the MCMG, the MMP should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed. • The plan may include the following with the ANOC: o Summary of Benefits o Provider and Pharmacy Directory o EOC (Member Handbook) o Formulary (List of Covered Drugs) o Form allowing enrollees to "opt-in" to receiving their upcoming ANOC and EOC (Member Handbook) via e-mail. o No additional plan communications unless otherwise directed.
Translation Required (5% Threshold):	Yes.

ANOC and EOC (Member Handbook) Errata	
To Whom Required:	Must be provided when plan errors are found in the ANOC or EOC (Member Handbook) and sent to current enrollees.
Timing:	Must send to enrollees immediately following CMS approval.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	• Code 17606 for ANOC Errata. • Code 17660 for EOC Errata. • ANOC errata must be submitted by October 15. • EOC (Member Handbook) errata must be submitted by November 15.
Format Specification:	Standardized model; a non-model document is not permitted.

ANOC and EOC (Member Handbook) Errata	
Guidance and Other Needed Information:	The MMP must use an errata notice to notify enrollees of plan errors in their original documents. We clarify that errata notices should only be used to notify enrollees of plan errors in plan materials. **Note:** Any mid-year changes, including but not limited to mid-year legislative benefit additions or removals and changes in enrollment policies, should be communicated to current enrollees consistent with the "Mid-Year Change Notification" guidance in this section. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to plan error. Instead the plan should use the HPMS marketing module replacement function for these changes.
Translation Required (5% Threshold):	Yes.

Coverage/Organization Determination, Discharge, Appeals and Grievance Notices	
To Whom Required:	• Must be provided to enrollees who have requested an appeal or have had an appeal requested on their behalf. • Grievances may be responded to electronically, orally, or in writing.
Timing:	Provided to enrollees (generally by mail) on an ad hoc basis, based on required timeframes in three-way contract.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Various codes for other CMS required notices. Refer to HPMS Marketing Code Look-up functionality for RI MMP codes.
Format Specification:	CMS models - modifications permitted.
Guidance and Other Needed Information:	Three-way contract, Chapter 13 of the Medicare Managed Care Manual, and Chapter 18 of the Medicare Prescription Drug Benefit Manual.
Translation Required (5% Threshold):	Yes.

Evidence of Coverage (EOC) / Member Handbook	
To Whom Required:	Must be provided to all enrollees of plan.

Evidence of Coverage (EOC) / Member Handbook	
Timing:	• Must send to current enrollees of plan for receipt by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current contract year, as well as an EOC (Member Handbook) document for the upcoming contract year. • We clarify that, for these members, the 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 a distinct and separate notice alerting enrollees how to access or receive the directory) for the upcoming year, must be received by one month after the effective date of enrollment, but not later than December 15th.
Method of Delivery:	Hard copy EOC (Member Handbook) or via Electronic Notice of Documents (consistent with section 100.2.1 of the MCMG); or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	• Code 17608. • Submitted prior to October 15 of each year.
Format Specification:	• RI MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	No additional information.
Translation Required (5% Threshold):	Yes.

Excluded Provider Letter	
To Whom Required:	Provided to enrollees when a sponsor has excluded a prescriber or pharmacy participating in the Medicare program based on an Office of Inspector General (OIG) exclusion.
Timing:	Provided to enrollees on an ad hoc basis.

Excluded Provider Letter	
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17637
Format Specification:	Model provided; modifications permitted.
Guidance and Other Needed Information:	https://oig.hhs.gov/fraud/exclusions.asp
Translation Required (5% Threshold):	Yes.

Explanation of Benefits (EOB) – Part D	
To Whom Required:	Must be provided anytime an enrollee utilizes their prescription drug benefit.
Timing:	Sent at the end of the month following the month when the benefit was utilized.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17636
Format Specification:	Part D EOB model; modifications permitted.
Guidance and Other Needed Information:	Three-way contract and Medicare Prescription Drug Benefit Manual, Chapters 5 and 6, and HPMS code usage instructions.
Translation Required (5% Threshold):	Yes.

Formulary (List of Covered Drugs)	
To Whom Required:	Must be provided to all enrollees of plan.
Timing:	• Must be sent to current enrollees of plan for receipt by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.

Formulary (List of Covered Drugs)	
Method of Delivery:	Hard copy, or via Electronic Notice of Documents (consistent with section 100.2.1 of the MCMG); or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17603
Format Specification:	Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• The MMP must make available a comprehensive integrated formulary (List of Covered Drugs) that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the plan. • OTC items and/or supplemental benefits that are in excess of Medicaid requirements may not be included in this document. • The MMP is only permitted to make available a comprehensive, not abridged, formulary (List of Covered Drugs).
Translation Required (5% Threshold):	Yes.

