

# Marketing Guidance for Illinois Medicare-Medicaid Plans

Contract Year (CY) 2022

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## Introduction

The Centers for Medicare & Medicaid Services (CMS) recently codified guidance contained in the Medicare Communications and Marketing Guidelines by integrating it with existing regulations.<sup>1</sup> Although the codified marketing and communications policies are not new policies, we updated this document to accurately reference the new regulations and follow the section numbers and headings used in the regulations. All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in 42 CFR Parts 422 and apply to Medicare-Medicaid Plans (MMPs) participating in the Illinois capitated financial alignment model demonstration, except as clarified or modified in this document.<sup>2</sup>

As defined in 42 CFR 422.2260 and 423.2260 prior to the implementation of CMS-4182-F,<sup>3</sup> CMS continues to consider all Contract Year (CY) 2022 MMP materials to be marketing materials, including those that promote the organization or any MMP offered by the organization; inform beneficiaries that they may enroll or remain enrolled in an MMP offered by the organization; explain the benefits of enrollment in an MMP, or rules that apply to enrollees; and/or explain how services are covered under an MMP, including conditions that apply to such coverage.

This document provides information only about those sections or subsections of the regulations that are not applicable or that are different for MMPs in Illinois. Information in this document is applicable to all marketing done for CY 2022 benefits.

## Additional Guidance for Illinois MMPs

The following are additional Illinois MMP-specific modifications for CY 2022 beyond those included in the new regulations:

### Contracted provider oversight responsibilities

We clarify that contracted providers of Medicaid-only services, who have a preferred MMP, must use the state's flyer and/or letter template (refer to [www.illinois.gov/hfs/SiteCollectionDocuments/PreferredProviderTemplates101917.pdf](http://www.illinois.gov/hfs/SiteCollectionDocuments/PreferredProviderTemplates101917.pdf)), and such contracted providers' preferred MMP must receive approval from the state for each preferred MMP flyer and/or letter prior to posting and/or distribution by the contracted provider.

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<sup>1</sup> Refer to CMS-4190-F2, Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, which may be found in the Final Rule published on January 19, 2021 ([www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicare-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare](http://www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicare-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare)).

<sup>2</sup> 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) do not apply unless specifically noted in this guidance.

<sup>3</sup> Refer to CMS-4182-F, 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 Final Rule published April 16, 2018 ([www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare](http://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare), p. 16625).

### **Formulary and formulary change notice requirements**

Illinois MMPs should refer to the November 1, 2018, CMS 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 Illinois MMPs are required to adhere to all new regulatory provisions and requirements.

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

- Formulary change notices must be sent for any negative formulary change (as described in 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.
- Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on Illinois MMP websites.

### **Informational and enrollment calls**

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. Customer service representatives may not take demographic information to complete an enrollment application. The MMP may do a warm transfer to the state's enrollment broker as long as MMP staff drop off the line once the transfer is complete. All enrollments into MMPs are submitted by the state's enrollment broker since Illinois MMPs are not allowed to market directly to individual potential enrollees.

We also clarify that MMPs may not ask callers if they would like to receive information about other Medicare lines of business they offer. Such information may only be provided at the proactive request of a member.

### **Marketing MMP and non-MMP offerings**

We clarify that organizations offering both MMPs and non-MMP Medicare health plan options in a service area may only market MMP offerings in their MMP materials.

We clarify that MMPs may not send marketing materials to current MMP members about other Medicare products they offer, and they may not send information requesting members' prior authorization to receive materials about other Medicare products they offer. MMPs may only send such materials when a current enrollee proactively makes a request for information about other Medicare products.

### **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 Contract Management Module.

## **Disclosure Requirements, Provision of Specific Information, Call Centers**

422.111, 422.111(h)

We clarify that hold time messages that include marketing content must be submitted in the HPMS Marketing Review Module.

Additionally, we clarify that MMPs must operate a toll-free call center during usual business hours. In light of the scope and nature of the services and benefits provided by MMPs, CMS interprets usual business hours for customer service call centers for both current and prospective enrollees as meaning the following: seven (7) days a week, at least from 8 a.m. to 8 p.m. CT, 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 federal holidays in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide required information, 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 (1) business day later. We also clarify that the remainder of 422.111(h) applies to MMPs.

## **Reward and Incentive Programs**

422.134

We clarify that MMPs may market rewards and incentives to current enrollees, consistent with the regulation.

