# Marketing Guidance for Rhode Island Medicare-Medicaid Plan

## 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.[1] 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 423 apply to the Medicare-Medicaid Plan (MMP) participating in the Rhode Island Financial Alignment Initiative capitated model demonstration, except as clarified or modified in this document.[2]

As defined in 42 CFR 422.2260 and 423.2260 prior to the implementation of CMS-4182-F,[3] CMS continues to consider all Contract Year (CY) 2022 MMP materials to be marketing materials, including those that promote the organization or the MMP offered by the organization; inform beneficiaries that they may enroll or remain enrolled in the MMP offered by the organization; explain the benefits of enrollment in the MMP, or rules that apply to enrollees; and/or explain how services are covered under the 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 the MMP in Rhode Island. Information in this document is applicable to all marketing done for CY 2022 benefits.

## Additional Guidance for the Rhode Island MMP

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

### Formulary and formulary change notice requirements

The Rhode Island MMP 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 the Rhode Island MMP is required to adhere to all new regulatory provisions and requirements.

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[1] 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-medicaid-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare).

[2] 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.

[3] 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, p. 16625).

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, 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 the Rhode Island MMP website.

**Informational and enrollment calls and scripts**

We clarify that MMP customer service representatives may conduct activities that do not require the use of state-licensed marketing representatives. We also clarify that, to provide more than factual information, MMP outbound callers must be state-licensed (and, when required, appointed) marketing agents. Furthermore, the MMP must use a state-licensed (and, when required, appointed) marketing agent for any marketing activity.

We clarify that informational calls to MMP call centers that become enrollment calls at the proactive request of the beneficiary must be transferred to the state's enrollment broker. We further clarify that telesales scripts are considered marketing, and the MMP must submit such scripts in the Health Plan Management System (HPMS) Marketing Review Module.

**Marketing MMP offerings**

We clarify that an organization offering an MMP and non-MMP health plan option(s) may only market the MMP in the MMP's materials.

**Use of Medicare Mark for Part D sponsors**

We clarify that the MMP has been required to sign a licensing agreement to use the official Medicare Mark as part of the three-way contract rather than through the HPMS 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 the MMP 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 the MMP, 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. ET, except as provided below. Customer service call center hours and days must be the same for all individuals regardless of whether they speak English, a non-English language, or use assistive devices for communication. Customer service representatives must be available to speak with current and prospective enrollees from 8 a.m. to 8 p.m. ET, Monday through Friday. The MMP may use alternative technologies on Saturdays, Sundays, and state and/or federal holidays other than New Year's Day in lieu of having live customer service representatives. For

example, the 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 the MMP.

**Reward and Incentive Programs**

422.134

We clarify that the MMP may market rewards and incentives to current enrollees, consistent with the regulation, as well as the following guidance:

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

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

- The MMP must submit to the Executive Office of Health and Human Services (EOHHS), at the direction of EOHHS, ad hoc report information relating to planned and implemented enrollee rewards and incentives programs and ensure that all such programs comply with all applicable CMS and state guidance and all relevant state and federal laws.

**Definitions**

422.2260, 423.2260

The MMP is 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 the MMP. 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. The MMP may obtain more information about the specific review parameters and timeframes for marketing materials in the HPMS Marketing Review Module and Users Guide.

We clarify that the File and Use certification process for the MMP 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, the MMP is required to include the plan type in each plan’s name using standard terminology consistent with the guidance provided in this section. CMS created the standardized plan type label “Medicare-Medicaid Plan” to refer generically to all plans participating in a Financial Alignment Initiative capitated model demonstration. The MMP must use the “Medicare-Medicaid Plan” plan type terminology following its plan name at least once on the front page or beginning of each marketing piece, excluding envelopes.

### Requirements when including certain telephone numbers in materials

422.2262(c), 423.2262(c)

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

> 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:** The MMP 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 the MMP.

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 for the MMP, and the material ID 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

### 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, the MMP is 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 the MMP.

## Beneficiary Contact

422.2264, 423.2264

### Unsolicited contact

422.2264(a), 423.2264(a)

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. We also clarify that the MMP marketing to current non-MMP enrollees (including those enrolled in other product lines such as its Medicaid managed care product) to promote an MMP offering is not considered unsolicited direct contact and, therefore, is permissible.

