Contract Year (CY) 2018 Marketing Guidance for Texas Medicare-Medicaid Plans

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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 Medicare-Medicaid Plans (MMPs) participating in the Texas 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 MMPs in Texas; 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 for Texas MMPs in this guidance.

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

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 10 - Introduction	Adds guidance on materials subject to State review.
Section 20 – Materials Not Subject to Review	Adds guidance on materials not subject to CMS or State review and clarifies that "general health promotion materials" has the same meaning as "health-related materials" in the three-way contract. 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 MMPs.
Section 30.6 – Required Materials with an Enrollment Form	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter	Replaces current guidance in the MMG with guidance for MMPs.
Section 30.8 – Enrollment Verification Requirements	Clarifies that the requirements of this section are not applicable to MMPs.

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

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 30.9 – Enrollee Referral Programs	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.10 – Star Ratings Information from CMS	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.10.1 – Referencing Star Ratings in Marketing Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.10.2 – Plans with an Overall 5-Star Rating	Clarifies that the requirements of this section are not applicable to MMPs.
Section 40.1 – Marketing Material Identification	Clarifies the terminology in this section and adds requirements regarding placement of the marketing material identification number.
Section 40.4 – Prohibited Terminology/Statements	Adds requirements for MMPs to current MMG requirements of this section.
Section 40.6 – Hours of Operation Requirements for Marketing Materials	Adds requirements for MMPs to current MMG requirements of this section.
Section 40.8.3 – Marketing Materials from Third Parties that Provide Non-Benefit/Non-Health Services	Clarifies that this section applies only with respect to marketing materials from third parties that provide non-benefit/non-health services only when they are specifically general health promotion/health-related materials. Clarifies that the requirements of this section do not apply to materials produced by the State and its administrative services contractor.
Section 40.10 – Standardization of Plan Name Type	Clarifies the requirements of this section for MMPs.
Section 60.1 – Summary of Benefits (SB)	Replaces current guidance in this section with guidance for MMPs.
Section 60.2 – ID Card Requirements	Clarifies the requirements of this section for MMPs.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 60.4 – Formulary and Formulary Change Notice Requirements	Clarifies the requirements of this section for MMPs. Adds an option for MMPs 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 MMPs.
Section 60.7 – Other Mid-Year Changes Requiring Enrollee Notification	Extends the requirements of this section to mid-year changes in Texas Medicaid benefits.
Section 70.2 – Marketing Through Unsolicited Contacts	Adds a requirement on marketing through unsolicited contacts by conventional mail and other print media.
Section 70.3 – Prospective Enrollee Educational Events	Adds requirements for MMPs to current MMG requirements of this section.
Section 70.4 – Marketing/Sales Events and Appointments	Adds requirements for MMPs to current MMG requirements of this section.
Section 70.4.2 – Personal/Individual Marketing Appointments	Adds requirements for MMPs to current MMG requirements of this section.
Section 70.5 – Marketing in the Health Care Setting	Replaces current guidance in this section with guidance for MMPs.
Section 70.5.1 – Provider Based Activities	Adds requirements for MMPs to current MMG requirements of this section.
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 administrative services contractor.
Section 80.1 – Customer Service Call Center Requirements	Replaces current guidance in this section regarding permissible use of alternate call center technologies on weekends and holidays with guidance for MMPs.
Section 80.2 – Informational Scripts	Clarifies requirements in this section for MMPs.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 80.3 – Enrollment Scripts/Calls	Clarifies that the requirements of this section are not applicable to MMPs.
Section 80.4.1 – Telephonic Contact	Clarifies and modifies the requirements of this section for MMPs.
Section 90 – The Marketing Review Process	Clarifies that references in this section (and subsections) to CMS in its role in marketing reviews also apply to the State.
Section 90.2.1 – 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 MMPs.
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 MMPs.
Section 100.1 – General Website Requirements	Adds requirements for MMPs to current MMG requirements of this section.
Section 100.2 – Required Content	Adds requirements for MMPs 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 MMPs.
Section 100.3 – Electronic Enrollment	Clarifies that the requirements of this section are not applicable to MMPs.
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 100.6 – Social Media	Adds requirements for MMPs to current MMG requirements of this section.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 100.8 – Mobile Apps	Adds requirements for MMPs to current MMG requirements of this section.
Section 110.1 – Promotional Activities	Adds requirements for MMPs to current MMG requirements of this section.
Section 110.2 – Marketing of Rewards and Incentives Programs	Clarifies that the requirements of this section, as well as those in CMS guidance regarding rewards and incentives programs, apply to MMPs.
Section 120 – Marketing and Sales Oversight and Responsibilities	Clarifies that starting for CY 2018 enrollments, MMPs will be permitted to compensate independent agent/brokers for certain opt-in enrollments. Clarifies that the requirements of this section (and subsections) apply to MMPs. Clarifies 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 120.3 – Agent/Broker Training and Testing	Clarifies that the State will not provide annual specifications for training and testing criteria and documentation requirements.
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 MMPs.
Section 150 – Use of Medicare Mark for Part D Sponsors	Clarifies the requirements of this section for MMPs.
Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received	Replaces current disclaimer in this section with a disclaimer for MMPs.
Appendix 5 – Disclaimers	Modifies and clarifies disclaimer requirements for MMPs.