Additionally, we clarify that any value added or supplemental benefits that the MMP wants to be considered for inclusion in the state's plan comparison tool, including gift cards as wellness incentives, must be submitted to the state at [HFS.HLTHPinOutreach@illinois.gov](mailto:HFS.HLTHPinOutreach@illinois.gov) for approval.

## **Definitions**

422.2260, 423.2260

MMPs are generally 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. We clarify that the definitions of communications and marketing as described in these sections of the regulations are not applicable to MMPs. CMS continues to consider all CY 2022 MMP materials to be marketing materials as stated in the "Introduction" in this document. For any other references to communications throughout 42 CFR Parts 422 and 423, the definition of marketing materials applies, and we provide additional details about materials in Appendix A and Appendix B of this document.

## **Submission, Review, and Distribution of Materials**

422.2261, 423.2261

### **General requirements**

422.2261(a), 423.2261(a)

CMS developed a Joint Review Process (JRP) for MMP materials under each Financial Alignment Initiative capitated model demonstration that combines state and CMS review requirements and parameters. Any references herein to CMS in its role in reviewing marketing materials are also references to the state for purposes of MMP marketing material review.

We also clarify that the multi-plan submission process is intended for third parties that submit materials for multiple organizations and is not applicable to MMPs.

### **CMS review of marketing materials and election forms**

422.2261(b), 423.2261(b)

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. MMPs may obtain more information about the specific review parameters and timeframes for marketing materials in the HPMS Marketing Review Module and User Guide.

We clarify that the File and Use certification process for MMPs is included in the three-way contract.

## **General Communications Materials and Activities Requirements**

422.2262, 423.2262

We clarify that an MMP is a “comparable plan as determined by the Secretary” as described in 422.2262(a) and is available only to, designed for, and marketed to beneficiaries who are dually eligible for Medicare and Medicaid.

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.

We also clarify that MMPs in Illinois that offer Medicare Advantage products in the same service area as their MMPs may not use the same plan marketing name for both of those products. Thus, for example, an organization offering both an MA HMO plan and an MMP in the same service area could not use the same name – e.g., Acme Duals Care (HMO) – for its MA product as for its MMP product – e.g., Acme Duals Care (Medicare-Medicaid Plan).

## **Requirements when including certain telephone numbers in materials**

422.2262(c), 423.2262(c)

In addition to the requirements of this section, MMPs must also provide the phone and TTY 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.

## **Standardized material identification (SMID)**

422.2262(d), 423.2262(d)

The provisions in these subsections of the regulations are 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 alphanumeric 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). **Note:** MMPs should include an approved status only after the material is approved and not when submitting the material for review.

We clarify that multi-plan materials are not applicable to MMPs.

In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization for materials the third party provides to MMP enrollees. The material must be submitted in HPMS using a separate material ID number for the MMP, and that material ID number must be included on the material. 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.

## **General Marketing Requirements**

422.2263, 423.2263

### **Offer gifts to beneficiaries**

422.2263(b)(2), 423.2263(b)(2)

Under the Illinois demonstration, MMPs may **not** offer financial or other incentives, including private insurance, to induce enrollees or potential enrollees to enroll with the MMP or to refer a friend, neighbor, or other person to enroll with the plan. We also clarify that, in accordance with guidance published by the HHS Office of Inspector General, MMPs are permitted to provide nominal gifts when the retail value is no more than \$15 per item or \$75 in aggregate per person on an annual basis.

### **Star Ratings**

422.2263(c), 423.2263(c)

Because the Medicare-Medicaid Coordination Office (MMCO) is in the process of developing a Star Ratings system for MMP performance, MMPs are not subject to the Star

Ratings requirements in these subsections of the regulations. Therefore, we clarify the provisions in these subsections do not apply to MMPs.

## **Beneficiary Contact**

422.2264, 423.2264

### **Unsolicited contact**

422.2264(a), 423.2264(a)

In Illinois, MMPs may not initiate email contact with any potential enrollees. Email contact may only be initiated with:

- An enrollee of the health plan who is enrolled in a different product of the health plan (e.g., an MLTSS or Medicare Advantage plan), or
- A current MMP enrollee of the health plan, or
- A future enrollee of the health plan who has been passively or voluntarily enrolled with a coverage effective date that has not occurred yet.

These subsections of the regulations provide 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. Direct mail must be submitted to HPMS for state review only.

In addition to the provisions of these subsections of the regulations, MMPs conducting permitted unsolicited marketing activities, such as through email (provided that they include an opt-out function), conventional mail and other print media, are required to include the following disclaimer on all materials used for that purpose:

“For information on <plan name> and other options for your health care, call the Illinois Client Enrollment Services at 1-877-912-8880 (TTY: 1-866-565-8576) or visit [enrollhfs.illinois.gov/](https://enrollhfs.illinois.gov/).”