### Contact for plan business

422.2264(b), 423.2264(b)

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

- Consistent with the provisions of these subsections of the regulations, calls made by the MMP to current members (including those enrolled in other product lines) are not considered unsolicited direct contact and are, therefore, permissible. The MMP may call its current non-MMP enrollees (e.g., those in Medicaid managed care products), including individuals who have previously opted out of passive enrollment into the MMP, to promote its MMP offering.

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

**Events with beneficiaries**

422.2264(c), 423.2264(c)

**Educational events, Marketing or sales events**

422.2264(c)(1), 422.2264(c)(2), 423.2264(c)(1), 423.2264(c)(2)

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

**Personal marketing appointments**

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

The provisions of these subsections of the regulations apply to the MMP, with the following modifications for appointments with agents or brokers:

- Agents or brokers are not permitted to conduct unsolicited personal or individual appointments.

- An individual appointment must only be set up at the request of the potential member, their authorized representative, or the state's broker or options counselor. The MMP's agent or broker can offer an individual appointment to a potential member who has contacted the MMP to request assistance or information. The MMP's agents or brokers are prohibited from making unsolicited offers of individual appointments.

- The MMP's agent or broker must make reasonable efforts to conduct an appointment in the potential member's preferred location and cannot require that an individual appointment occur in the potential member's home.

**Websites**

422.2265, 423.2265

**General website requirements**

422.2265(a), 423.2265(a)

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

Additionally, we clarify that the MMP should submit its website via links on a document. State reviewers should be able to review the information as it will be displayed on the

website. The link may provide access to a live website or a test website, provided that the test site displays information as it will appear to the beneficiary/consumer. Submitting screen shots or text on a document is not acceptable. If the option to view online is not feasible, the MMP should contact its marketing reviewers prior to submission to receive permission to submit information in a manner other than a live link.

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

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

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

### Required content

422.2265(b), 423.2265(b)

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

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

### 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, the MMP is 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

### 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 the state's enrollment broker.

## 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 the MMP.

### 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 Rhode Island's standard for translation of marketing materials is more stringent. The Rhode Island translation standard requires translation if 50 or more enrollees speak a single language other than English as a primary language. Guidance on the translation requirements for all plans, including the Rhode Island MMP, is released 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.[4] This information is located in Appendix A of this document.

The MMP 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.

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[4] CMS makes available Spanish translations of the Rhode Island MMP SB, Formulary (List of Covered Drugs), Provider and Pharmacy Directory, and ANOC/EOC (Member Handbook). These are posted at 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.

We note that materials the MMP creates 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 the MMP 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 the MMP to the following available models:

- MMP-specific models tailored to the MMP in Rhode Island, including an Annual Notice of Change (ANOC), Summary of Benefits, Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated Formulary (List of Covered Drugs), combined provider/pharmacy directory (Provider and Pharmacy Directory), single Member ID Card, integrated denial notice, and welcome letters for opt-in and passively enrolled individuals: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.

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

- 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 and 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 and 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.

**CMS required materials and content**

422.2267(e), 423.2267(e)

We clarify that required materials and instructions for the Rhode Island MMP 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. We further clarify that the Pre-Enrollment Checklist referenced in 422.2267(e)(4) and 423.2267(e)(4) is not

applicable to MMPs since the state's enrollment broker submits all enrollments. As stated in the "Introduction" in this document, CMS continues to consider all CY 2022 MMP materials to be marketing materials. As a result, the MMP submits all materials in HPMS.

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

422.2274, 423.2274

We clarify that all requirements applicable to independent agents or brokers throughout these sections of the regulations are applicable to the MMP in Rhode Island. We also clarify that CMS does not regulate compensation of employed agents. Employed MMP staff conducting marketing activities 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 the MMP. Annually by the last Friday in July, the MMP must enter information in HPMS and attest to their intention to use agents or brokers in the upcoming plan year. The MMP must report its use of employed, captive, or independent agents or brokers in accordance with Rhode Island and CMS guidelines. For further instructions, refer to the "Agent/Broker Compensation" sections of the HPMS Marketing Review Module and Users Guide. Following the reporting deadline, the MMP may not change its decision related to agent or broker type until the next plan year.