Use of Independent Agents and Brokers

We clarify that Texas MMPs may compensate independent agents/brokers for certain opt-in enrollments as detailed in section 120 of this guidance. The requirements applicable to

independent agents/brokers throughout the MMG are therefore applicable to Texas MMPs in the scenarios described in section 120 of this guidance.

Model Materials

We note that materials MMPs create should take into account the reading level requirements established in the three-way contract. Available model materials reflect acceptable reading levels. Current Part D models are acceptable for use as currently provided, and MMPs must add required disclaimers in Appendix 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 MMPs to the following available model materials:

- MMP-specific model materials tailored to MMPs in Texas, 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, welcome letter for passively enrolled individuals, and welcome letter for individuals who voluntarily enrolled: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

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

- Required Drug-Only Explanation of Benefits (EOB) as either, (1) the Part D EOB: http://cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html; or (2) the MMP Drug-Only EOB: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. Texas MMPs will have the option to use either model to meet the requirement to send a Part D EOB.

- 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 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 MMPs in creating their 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 submissions applies to the MMP with the following modifications:

- MMPs are required to make available a single, combined Provider and Pharmacy Directory. Separate provider and pharmacy directories are not permitted.

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

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

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

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/.

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

Section 10 – Introduction

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

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

- Materials in the Critical Elements chapter of the Uniform Managed Care Manual
- Health risk assessment forms
- Member surveys
- Flexible benefits and rewards and incentives materials
- Press releases that include Medicare/Texas Medicaid/STAR+PLUS program references and name recognition, regardless of whether they contain plan-specific information
- LTSS non-acute service documents, along with the original corresponding STAR+PLUS documents and HHSC approval forms
- MMP apps that are not health related

MMPs will submit these materials to the State via HPMS. The State will adopt the same timeframes for review of these materials as apply to marketing materials (10 days for a model review and 45 days for a non-model review). MMPs will submit provider materials to the State at Dual_Demo_Pilot@hhsc.state.tx.us.

Section 20 – Materials Not Subject to Review

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

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

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

We also modify section 20 of the MMG with respect to the MMP Provider and Pharmacy Directory, which 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 Texas 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 Texas' standard for translation of marketing materials is more stringent. Guidance regarding the translation requirements for all plans, including MMPs, is released annually each fall. The required languages for translation for each

MMP are also updated annually, as needed, in the HPMS Marketing Module. We expect the standard will remain unchanged relative to the standard for CY 2016 and that MMPs must translate all required marketing materials into Spanish for all service areas.

Required materials are 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 referenced in Chapter 4 of the Medicare Managed Care Manual, notices of appeals decisions, Member ID Card, integrated denial notice, and the Part D transition letter.[2] MMPs will only be required to translate into Spanish those elements of the Member ID Card that are directed to enrollees, consistent with the Texas MMP Member ID Card model.

MMPs are also required to make required materials available in alternate formats upon request (e.g., large print, braille, audio).

MMPs must have a process for ensuring that enrollees can make standing request to receive the materials identified in this section, in alternate formats and in all non-English languages identified in this section 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).