For purposes of these subsections of the regulations, enrollment materials sent to passively enrolled individuals are not considered marketing through unsolicited contact.

### **Contact for plan business**

422.2264(b), 423.2264(b)

The requirements of these subsections of the regulations apply with the following clarifications and modifications:

- MMPs may not call current MMP enrollees to promote other Medicare plan types. Information about other Medicare plan types can only be provided at the proactive request of a current MMP enrollee.
- Organizations that offer non-MMP and MMP products may call their current non-MMP enrollees (e.g., those in 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 warm transferred to 1-800-MEDICARE or to the State Health Insurance Assistance Program (known as the Senior Health Insurance Program, or SHIP, in Illinois) for information and assistance.
- MMPs may call current MMP enrollees to assist with Medicaid redeterminations prior to disenrollment.
- MMPs may place phone calls to disenrolling members to conduct disenrollment surveys for quality improvement services up to the last day of their coverage in the plan, but they may not call former enrollees **after** the disenrollment effective date. However, MMPs may mail a disenrollment survey at any time, including after the disenrollment effective date. Surveys may not include sales or marketing information and must be submitted for review in HPMS. If an MMP's disenrolling member elected to receive information electronically consistent with requirements of these subsections of the regulations, the MMP may email the member up until their last day of coverage in the MMP.

#### **Events with beneficiaries**

422.2264(c), 423.2264(c)

##### **Educational events**

422.2264(c)(1), 423.2264(c)(1)

We clarify that MMPs may provide contact information directly to an individual at an educational event if the individual asks for such information. MMPs may provide nominal gifts, when the retail value is no more than \$15 per item, that include the plan name, logo, toll-free customer service number, and website, provided they otherwise meet the guidance provided in these subsections of the regulations. We clarify that MMPs can make available information about multiple plan products at the same physical table at educational events, as long as all information has previously been appropriately approved by CMS and the state. If HealthChoice Illinois information is available, the state must approve the event.

##### **Marketing or sales events**

422.2264(c)(2), 423.2264(c)(2)

The provisions in these subsections of the regulations do not apply to MMPs since marketing/sales events are not permitted in Illinois.

##### **Personal marketing appointments**

422.2264(c)(3), 423.2264(c)(3)

Since Illinois MMPs are not allowed to market directly to individual potential enrollees, the provisions of these subsections of the regulations do not apply. This prohibition

extends to MMPs calling prospective enrollees to solicit an individual marketing appointment after public events.

## **Websites**

422.2265, 423.2265

### **General website requirements**

422.2265(a), 423.2265(a)

We clarify that MMPs should consult the HPMS Marketing Review Module and User Guide for instructions about submitting websites and webpages for review.

### **Required content**

422.2265(b), 423.2265(b)

In addition to the provisions in these subsections of the regulations, MMPs must also include on their websites a direct link to the state's enrollment broker website. MMPs must also include information on the potential for contract termination (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).

We clarify that MMPs are not required to post the low-income subsidy (LIS) Premium Summary Chart as this document is not applicable to MMPs.

The provisions in these subsections of the regulations are modified for Illinois MMPs, in accordance with their three-way contracts, as follows:

While MMPs are encouraged to have searchable, machine-readable formularies, MMPs must make their online directories available in a searchable, machine-readable file and format.

### **Required posted materials**

422.2265(c), 423.2265(c)

The provisions of these subsections of the regulations apply with a modification. As indicated in 422.2263(c) and 423.2263(c) in the "Star Ratings" subsection of this document, MMPs are not subject to Star Ratings requirements and, therefore, are not required to post a CMS Star Ratings document on their websites.

## **Activities with Healthcare Providers or in the Healthcare Setting**

422.2266, 423.2266

### **Where marketing is prohibited, Where marketing is permitted, MA organization/Part D sponsor activities in the healthcare setting**

422.2266(a), 423.2266(a), 422.2266(b), 423.2266(b), 422.2266(e), 423.2266(e)

We clarify that MMPs may not conduct sales activities, including sales presentations, or distribute or collect enrollment forms in Illinois. Additionally, MMPs may not distribute

marketing materials in common entryways or vestibules. However, making state-approved materials available in hospital or nursing home cafeterias, community rooms, recreational rooms, and conference rooms is allowed.