## Appendix A. Required Materials and Instructions for the MMP

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

The MMP 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) | |
|---|---|
| *To Whom Required:* | Must be provided to current enrollees of plan, including those with October 1, November 1, and December 1 effective dates. |
| *Timing:* | • The MMP must send for enrollee receipt no later than September 30 of each year. (**Note**: ANOC must be posted on the MMP website by October 15.)<br>• 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. |
| *Method of Delivery:* | Hard copy or electronically if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | • Refer to the HPMS Marketing Review Module and Users Guide.<br>• Must be submitted prior to mailing ANOCs. |
| *Format Specification:* | • Rhode Island MMP model required for current CY.<br>• Standardized model; a non-model document is not permitted. |
| *Guidance and Other Needed Information:* | • Actual Mail Dates (AMDs) and number of recipients (not the number of ANOCs mailed) must be entered into HPMS within 15 days of mailing. This includes mail dates for alternate materials. An MMP that mails in waves should enter the AMD for each wave. An MMP may enter up to ten (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 Users Guide. (**Note:** For a single mailing to multiple recipients, an MMP should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed.)<br>• The MMP may include the following with the ANOC:<br>  o Summary of Benefits<br>  o Provider and Pharmacy Directory<br>  o EOC (Member Handbook)<br>  o Formulary (List of Covered Drugs)<br>  o Notification of Electronic Documents<br>• No additional plan communications unless otherwise directed. |
| *Translation Required:* | Yes. |

| ANOC and EOC (Member Handbook) Errata | |
|---|---|
| *To Whom Required:* | Must be provided when plan errors are found in the ANOC or EOC (Member Handbook) and sent to current enrollees. |
| *Timing:* | Must send to enrollees immediately following CMS approval. |
| *Method of Delivery:* | Hard copy or electronically if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | • Refer to the HPMS Marketing Review Module and Users Guide.<br>• ANOC errata must be submitted by October 15.<br>• EOC (Member Handbook) errata must be submitted by November 15. |
| *Format Specification:* | Standardized model; a non-model document is not permitted. |
| *Guidance and Other Needed Information:* | The MMP must use an errata notice to notify enrollees of plan errors in its original documents. We clarify that errata notices should only be used to notify enrollees of plan errors in plan materials.<br><br>**Note:** Any mid-year changes, including but not limited to mid-year legislative benefit additions or removals and changes in enrollment policies, should be communicated to current enrollees consistent with the "Mid-Year Change Notification" guidance in this section. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to MMP error. Instead the MMP should use the HPMS marketing module replacement function for these changes. |
| *Translation Required:* | Yes. |

| Coverage/Organization Determination, Discharge, Appeals and Grievance Notices | |
|---|---|
| *To Whom Required:* | • Must be provided to enrollees who have requested an appeal or have had an appeal requested on their behalf.<br>• Grievances may be responded to electronically, orally, or in writing. |
| *Timing:* | Provided to enrollees (generally by mail) on an ad hoc basis, based on required timeframes in three-way contract. |
| *Method of Delivery:* | Hard copy or electronically, if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | CMS models - modifications permitted. |
| *Guidance and Other Needed Information:* | Three-way contract, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. |
| *Translation Required:* | Yes. |

| Evidence of Coverage (EOC)/Member Handbook | |
|---|---|
| *To Whom Required:* | Must be provided to all enrollees of plan. |
| *Timing:* | • 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.<br>• Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.<br>• 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).<br>• 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 combined ANOC/EOC (Member Handbook) for the upcoming year, as well as the Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the Formulary), and the Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) for the upcoming year, must be received by one (1) month after the effective date of enrollment, but not later than December 15. |
| *Method of Delivery:* | Hard copy EOC (Member Handbook) or via Electronic Notice of Documents, or electronically if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | • Refer to the HPMS Marketing Review Module and Users Guide.<br>• Submitted prior to October 15 of each year. |
| *Format Specification:* | • Rhode Island MMP model required for current CY.<br>• Standardized model; a non-model document is not permitted. |
| *Guidance and Other Needed Information:* | No additional information. |
| *Translation Required:* | Yes. |

| Excluded Provider Letter | |
|---|---|
| *To Whom Required:* | Provided to enrollees when a sponsor has excluded a prescriber or pharmacy participating in the Medicare program based on an Office of Inspector General (OIG) exclusion. |
| *Timing:* | Provided to enrollees on an ad hoc basis. |
| *Method of Delivery:* | Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Model provided; modifications permitted. |
| *Guidance and Other Needed Information:* | oig.hhs.gov/exclusions/index.asp. |
| *Translation Required:* | Yes. |