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, Texas MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, Texas MMPs will not be required to include the Star Ratings Information document when a beneficiary is provided with pre-enrollment information. We further clarify that the responsibility for sending enrollment and disenrollment notices to enrollees will be delegated to the State's administrative services contractor, with the exception of any notices delegated to MMPs in Texas, 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).

[2] CMS will make available Spanish translations of the Texas MMP Summary of Benefits (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.

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 Texas 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, Texas Medicaid, and additional benefits, or a 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 identification (ID) card for accessing all covered services under the plan (required at the time of enrollment and as needed or required by the MMP post-enrollment).
>
> - For individuals enrolled through passive enrollment, a demonstration plan-specific 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 an MMP must send an SB to current enrollees post-enrollment.
>
> MMPs must send enrollees who opt in to the demonstration the following materials for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever occurs

later. We clarify that this group of enrollees who opt in includes individuals who are eligible for passive enrollment but select a different MMP or initiate an earlier enrollment date than their passive enrollment effective date. For late-month enrollment transactions (those for which CMS confirmation of enrollment is received less than ten (10) calendar days before the end of the month prior to the effective date), MMPs must send these materials for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment. MMPs should refer to the date of the Daily Transaction Reply Report (DTRR) that has the notification to identify the start of the ten (10) calendar-day timeframe.

- A welcome letter, 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 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)

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

- A welcome letter, 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

- An SB

In addition, MMPs must send 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 July 31 for an August 1 effective enrollment date).

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

Additional informational materials about 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 Enrollees

Enrollment Mechanism	Required Materials for New Enrollees	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 distinct and separate notice alerting enrollees how to access or receive the directory) • SB	30 calendar days prior to the effective date of 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 Enrollees	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received more than 10 calendar days before the end of the month)	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or 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 10 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 distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook)	No later than 10 calendar days from receipt of the CMS confirmation of enrollment

Table 3: Required Materials for Renewing Members

Required Materials for Renewing Members	Timing of Beneficiary Receipt
• ANOC/EOC (Member Handbook) • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) OR • ANOC • SB • Formulary (List of Covered Drugs) (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 MMP 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 (List of Covered Drugs) are sent by September 30: • EOC (Member Handbook)	December 31 The EOC (Member Handbook) must be posted on MMP 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's website 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 MMPs are submitted by the State's administrative services contractor, the requirements of this section do not apply.

Section 30.9 – Enrollee Referral Programs

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

Section 30.10 – Star Ratings Information from CMS

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

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, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this section does not apply to MMPs.

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, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this section does not apply to MMPs.

Section 40.1 – Marketing Material Identification

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

Section 40.4 – Prohibited Terminology/Statements

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

Section 40.6 – Hours of Operation Requirements for Marketing Materials

In addition to the requirements of this section, MMPs must also provide the phone and TTY/TDD numbers and days and hours of operation information for the State's administrative services contractor at least once in any marketing materials detailed in section 30.7 of this guidance, as well as any materials that are provided prior to the time of enrollment and where an MMP's customer service number is provided for enrollees to call.

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

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

In addition to the guidance in this section, CMS and the State clarify that materials produced by the State and distributed by the State's administrative services contractor do not constitute non-benefit/non-health service-providing third party marketing materials. Therefore, such materials do not need to be submitted to the plan 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.

Section 40.10 – Standardization of Plan Name Type

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

CMS is unable to create state-specific plan type labels in HPMS for each state's demonstration plans; therefore, all MMPs are referred to by the standardized plan name type "Medicare-Medicaid Plan" in CMS' external communications – e.g., the Medicare & You handbook and the Medicare Plan Finder tool on www.medicare.gov. The State also refers to MMPs as STAR+PLUS Medicare-Medicaid Plans and has provided additional guidance on branding for the demonstration. MMPs will be required to use the STAR+PLUS MMP program logo on all marketing materials, including the Member ID Card.

To reduce beneficiary confusion, we also clarify that MMPs in Texas that offer Medicare Advantage products, including SNPs, in the same service area as their MMPs, may not use the same plan marketing name for both those products. Thus, for example, an organization offering both a SNP and an MMP in the same service area could not use the same name – e.g., Acme Duals Care (HMO SNP) – for its SNP product as for its MMP product – e.g., Acme Duals Care (Medicare-Medicaid Plan).