#### **Provider-initiated activities**

422.2266(c), 423.2266(c)

We clarify that referring patients to other sources of information such as the “State Medicaid Office” also applies to materials produced and/or distributed by Illinois’ enrollment broker. In addition, we clarify that MMPs may allow contracted providers to assist MMP enrollees with Medicaid redeterminations prior to disenrollment. We also clarify that provider-initiated discussions that answer questions or discuss the merits of an MMP, including cost sharing and benefit information, may not occur in areas where care is delivered.

#### **Plan-initiated provider activities**

422.2266(d), 423.2266(d)

We clarify that MMPs may not allow contracted providers to make available, distribute, or display marketing materials in areas where health care is being delivered. MMPs may not allow contracted providers to make available marketing materials in common entryways or vestibules. However, making state-approved materials available in hospital or nursing home cafeterias, community rooms, recreational rooms, and conference rooms is allowed. Additionally, MMPs may not allow contracted providers to make enrollment forms available where health care is being delivered or outside of the areas where care is being delivered.

### **Required Materials and Content**

422.2267, 423.2267

We clarify that, unless otherwise modified and/or specifically indicated in this section of the document, these sections of the regulations, and all of their subsections, apply to MMPs.

#### **Standards for required materials and content**

422.2267(a)(2), 423.2267(a)(2)

The provisions of these subsections of the regulations apply with the modifications and clarifications included in this document. The standard articulated for translation of marketing materials into non-English languages is superseded to the extent that Illinois’ standard for translation of marketing materials is more stringent. The Illinois translation standard – which requires translation of materials into “prevalent languages” (i.e., Spanish and any language that is the primary language of five (5) percent or more of the plan’s service area population) – typically exceeds the Medicare standard for translation in Illinois MMP service areas. Guidance on the translation requirements for all plans, including MMPs, is released annually each fall via HPMS. Required languages for translation for each MMP are also updated annually, as needed, in the HPMS Marketing Review Module.

CMS and the state have designated materials that are vital and, therefore, must be translated into specified non-English languages.<sup>4</sup> This information is located in Appendix A of this document.

MMPs must have a process for ensuring that enrollees can make a standing request to receive materials identified in this section, in alternate formats and in all non-English languages identified above and in the HPMS Marketing Review Module, at the time of request and on an ongoing basis thereafter. The process should include how the MMP will keep a record of the member's information and utilize it as an ongoing standing request so the member does not need to make a separate request for each material and how a member can change a standing request for preferred language and/or format.

### **Model materials**

422.2267(c), 423.2267(c)

We modify these subsections of the regulations, in addition to 42 CFR Parts 417 and 438, with the following guidance about model materials.

We note that materials MMPs create should take into account the average reading level established in the three-way contract. Available models reflect acceptable average reading levels. Current Part D models are acceptable for use as currently provided, and MMPs must add required disclaimers included in Appendix B of this document, 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 and Use materials.

We refer MMPs to the following available models:

- MMP-specific models tailored to MMPs in Illinois, including an Annual Notice of Changes (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, welcome letters, state-specific appeals notices, and other plan-delegated enrollment notices: [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources).

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<sup>4</sup> CMS makes available Spanish translations of the Illinois MMP SB, Formulary (List of Covered Drugs), Provider and Pharmacy Directory, and ANOC/EOC (Member Handbook). These are posted at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources). CMS makes available a Spanish and Chinese translation of the Part D transition letter to all Medicare health plans at [www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials).

- Required Part D materials, including the Excluded Provider Letter, Prescription Transfer Letter, and Transition Letter: [www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials).
- Required Drug-Only Explanation of Benefits (EOB) as either (1) the Part D EOB model: [www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Materials) or (2) the MMP Drug-Only EOB model: [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources).
- The Fully Integrated MMP EOB, an optional document, but one that can be used to meet the required Drug-Only EOB requirement: [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources).
- Part D appeals and grievances models and notices (including those in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance): [www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev](http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev) and [www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms](http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms).
- Part C appeals and grievances models and notices (including those in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance): [www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG](http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG) and [www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms](http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms).
- MMP-specific ANOC/EOC (Member Handbook) errata model: [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources).

### **CMS required materials and content**

422.2267(e), 423.2267(e)

We clarify that required materials and instructions for Illinois MMPs are in Appendix A and Appendix B of this document, which replace the requirements in 422.2267(e) and 423.2267(e) unless otherwise specifically indicated. As stated in the “Introduction” in this document, CMS continues to consider all CY 2022 MMP materials to be marketing materials. As a result, MMPs submit all materials in HPMS.