Integrated Denial Notice	
To Whom Required:	Any enrollee with an adverse benefit determination.
Timing:	Provided to enrollees (generally by mail) on an ad hoc basis, at least 10 days in advance of any adverse benefit determination.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17621
Format Specification:	• RI MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	Three-way contract.
Translation Required (5% Threshold):	Yes.

Member ID Card	
To Whom Required:	Must be provided to all plan enrollees.

Member ID Card	
Timing:	• Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • Must also be provided to all enrollees if information on existing card changes.
Method of Delivery:	Must be provided in hard copy. In addition to the hard copy, plans may also provide a digital version (e.g., app).
HPMS Timing and Submission:	Code 17611
Format Specification:	Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	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.
Translation Required (5% Threshold):	No.

Mid-Year Change Notification to Enrollees	
To Whom Required:	Must be provided to all applicable enrollees when there is a mid-year change in benefits, plan rules, formulary, provider network, or pharmacy network.
Timing:	Ad hoc, based on specific requirements for each issue.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Various codes. Refer to HPMS Marketing Code Look-up functionality for RI MMP codes.
Format Specification:	Model not available; must include required content.

Mid-Year Change Notification to Enrollees	
Guidance and Other Needed Information:	• Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until model notice is received from CMS. • The MMP may elect to share Non-Renewal and Service Area Reduction (NR/SAR) information only with first tier, downstream, and related entities (FDRs) or anyone that the MAO does business with (i.e., contracted providers). • Additional NR/SAR notice information can be found in the annual "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models" HPMS memo. • If a non-model document is created the document must contain all the elements in the model.
Translation Required (5% Threshold):	Yes.

Prescription Transfer Letter	
To Whom Required:	When a Part D sponsor requests permission from an enrollee to fill a prescription at a different network pharmacy than the one currently being used by enrollee.
Timing:	Ad hoc.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17638
Format Specification:	Part D model provided; modifications permitted.
Guidance and Other Needed Information:	The model notice should only be used when the transfer of the prescription is not initiated by the beneficiary (or someone on his or her behalf).
Translation Required (5% Threshold):	Yes.

Provider and Pharmacy Directory	
To Whom Required:	Must be provided to all current enrollees of the plan.
Timing:	• Must be sent to current enrollees of Plan for receipt by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be provided to current enrollees upon request, within

Provider and Pharmacy Directory	
	three (3) business days of the request. • Must update directory information any time they become aware of changes. All updates to the online provider and pharmacy directories are expected to be completed within 30 days of receiving information. Updates to hard copy provider and pharmacy directories must be completed within 30 days; however, hard copy directories that include separate updates via addenda are considered up-to-date.
Method of Delivery:	Hard copy or via Electronic Notice of Documents (consistent with section 100.2.1 of the MCMG); or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17604
Format Specification:	• RI MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• The MMP is required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. The MMP may print separate directories for primary care physicians (PCPs) and specialists provided both directories are made available to enrollees at the time of enrollment. • The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits. • For 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 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. • As applicable, refer to the language and guidelines issued in the August 16, 2018, HPMS memo, "Pharmacy Directories and Disclaimers" for the pharmacy portion of the combined directory.
Translation Required (5% Threshold):	Yes.

Provider and Pharmacy Directory	
To Whom Required:	Must be provided to all current enrollees of the plan.
Timing:	• Must be sent to current enrollees of Plan for receipt by October 15 of each year. • Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be provided to current enrollees upon request, within three (3) business days of the request. • Must update directory information any time they become aware of changes. All updates to the online provider and pharmacy directories are expected to be completed within 30 days of receiving information. Updates to hard copy provider and pharmacy directories must be completed within 30 days; however, hard copy directories that include separate updates via addenda are considered up-to-date.
Method of Delivery:	Hard copy or via Electronic Notice of Documents (consistent with section 100.2.1 of the MCMG); or electronically, if enrollee has opted into receiving electronic version as permitted in section 100.2.2 of the MCMG.
HPMS Timing and Submission:	Code 17604
Format Specification:	• RI MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• The MMP is required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. The MMP may print separate directories for primary care physicians (PCPs) and specialists provided both directories are made available to enrollees at the time of enrollment. • The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits. • For 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 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	
	Provider and Pharmacy Directory marketing code. • As applicable, refer to the language and guidelines issued in the August 16, 2018, HPMS memo, “Pharmacy Directories and Disclaimers” for the pharmacy portion of the combined directory.
Translation Required (5% Threshold):	Yes.