Section 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 MMPs:

> **Section 60.1 – Summary of Benefits (SB)**
>
> 42 CFR 422.111(b)(2), 423.128(b)(2)

MMPs must use the 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

MMPs are 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 MMPs must issue a single Member ID Card meeting these requirements for all services offered under the plan. Separate pharmacy and health benefits Member ID Cards are not permitted. MMPs 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 MMPs with the following modifications:

- MMPs must make available a comprehensive integrated formulary (List of Covered Drugs) that includes Medicare and Texas Medicaid outpatient prescription drugs and pharmacy products provided under the plan;

- MMPs are only permitted to make available a comprehensive, not abridged, formulary; and

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

In addition, we clarify that, to conform to HHSC's process for Medicaid formulary updates, MMPs may market mid-year changes to their Additional Demonstration Drug (ADD) file drugs prior to receiving State approval of their revised ADD file.

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 Texas MMPs 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)
>
> MMPs are 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.
>
> MMPs must send the ANOC for member receipt by September 30 each year. The EOC (Member Handbook) may be sent as a standalone document as follows:
>
> - MMPs must send new enrollees (whether they opt 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 CMS confirmation of enrollment is received less than ten (10) calendar days before the end of the month prior to the effective date), MMPs must send these materials for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment.
>
> - For all current enrollees, MMPs must annually send an EOC (Member Handbook) for member receipt by December 31. MMPs choosing this option (rather than a combined ANOC/EOC (Member Handbook) by September 30) must also send an SB with the ANOC.
>
> New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current contract year, as well as a combined ANOC/EOC (Member Handbook) document for the upcoming contract year. We clarify that, for these members, the combined ANOC/EOC (Member Handbook) for the upcoming year, as well as the formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary), and 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 MMPs that they must upload in HPMS either (1) a standalone ANOC and a standalone EOC (Member Handbook), or (2) a combined ANOC/EOC (Member Handbook). MMPs should only use the combined ANOC/EOC (Member Handbook) material code if they are sending enrollees a combined document. Otherwise, MMPs 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 MMPs to compliance action.

To ensure timely mailing of their annual ANOC/EOC (Member Handbook), plans must indicate the actual mail date (AMD) and the number of enrollees who were mailed the documents in in HPMS within fifteen (15) calendar days of mailing. This includes mail dates for alternate materials. We remind MMPs that they should enter AMD information in HPMS for mailings to current members only. Plans should not enter AMD information for October 1, November 1, or December 1 effective dates, or for January 1 effective dates for new members. MMPs that mail in waves should enter the AMD for each wave. MMPs may enter up to ten waves of mailings. MMPs that use a standalone ANOC and a standalone EOC (Member Handbook) must enter AMD information for one to ten mailing waves, as applicable, separately for both materials. MMPs that use a combined ANOC/EOC (Member Handbook) 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 Users Guide in HPMS.

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

MMPs 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 MMP 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 Texas Medicaid or required demonstration additional benefit changes.

Section 70.2 – Marketing Through Unsolicited Contacts

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

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

Section 70.3 – Prospective Enrollee Educational Events

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

- Events may only focus on health and program education.
- Events may be hosted by MMPs but must be held in public venues. Events must be physically accessible to all current or potential enrollees, including persons with disabilities and persons using public transportation.
- Events cannot be held at in-home or one-on-one settings, in or around public offices, or in the common areas of provider offices.
- MMPs may not charge members for goods or services distributed at educational events.
- MMPs may offer free health screenings to potential members at educational events, as long as they are *not* conditioned upon enrollment into the MMP. The health screenings cannot be used to identify and discourage less healthy potential members from enrolling in the MMP.

In addition to the guidance in this section of the MMG, we note that, as provided under the three-way contract, the state may request that Texas MMPs provide current schedules of all educational events conducted for current or prospective enrollees.