## **Agent, Broker, and Other Third Party Requirements**

422.2274, 423.2274

We clarify that Illinois does not permit the use of independent agents and brokers. The state's enrollment broker processes all MMP enrollments. We also clarify that CMS does not regulate compensation of employed agents. Employed MMP staff conducting marketing activity of any kind, as defined in this document, must be licensed in the state (and, when required, appointed) as an insurance agent or broker.

Additionally, we clarify reporting responsibilities for MMPs. Annually by the last Friday in July, MMPs must enter information in HPMS and attest to their intention to use agents or brokers in the upcoming plan year. MMPs must report their use of employed, captive, or independent agents or brokers in accordance with Illinois and CMS guidelines. For further instructions, refer to the "Agent/Broker Compensation" sections of the HPMS Marketing Review Module and User Guide. Following the reporting deadline, MMPs may not change their decisions related to agent or broker type until the next plan year.

The remainder of these sections of the regulations do not apply to MMPs.

## **Appendix A. Required Materials and Instructions for MMPs**

The tables on the following pages contain required materials for Illinois MMPs and high-level information for each material. MMPs should review any noted “Guidance and Other Needed Information” as applicable. Additionally, MMPs should consult the HPMS Marketing Review Module and User Guide for instructions about uploading required materials.

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

Annual Notice of Changes (ANOC)	
<i>To Whom Required:</i>	Must be provided to current enrollees of plan, including those with October 1, November 1, and December 1 effective dates.
<i>Timing:</i>	<ul style="list-style-type: none"> <li>• MMPs must send for enrollee receipt no later than September 30 of each year. (<b>Note:</b> ANOC must be posted on MMP website by October 15.)</li> <li>• Enrollees with October 1, November 1, and December 1 enrollment effective dates must receive the ANOC for the upcoming year by one (1) month after the effective date of enrollment but not later than December 15.</li> </ul>
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> <li>• Refer to the HPMS Marketing Review Module and User Guide.</li> <li>• Must be submitted prior to mailing ANOCs.</li> </ul>
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Illinois MMP model required for current CY.</li> <li>• Standardized model; a non-model document is not permitted.</li> </ul>
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> <li>• 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. MMPs that mail in waves should enter the AMD for each wave. MMPs may enter up to ten (10) waves of mailings. For instructions on meeting this requirement, refer to the "Manage Material AMD/Beneficiary Information" section of the HPMS Marketing Review Module and User Guide. (<b>Note:</b> For a single mailing to multiple recipients, MMPs should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed.)</li> <li>• Plans may include the following with the ANOC: <ul style="list-style-type: none"> <li>○ Summary of Benefits</li> <li>○ Provider and Pharmacy Directory</li> <li>○ EOC (Member Handbook)</li> <li>○ Formulary (List of Covered Drugs)</li> <li>○ Notification of Electronic Documents</li> </ul> </li> <li>• No additional plan communications unless otherwise directed.</li> </ul>
<i>Translation Required:</i>	Yes.



<b>ANOC and EOC (Member Handbook) Errata</b>	
<i>To Whom Required:</i>	Must be provided when plan errors are found in the ANOC or EOC (Member Handbook) and sent to current enrollees.
<i>Timing:</i>	Must send to enrollees immediately following CMS approval.
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> <li>• Refer to the HPMS Marketing Review Module and User Guide.</li> <li>• ANOC errata must be submitted by October 15.</li> <li>• EOC (Member Handbook) errata must be submitted by November 15.</li> </ul>
<i>Format Specification:</i>	Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<p>MMPs 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.</p> <p><b>Note:</b> 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, plans should use the HPMS Marketing Review Module replacement function for these changes.</p>
<i>Translation Required:</i>	Yes.

<b>Coverage/Organization Determination, Discharge, Appeals and Grievance Notices</b>	
<i>To Whom Required:</i>	<ul style="list-style-type: none"> <li>• Must be provided to enrollees who have requested an appeal or have had an appeal requested on their behalf.</li> <li>• Grievances may be responded to electronically, orally, or in writing.</li> </ul>
<i>Timing:</i>	Provided to enrollees (generally by mail) on an ad hoc basis, based on required timeframes in three-way contract.
<i>Method of Delivery:</i>	Hard copy or electronically, if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Illinois MMP models - standardized model; a non-model document is not permitted.</li> <li>• Other CMS models - modifications permitted.</li> </ul>
<i>Guidance and Other Needed Information:</i>	Three-way contract, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.
<i>Translation Required:</i>	Yes.