| Explanation of Benefits (EOB) – Part D | |
|---|---|
| *To Whom Required:* | Must be provided anytime an enrollee utilizes their prescription drug benefit. |
| *Timing:* | Sent at the end of the month following the month when the benefit was utilized. |
| *Method of Delivery:* | Hard copy or electronically if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Part D EOB model - modifications permitted. |
| *Guidance and Other Needed Information:* | Three-way contract and 422.2267(e)(2). |
| *Translation Required:* | Yes. |

| Formulary (List of Covered Drugs) | |
|---|---|
| *To Whom Required:* | Must be provided to all enrollees of plan. |
| *Timing:* | • Must be sent to current enrollees of plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year.<br>• Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.<br>• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. |
| *Method of Delivery:* | Hard copy or via Electronic Notice of Documents, or electronically if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Standardized model; a non-model document is not permitted. |
| *Guidance and Other Needed Information:* | • The MMP must make available a comprehensive integrated Formulary (List of Covered Drugs) that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the MMP.<br>• OTC items and/or supplemental benefits that are in excess of Medicaid requirements may not be included in this document.<br>• The MMP is only permitted to make available a comprehensive, not abridged, Formulary (List of Covered Drugs). |
| *Translation Required:* | Yes. |

| Integrated Denial Notice | |
|---|---|
| *To Whom Required:* | Any enrollee with an adverse benefit determination. |
| *Timing:* | Provided to enrollees (generally by mail) on an ad hoc basis, at least ten (10) days in advance of any adverse benefit determination. |
| *Method of Delivery:* | Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | • Rhode Island MMP model required for current CY.<br>• Standardized model; a non-model document is not permitted. |
| *Guidance and Other Needed Information:* | Three-way contract. |
| *Translation Required:* | Yes. |

| Member ID Card | |
|---|---|
| *To Whom Required:* | Must be provided to all plan enrollees. |
| *Timing:* | • Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.<br>• 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).<br>• Must also be provided to all enrollees if information on existing card changes. |
| *Method of Delivery:* | Must be provided in hard copy. In addition to hard copy, the MMP may provide a digital version (e.g., app). |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Standardized model; a non-model document is not permitted. |
| *Guidance and Other Needed Information:* | • The MMP must issue a single Member ID Card meeting these requirements for all services offered under the plan.<br>• Separate pharmacy and health benefits Member ID cards are not permitted. |
| *Translation Required:* | No. |

| Mid-Year Change Notification to Enrollees | |
|---|---|
| *To Whom Required:* | Must be provided to all applicable enrollees when there is a mid-year change in benefits, plan rules, formulary, provider network, or pharmacy network. |
| *Timing:* | Ad hoc, based on specific requirements for each issue as defined in 422.2267(e)(9). |
| *Method of Delivery:* | 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. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Model not available; must include required content. |
| *Guidance and Other Needed Information:* | • Notices of changes in MMP rules unless otherwise addressed in a regulation must be provided 30 days in advance.<br>• National Coverage Determination (NCD) changes announced or finalized less than 30 days before effective date, notification required as soon as possible.<br>• 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.<br>• Medicare Managed Care Manual - Chapter 4.<br>• 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.<br>• National Coverage Determination website. |
| *Translation Required:* | Yes. |

| Non-Renewal and Termination Notices | |
|---|---|
| *To Whom Required:* | 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. |
| *Timing:* | At least 90 days before the end of the current contract period. |
| *Method of Delivery:* | Notices must be hard copy and sent via U.S. mail. First class postage is recommended. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Rhode Island MMP model required for current contract year. Modifications permitted per instructions. |
| *Guidance and Other Needed Information:* | • 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.<br>• The MMP may elect to share Non-Renewal and Service Area Reduction (NR/SAR) information only with first tier, downstream, and related entities (FDRs) or anyone that the MMP does business with (i.e., contracted providers).<br>• Additional NR/SAR notice information can be found in the annual "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models" HPMS memo.<br>• For terminations, relevant notice requirements are provided in 42 CFR 422.506, 422.508, and 422.512. |
| *Translation Required:* | Yes. |