Section 70.4 - Marketing/Sales Events and Appointments

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

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

Section 70.4.2 – Personal/Individual Marketing Appointments

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

- MMP representatives are not permitted to conduct unsolicited personal/individual appointments. An individual appointment must only be set up at the request of a beneficiary or his/her authorized representative. An MMP can offer an individual appointment to a beneficiary who has contacted the MMP to request assistance or information. However, MMPs are prohibited from making unsolicited offers of individual appointments.

- An MMP must make reasonable efforts to conduct an appointment in the beneficiary's preferred location. An MMP cannot require that an individual appointment occur in a beneficiary's home.

- MMP representatives may not assist individuals with completing enrollment forms.

Section 70.5 – Marketing in the Health Care Setting

This section is replaced with the following revised guidance:

> **Section 70.5 – Marketing in the Health Care Setting**
>
> 42 CFR 422.2268(e), (j) and (k), 423.2268(e), (j) and (k)
>
> MMPs may have agreements with providers in connection with plan activities and should ensure that those agreements address marketing activity in a manner consistent with Medicare and Texas Medicaid regulations. These requirements are discussed throughout this section. MMPs and providers with whom MMPs have a relationship (contractual or otherwise) who assist beneficiaries with plan selection should ensure that provider assistance results in plan selection that is always in the best interest of the beneficiary. MMPs may not cobrand or conduct plan marketing activities in health care settings.
>
> MMPs may not use providers to make available and/or distribute plan marketing materials, with the exception of plan stickers. Providers may choose to distribute or display general health promotion materials/health-related materials and/or plan stickers for all contracted MMPs, or may choose not to distribute or display for any contracted MMP. MMPs may provide health-related display posters and materials for providers to display in common areas, subject to the following requirements:
>
> - Health-related posters cannot be larger than 16" x 24".
>
> - Materials may include the MMP's name, logo, and contact information.
>
> - MMP stickers may not be larger than 5"x7" and may not indicate anything more than MMP is accepted or welcomed here.
>
> Providers are not required to distribute or display all general health promotion materials provided by each MMP with whom they contract. Providers can choose which items to distribute or display, as long as they distribute/display one or more items from each contracted MMP without giving the appearance of supporting one MMP over another.
>
> Providers may choose whether to display items such as pens or pencils provided by each contracted MMP. Providers can choose which items to display as long as they display one or more from each contracted MMP. Items may only be placed in common areas.

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

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

Section 70.5.1 – Provider Based Activities

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

- Make any oral or written statements that the MMP is endorsed by CMS, a Federal or State governmental agency, or similar entity.
- Market to persons currently enrolled in another MMP.
- Recommend one MMP over another or assist a beneficiary in deciding to select a specific MMP.
- Induce or accept a current or prospective member's enrollment in or disenrollment from an MMP.
- Assist an enrollee with enrollment forms.
- Portray other plans in a negative manner.
- Provide promotional items or nominal gifts to a select MMP's current or prospective members or condition promotional or nominal gifts on enrollment with an MMP.
- Use terms that would influence, mislead, or cause prospective members to contact the MMP, rather than the State’s administrative services contractor, for enrollment in the MMP.
- Discriminate against current or prospective member based on race, creed, age, color, religion, national origin, ancestry, marital status, sexual orientation, physical or mental disability, health status, or existing need for medical care.
- Use telephone number "2-1-1" for enrollment purposes to promote enrollment in an MMP.

Section 70.5.4 – 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 its administrative services contractor.

Section 80.1 – Customer Service Call Center Requirements

This section is replaced with the following revised guidance:

> **Section 80.1 – Customer Service Call Center Requirements**
>
> 42 CFR 422.111(h)(1), 423.128(d)(1)
>
> MMPs must operate a toll-free call center for both current and prospective enrollees seven (7) days a week, at least from 8:00 a.m. to 8:00 p.m. CT, except as provided below. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. MMPs may use alternative technologies on Saturdays, Sundays, and all Federal and State holidays except New Year's Day, as specified in the three-way contract, in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide the required information listed below, and/or allow a beneficiary to leave a message in a voice mail box. A customer service representative must then return the call in a timely manner, no more than one business day later.
>
> The use of a call center and the provision of information through a call center are mandatory for all MMPs.
>
> Call centers 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 service to all non-English speaking, limited English proficient, and deaf or 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.