<b>Evidence of Coverage (EOC)/Member Handbook</b>	
<i>To Whom Required:</i>	Must be provided to all enrollees of plan.
<i>Timing:</i>	<ul style="list-style-type: none"> <li>• Must send to current enrollees of plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year.</li> <li>• Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.</li> <li>• 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).</li> <li>• New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current CY, as well as an EOC (Member Handbook) document for the upcoming CY. We clarify that, for these members, the ANOC may be included in the EOC (Member Handbook) or provided separately, 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 (1) month after the effective date of enrollment, but not later than December 15.</li> </ul>
<i>Method of Delivery:</i>	Hard copy EOC (Member Handbook) or via Electronic Notice of Documents, or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	<ul style="list-style-type: none"> <li>• Refer to the HPMS Marketing Review Module and User Guide.</li> <li>• Submitted prior to October 15 of each year.</li> </ul>
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Illinois MMP model required for current CY.</li> <li>• Standardized model; a non-model document is not permitted.</li> </ul>
<i>Guidance and Other Needed Information:</i>	No additional information.
<i>Translation Required:</i>	Yes.

<b>Excluded Provider Letter</b>	
<i>To Whom Required:</i>	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.
<i>Timing:</i>	Provided to enrollees on an ad hoc basis.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Model provided; modifications permitted.
<i>Guidance and Other Needed Information:</i>	<a href="http://oig.hhs.gov/exclusions/index.asp">oig.hhs.gov/exclusions/index.asp</a> .
<i>Translation Required:</i>	Yes.

<b>Explanation of Benefits (EOB) – Part D</b>	
<i>To Whom Required:</i>	Must be provided anytime an enrollee utilizes their prescription drug benefit.
<i>Timing:</i>	Sent at the end of the month following the month when the benefit was utilized.
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Part D EOB model - modifications permitted.</li> <li>• Illinois MMP specific models - standardized model; a non-model document is not permitted.</li> </ul>
<i>Guidance and Other Needed Information:</i>	Three-way contract and 423.2267(e)(2).
<i>Translation Required:</i>	Yes.

<b>Formulary (List of Covered Drugs)</b>	
<i>To Whom Required:</i>	Must be provided to all enrollees of plan.
<i>Timing:</i>	<ul style="list-style-type: none"> <li>• Must be sent to current enrollees of plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year.</li> <li>• Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.</li> <li>• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.</li> </ul>
<i>Method of Delivery:</i>	Hard copy or via Electronic Notice of Documents, or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> <li>• MMPs 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.</li> <li>• OTC items and/or supplemental benefits that are in excess of Medicaid requirements may not be included in this document.</li> <li>• MMPs are only permitted to make available a comprehensive, not abridged, Formulary (List of Covered Drugs).</li> </ul>
<i>Translation Required:</i>	Yes.

<b>Integrated Denial Notice</b>	
<i>To Whom Required:</i>	Any enrollee with an adverse benefit determination.
<i>Timing:</i>	Provided to enrollees (generally by mail) on an ad hoc basis, at least 10 (ten) days in advance of any adverse benefit determination.
<i>Method of Delivery:</i>	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Illinois MMP model required for current CY.</li> <li>• Standardized model; a non-model document is not permitted.</li> </ul>
<i>Guidance and Other Needed Information:</i>	Three-way contract.
<i>Translation Required:</i>	Yes.

<b>Member ID Card</b>	
<i>To Whom Required:</i>	Must be provided to all plan enrollees.
<i>Timing:</i>	<ul style="list-style-type: none"> <li>• Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.</li> <li>• 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).</li> <li>• Must also be provided to all enrollees if information on existing card changes.</li> </ul>
<i>Method of Delivery:</i>	Must be provided in hard copy. In addition to hard copy, MMPs may provide a digital version (e.g., app).
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Standardized model; a non-model document is not permitted.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> <li>• MMPs must issue a single Member ID Card meeting these requirements for all services offered under the plan.</li> <li>• Separate pharmacy and health benefits Member ID cards are not permitted.</li> </ul>
<i>Translation Required:</i>	No.