Scope of Appointment	
To Whom Required:	Must be documented for all marketing activities, in-person, telephonically, including walk-ins to MMP or agent offices.
Timing:	Prior to the appointment.
Method of Delivery:	Beneficiary signed hard copy, telephonic recording, or electronically signed.
HPMS Timing and Submission:	Code 17649
Format Specification:	No model required, must include required content.
Guidance and Other Needed Information:	• One-on-one appointments with potential MMPs enrollees are generally not permitted unless proactively requested by a current or prospective MMP enrollee. • The following requirements must be on the scope of appointment (SOA) form or on the recorded call: o Product types to be discussed o Date of appointment o Beneficiary and agent contact information o Statement stating there is no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur. • A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon.
Translation Required (5% Threshold):	Yes.

Summary of Benefits	
To Whom Required:	Enrollees who are passively enrolled. Optional with the ANOC and as requested for other enrollees.

Summary of Benefits	
Timing:	• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be available by October 15 of each year, but can be released as early as October 1 of each year.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17601. Submitted prior to October 15 of each year.
Format Specification:	• RI MMP model required for current Contract Year. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• The SB must contain a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including applicable copays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. • Appendix 5 of the MCMG, Summary of Benefit Instructions, does not apply.
Translation Required (5% Threshold):	Yes.

Welcome Letter	
To Whom Required:	Must be provided to all new enrollees of MMP.
Timing:	• Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Code 17602
Format Specification:	RI MMP model required for Contract Year.
Guidance and Other Needed Information:	• Must contain 4Rx information consistent with the model. • National Enrollment/Disenrollment Guidance for States & MMPs section 30.5.1
Translation Required (5% Threshold):	Yes

Required Materials for New MMP Enrollees

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

Table 1. Required Materials for New Members

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Passive enrollment	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • SB	30 calendar days prior to the effective date of enrollment
Passive enrollment	• Member ID Card • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC)	No later than the day prior to the effective date of enrollment
Opt-in enrollment (with enrollment confirmation received more than 8 calendar days before the end of the month)[6]	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC)	No later than the last day of the month prior to the effective date

[6]We clarify that this group of enrollees who opt in includes individuals who are eligible for passive enrollment but select a different MMP or initiate an earlier enrollment date than their passive enrollment effective date. The MMP should refer to the date of the Enrollment E-file to identify the start of the eight (8) calendar-day timeframe.

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received less than 8 calendar days before the end of the month)[7]	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook (or a distinct and separate notice alerting enrollees how to access or receive the EOC)	No later than 8 calendar days from receipt of the CMS confirmation of enrollment

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

The provisions in this section of the MCMG and all its subsections applicable to independent agents/brokers do not apply to 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 section 20 of this guidance – must be licensed in the State (and, when required, appointed) as an insurance broker/agent.

Appendix 2 - Disclaimers

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

Table 2. State-specific MMP Disclaimers

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Federal Contracting	<Plan's legal or marketing name> is a health plan that contracts with both Medicare and Rhode Island Medicaid to provide benefits of both programs to enrollees.	Required on materials as described in the "Applicable Documents and Notes" column in Appendix 2 of the MCMG.

[7] 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. The MMP should refer to the date of the Enrollment E-file to identify the start of the eight (8) calendar-day timeframe.

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Benefits – "This is not a complete list…"	This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the <plan name> Member Handbook.	Required on the SB and all materials with 10 or more benefits except the Member Handbook (EOC)
Availability of Non-English Translations	ATTENTION: If you speak <language of disclaimer>, language assistance services, free of charge, are available to you. Call <Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation>. The call is free.	Required on materials as described in the "Applicable Documents and Notes" column in Appendix 2 of the MCMG
Plan Online Enrollment Center	This disclaimer does not apply to the MMP.	N/A
Star Ratings	This disclaimer does not apply to the MMP.	N/A
Materials Developed by a Third Party	This disclaimer does not apply to the MMP.	N/A
Non-plan and Non-health information	Neither Medicare nor Rhode Island Medicaid has reviewed or endorsed this information.	Required on non-plan and non-health related information once prior authorization from the enrollee is granted to receive materials.

Appendix 3 - Pre-Enrollment Checklist

This appendix does not apply to the MMP since all enrollments are submitted by the Rhode Island enrollment broker.

Appendix 7 - Use of Medicare Mark for Part D Sponsors

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