- Have a process to measure the time from which the telephone is answered to the point at which the caller reaches a customer service representative capable of responding to the caller's question in a manner sensitive to the caller's language and cultural needs.

- Ensure that ninety-nine (99) percent of calls are answered by the fourth ring by a customer service representative or an automated call pick-up system.

- Ensure that no more than one (1) percent of incoming calls receive a busy signal.

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). MMPs are 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 administrative services contractor.

MMPs 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. MMPs 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 MMPs because enrollment requests must be transferred to the State's administrative services contractor.

Section 80.4.1 – Telephonic Contact

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

- MMPs may not contact individuals who submit enrollment applications to conduct quality control and agent oversight activities.

- MMPs may not contact members who have been involuntarily disenrolled to resolve eligibility issues.

- Consistent with section 80.4.1 of the MMG, calls made by MMPs to current members (including those enrolled in other product lines) are not considered unsolicited direct contact and are therefore permissible. Organizations that offer non-MMP and MMP products may call their current non-MMP members (for example, those in Texas Medicaid managed care products), including individuals who have previously opted out of passive enrollment into an MMP, to promote their MMP offerings.

- Plans may use reasonable efforts to contact current non-MMP enrollees who are eligible for MMP enrollment to provide information about their MMP products. Callers with questions about other Medicare program options should be transferred to 1-800-MEDICARE or to the State Health Insurance Assistance Program (known as the Health Information Counseling & Advocacy Program of Texas, or HICAP, in Texas) for information and assistance.

Section 90 – The Marketing Review Process

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

Section 90.2.1 – Submission of Non-English and Alternate Format Materials

The requirements of this section apply without modification. We note, however, that MMPs should use state-specific MMP errata codes. For more information about errata codes, MMPs 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 MMPs.

Section 90.3 – HPMS Material Statuses

We clarify that, for purposes of MMP materials, there is no “deeming” of materials requiring either a dual review by CMS and the State or a one-sided State review, and materials remain in a “pending” status until the State and CMS reviewer dispositions match. However, CMS and State marketing reviewers have standard operating procedures for ensuring materials are reviewed in a timely manner and differences in dispositions are resolved expeditiously.

Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MMPs may obtain more information about the specific review parameters and timeframes for marketing materials under the Texas 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. However, CMS and State marketing reviewers have standard operating procedures for ensuring materials are reviewed in a timely manner and differences in dispositions are resolved expeditiously. Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MMPs may obtain more information about the specific review parameters and timeframes for marketing materials under the Texas 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 MMPs become certified for File & Use through the three-way contract. All other guidance in section 90.6 of the MMG and all its subsections applies.

Section 100.1 – General Website Requirements

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

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

Section 100.2 – Required Content

In addition to the requirements outlined in this section, MMPs must also include on their websites:

- A direct link to the State's administrative services contractor.
- Information on the potential for contract termination, as required under 42 CFR 422.111(f)(4)).
- Information that materials are published in alternate formats (e.g., large print, braille, audio).

- General information about the program, including how to access the MMP's call center(s).

Section 100.2.2 – Required Documents for Part D Sponsors

The requirements of this section apply with the following modifications:

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

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

Section 100.3 – Electronic Enrollment

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

Section 100.4 – 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 MMP websites as required in this section. All other guidance in this section applies without modification.

Section 100.6 – Social Media

In addition to the requirements of this section, we clarify that MMP use of electronic media is permitted. For Texas MMPs, electronic media refers to television, radio, and MMP-specific apps. MMPs may use both social and electronic media to disseminate health-related material, but MMPs may not use social media to disseminate plan or program-specific information.

Section 100.8 – Mobile Applications

We clarify that MMPs must notify CMS and the State of any intent to implement an MMP-specific app. Any apps that are not health related, regardless of whether they are targeted to current or potential enrollees, must be submitted as state-only marketing materials in HPMS (see section 10 of this guidance).

Section 110.1 – Promotional Activities

In addition to the requirements of this section, we clarify that any promotional activities or items offered by MMPs:

- May not be provided to providers for the purpose of distributing to prospective or current members;

- May be provided to encourage prospective or current member attendance at MMP events; and

- May be provided to encourage current enrollees to participate in periodic surveys.