<b>Mid-Year Change Notification to Enrollees</b>	
<i>To Whom Required:</i>	Must be provided to all applicable enrollees when there is a mid-year change in benefits, plan rules, formulary, provider network, or pharmacy network.
<i>Timing:</i>	Ad hoc, based on specific requirements for each issue as defined in 422.2267(e)(9).
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted. If the mid-year change affects a document that the MMP has not sent to the member in hard copy (e.g., the EOC (Member Handbook)), the MMP is not required to send a hard copy mid-year change notification.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Model not available; must include required content.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> <li>• Notices of changes in MMP rules unless otherwise addressed in a regulation must be provided 30 days in advance.</li> <li>• National Coverage Determination (NCD) changes announced or finalized less than 30 days before effective date, notification required as soon as possible.</li> <li>• Mid-year NCD or legislative changes must be published no later than 30 days after the NCD is announced. MMPs may include change in the next plan mass mailing (e.g., newsletter), provided it is within 30 days and must be reflected on their website.</li> <li>• Medicare Managed Care Manual - Chapter 4.</li> <li>• Medicare Prescription Drug Benefit Manual - Chapter 6 and forthcoming guidance effectuating 423.120(b)(5) on formulary changes and required notice to beneficiaries and other entities.</li> <li>• National Coverage Determination website.</li> </ul>
<i>Translation Required:</i>	Yes.

<b>Non-Renewal and Termination Notices</b>	
<i>To Whom Required:</i>	Must be provided to each affected enrollee after MMP decides to non-renew or reduce its plan's service area or before the termination effective date.
<i>Timing:</i>	At least 90 days before the end of the current contract period.
<i>Method of Delivery:</i>	Notices must be hard copy and sent via U.S. mail. First class postage is recommended.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Illinois MMP model required for current CY.</li> <li>• Modifications permitted per instructions.</li> </ul>
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> <li>• Information about non-renewals or service area reductions may not be released to the public, including current enrollees, until notice is received from CMS and the state.</li> <li>• MMPs 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 MMP does business with (i.e., contracted providers).</li> <li>• Additional NR/SAR notice information can be found in the annual CMS memorandum, "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models," issued through HPMS.</li> <li>• For terminations, relevant notice requirements are provided in 42 CFR 422.506, 422.508, and 422.512.</li> </ul>
<i>Translation Required:</i>	Yes.

<b>Part D Transition Letter</b>	
<i>To Whom Required:</i>	Must be provided when a beneficiary receives a transition fill for a non-formulary drug.
<i>Timing:</i>	Must be sent within three (3) days of adjudication of temporary transition fill.
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Model provided; modifications permitted.
<i>Guidance and Other Needed Information:</i>	Medicare Prescription Drug Benefit Manual, Chapter 6.
<i>Translation Required:</i>	Yes.



<b>Plan-Delegated Enrollment and Disenrollment Notices</b>	
<i>To Whom Required:</i>	Must be provided as outlined in National Enrollment and Disenrollment Guidance for States and MMPs.
<i>Timing:</i>	Varies; must follow required timeframes as outlined in National Enrollment and Disenrollment Guidance for States and MMPs.
<i>Method of Delivery:</i>	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Illinois MMP model required for current CY.</li> <li>• Standardized model; a non-model document is not permitted.</li> </ul>
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> <li>• National Enrollment/Disenrollment Guidance for States &amp; MMPs.</li> <li>• Illinois Enrollment Guidance Appendix 5.</li> <li>• MMPs must follow specifications in the HPMS Marketing Review Module, along with the enrollment/disenrollment guidance, to determine how to submit appropriately.</li> </ul>
<i>Translation Required:</i>	Yes.

<b>Prescription Transfer Letter</b>	
<i>To Whom Required:</i>	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.
<i>Timing:</i>	Ad hoc.
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Part D model provided; modifications permitted.
<i>Guidance and Other Needed Information:</i>	The MMP uses the model notice only when the transfer of the prescription is not initiated by the beneficiary (or someone on their behalf).
<i>Translation Required:</i>	Yes.

<b>Provider and Pharmacy Directory</b>	
<i>To Whom Required:</i>	Must be provided to all current enrollees of the plan.
<i>Timing:</i>	<ul style="list-style-type: none"> <li>• Must be sent to current enrollees of Plan for receipt by October 15 of each year. Must be posted to plan website by October 15 of each year.</li> <li>• Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.</li> <li>• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.</li> <li>• Must be provided to current enrollees upon request, within three (3) business days of the request.</li> <li>• 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.</li> </ul>
<i>Method of Delivery:</i>	Hard copy or via Electronic Notice of Documents, or electronically if enrollee has opted into receiving electronic version as permitted.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Illinois MMP model required for current CY.</li> <li>• Standardized model; a non-model document is not permitted.</li> </ul>

<b>Provider and Pharmacy Directory</b>	
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> <li>• MMPs are required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. MMPs may print separate directories for primary care physicians (PCPs) and specialists provided both directories are made available to enrollees at the time of enrollment.</li> <li>• The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits.</li> <li>• 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.</li> <li>• Illinois MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the Illinois MMP Provider and Pharmacy Directory.</li> <li>• As applicable, refer to the language and guidelines in the CMS memorandum, dated August 16, 2016, "Pharmacy Directories and Disclaimers" for the pharmacy portion of the combined directory.</li> </ul>
<i>Translation Required:</i>	Yes.