MMPs are allowed to accept promotional items from third-party sources and distribute to prospective or current enrollees subject to the dollar limits stated in section 110.1 of the MMG. MMPs may adhere their plan sticker to promotional items provided by third-party sources.

Section 110.2 – Marketing of Rewards and Incentives Programs

MMPs may market rewards and incentives 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.

Section 120 – Marketing and Sales Oversight and Responsibilities

All MMP enrollments will continue to be processed by the State's administrative services contractor. However, we clarify that starting for CY 2018 enrollments, Texas MMPs will be permitted to compensate independent agent/brokers in two scenarios, further detailed in the table below, in which individuals opt in to MMPs that are offered by the same parent organization as their previous coverage (for example, a Dual Eligible Special Needs Plan, or D-SNP), and that enrollment into the previous coverage was facilitated by an independent agent/broker. This situation can occur in the middle of the initial compensation year or in a subsequent year in which the agent/broker is receiving a renewal compensation for retention in that Medicare Advantage (MA) plan.

Essentially, this policy allows the MMP to compensate an independent agent/broker based on the circumstances in which the same independent agent/broker would have received compensation had the member stayed in the parent organization's MA product instead of opting into the MMP. This prevents independent agent/brokers from experiencing a financial penalty if a member stays with the same parent organization but eventually elects to join the parent organization's MMP.

Table 4: Permissible Options for Compensating Independent Agents/Brokers when a Member Transitions from a Compensation-eligible MA Product by Opting into a Texas MMP

Original Enrollment	New Enrollment	Relationship between New and Old Enrollments	Method of Enrollment into the New Plan	Current Compensation Situation	Compensation Situation after MMP Enrollment
MA plan	MMP	Same parent organization	Member-initiated opt-in enrollment through the state's administrative services contractor	MA plan is currently paying initial compensation for MA plan enrollment	MMP may elect to pay agent/broker a pro-rated initial compensation payment, as applicable depending on the timing of the enrollment, and may make renewal compensation payments for subsequent compensation cycle years
MA plan	MMP	Same parent organization	Member-initiated opt-in enrollment through the state's administrative services contractor	MA plan is currently paying renewal compensation for MA plan enrollment	MMP may elect to pay agent/broker a pro-rated share of the renewal compensation payment, depending on the timing of the enrollment, and may make renewal compensation payments for subsequent compensation cycle years

Consistent with the guidance in section 120.4 et. seq. of the Medicare Marketing Guidelines (MMG), in the initial compensation scenario in the table above, the MA plan would be required to pro-rate the compensation paid to the agent for the months the enrollee was no longer enrolled in the MA plan.

In addition, we clarify that all other requirements applicable to independent agents/brokers throughout the MMG, including section 120 of the MMG, will be applicable to Texas MMPs with this policy change for CY 2018. We remind plans that all MMP enrollments will continue to be processed by the State's administrative services contractor.

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 120.3 – Agent/Broker Training and Testing

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

Section 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 MMPs have been required to sign a licensing agreement to use the official Medicare Mark as part of the three-way contract, rather than through the HPMS contracting module. All other guidance in section 150 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 Texas 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. MMPs 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 Texas 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> or read the <plan name> Member Handbook."
>
> "Benefits [and/or copays] may change on January 1 of each year."

Plan Premiums Are Mentioned

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

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)

Texas MMPs 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 <insert Member Services 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 more stringent of either the Medicare or the Medicaid translation standard (refer to 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 MMPs. MMPs may only include the following information related to their National Committee for Quality Assurance (NCQA) model of care approval:

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

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

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

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

Plans Accepting Online Enrollment Requests

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

Third Party Materials

This disclaimer relates to third party materials that are specifically not subject to review and applies to MMPs with the following modification to the disclaimer language:

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

Referencing Star Ratings Information

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

Pharmacy/Provider Network and Formulary

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

> **Provider and Pharmacy Network and Formulary (List of Covered Drugs)**
>
> 42 CFR 422.111(a) and (b), 423.128(a) and (b)
>
> The following disclaimer must be included on materials whenever the formulary (List of Covered Drugs) or provider and pharmacy networks are mentioned:
>
> > "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."