<b>Summary of Benefits</b>	
<i>To Whom Required:</i>	Enrollees who are passively enrolled. Optional with the ANOC and as requested for other enrollees.
<i>Timing:</i>	<ul style="list-style-type: none"> <li>• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.</li> <li>• Must be available by October 15 of each year, but can be released as early as October 1 of each year. Must be posted on MMP website by October 15 of each year.</li> </ul>
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	<ul style="list-style-type: none"> <li>• Illinois MMP model required for current CY.</li> <li>• Standardized model; a non-model document is not permitted.</li> </ul>
<i>Guidance and Other Needed Information:</i>	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.
<i>Translation Required:</i>	Yes.

<b>Welcome Letter</b>	
<i>To Whom Required:</i>	Must be provided to all new enrollees of MMP.
<i>Timing:</i>	<ul style="list-style-type: none"> <li>• Must send to enrollees who opt in to the MMP for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.</li> <li>• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.</li> </ul>
<i>Method of Delivery:</i>	Hard copy.
<i>HPMS Timing and Submission:</i>	Refer to the HPMS Marketing Review Module and User Guide.
<i>Format Specification:</i>	Illinois MMP model required for CY.
<i>Guidance and Other Needed Information:</i>	<ul style="list-style-type: none"> <li>• Must contain 4Rx information consistent with the model.</li> <li>• National Enrollment/Disenrollment Guidance for Stand and MMPs, section 30.5.1.</li> </ul>
<i>Translation Required:</i>	Yes.

### Required Materials for New MMP Enrollees

The following tables summarize the required materials, and timing of receipt, for new MMP enrollees.

**Table 1: Required Materials for New Members – Passive Enrollment**

<b>Enrollment Mechanism</b>	<b>Required Materials for New Members</b>	<b>Timing of Beneficiary Receipt</b>
Passive enrollment	<ul style="list-style-type: none"><li>• Welcome letter</li><li>• Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary)</li><li>• Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory)</li><li>• SB</li></ul>	30 calendar days prior to the effective date of enrollment
Passive enrollment	<ul style="list-style-type: none"><li>• Member ID Card</li><li>• EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC)</li></ul>	No later than the day prior to the effective date of enrollment

**Table 2: Required Materials for New Members – Opt-in Enrollment**

Enrollment Mechanism	Required Materials for New Members	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received more than ten (10) calendar days before the end of the month) <sup>5</sup>	<ul style="list-style-type: none"> <li>• Welcome letter</li> <li>• Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary)</li> <li>• Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory)</li> <li>• Member ID Card</li> <li>• EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC)</li> </ul>	No later than the last day of the month prior to the effective date
Opt-in enrollment (with enrollment confirmation received less than ten (10) calendar days before the end of the month) <sup>5</sup>	<ul style="list-style-type: none"> <li>• Welcome letter</li> <li>• Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary)</li> <li>• Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory)</li> <li>• Member ID Card</li> <li>• EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC)</li> </ul>	No later than ten (10) calendar days from receipt of the CMS confirmation of enrollment

<sup>5</sup> 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. 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.

## Appendix B. State-specific MMP Disclaimers

We clarify that MMPs include specific disclaimer language in the table below. We also clarify that, as applicable, MMPs include additional disclaimers contained in subsections 422.2267(e) and 423.2267(e) of the regulations. In addition, we clarify that MMPs are not required to include disclaimers on the following material types: Member ID Cards, call scripts not related to sales or enrollment, banners and banner-like ads, envelopes, outdoor advertising, text messages, and social media.

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 Illinois Medicaid to provide benefits of both programs to enrollees.	Required on materials except those specifically excluded above
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 ten (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 numbers, and days and hours of operation>. The call is free.	Required in applicable non-English languages in those models in Appendix A for which the last row of the table indicates, “ <i>Translation required: Yes</i> ”
Non-plan and Non-health Information	Neither Medicare nor Illinois 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

**Note:** For model materials, MMPs must continue to include disclaimers where they currently appear in the models. For non-model materials, MMPs may include disclaimers as footnotes or incorporate them into the body of the material.