| Outbound Enrollment Verification | |
|---|---|
| *To Whom Required:* | Must be provided for all agent or broker assisted enrollments. |
| *Timing:* | Must be conducted within 15 calendar days following the receipt of the enrollment request. |
| *Method of Delivery:* | Hard copy, telephonic, email. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Model not available; must include required content. |
| *Guidance and Other Needed Information:* | • Communication must address enrollment into Part C or Part D Plan and provide customer service number for beneficiary questions regarding costs, benefits, rules, or any other question about the Part C/Part D Plan.<br>• May be completed via phone call (including during welcome call) or via email, if email is requested by an enrollee.<br>• Must send a written communication if the Plan/Part D sponsor fails to speak with the individual within 15 calendar days of enrollment requests.<br>• Agents or brokers are not permitted to be part of the enrollment verification call.<br>• Enrollment verification processes must stop if Plan/Part D sponsor is notified that beneficiary is ineligible to enroll in plan or if beneficiary has canceled the enrollment.<br>• Method and timing of the enrollment verification must be documented (date, time, and method of contact).<br>**Note:** We clarify that we consider a Medicare Advantage to MMP plan change, even if within the same parent organization, to be a plan switch that triggers the outbound enrollment verification requirements. |
| *Translation Required:* | Yes. |

| Prescription Transfer Letter | |
|---|---|
| *To Whom Required:* | When a Part D sponsor requests permission from an enrollee to fill a prescription at a different network pharmacy than the one currently being used by enrollee. |
| *Timing:* | Ad hoc. |
| *Method of Delivery:* | Hard copy. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Part D model provided; modifications permitted. |
| *Guidance and Other Needed Information:* | The MMP uses the model notice only when the transfer of the prescription is not initiated by the beneficiary (or someone on their behalf). |
| *Translation Required:* | Yes. |

| Provider and Pharmacy Directory | |
|---|---|
| *To Whom Required:* | Must be provided to all current enrollees of the MMP. |
| *Timing:* | • Must be sent to current enrollees of the MMP for receipt by October 15 of each year. Must be posted to plan website by October 15 of each year.<br>• Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.<br>• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.<br>• Must be provided to current enrollees upon request, within three (3) business days of the request.<br>• Must update directory information any time they become aware of changes. All updates to the online provider and pharmacy directories are expected to be completed within 30 days of receiving information. Updates to hard copy provider and pharmacy directories must be completed within 30 days; however, hard copy directories that include separate updates via addenda are considered up-to-date. |
| *Method of Delivery:* | Hard copy or via Electronic Notice of Documents, or electronically if enrollee has opted into receiving electronic version as permitted. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |

| Provider and Pharmacy Directory | |
|---|---|
| *Format Specification:* | • Rhode Island MMP model required for current CY.<br>• Standardized model; a non-model document is not permitted. |
| *Guidance and Other Needed Information:* | • The MMP is required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. The MMP may print separate directories for primary care physicians (PCPs) and specialists provided both directories are made available to enrollees at the time of enrollment.<br>• The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits.<br>• For multi-county service areas, the combined Provider and Pharmacy Directory may be provided for all providers by county, provided the directory includes a disclaimer that the directory only includes providers in that particular county (or counties), that a complete directory is available on the MMP's website, and that the enrollee may contact the MMP'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.<br>• The MMP must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the Rhode Island MMP Provider and Pharmacy Directory.<br>• 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. |
| *Translation Required:* | Yes. |

| Scope of Appointment | |
|---|---|
| *To Whom Required:* | Must be documented for all marketing activities, in-person, telephonically, including walk-ins to MMP or agent offices. |
| *Timing:* | Prior to the appointment. |
| *Method of Delivery:* | Beneficiary signed hard copy, telephonic recording, or electronically signed. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | No model required, must include required content. |

| Scope of Appointment | |
|---|---|
| *Guidance and Other Needed Information:* | • One-on-one appointments with potential MMP enrollees must only be set up at the request of the potential member, their authorized representative, or the state's broker or options counselor.<br>• The following requirements must be on the scope of appointment (SOA) form or on the recorded call:<br>o Product types to be discussed<br>o Date of appointment<br>o Beneficiary and agent contact information<br>o Statement stating there is no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur.<br>A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon. |
| *Translation Required:* | Yes. |

| Summary of Benefits | |
|---|---|
| *To Whom Required:* | Enrollees who are passively enrolled. Optional with the ANOC and as requested for other enrollees. |
| *Timing:* | • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment.<br>• 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. |
| *Method of Delivery:* | Hard copy. |
| *HPMS Timing and Submission:* | • Refer to the HPMS Marketing Review Module and Users Guide.<br>• Submitted prior to October 15 of each year |
| *Format Specification:* | • Rhode Island MMP model required for current CY.<br>• Standardized model; a non-model document is not permitted. |
| *Guidance and Other Needed Information:* | • The SB must contain a concise description of the important aspects of enrolling in the MMP, as well as the benefits offered under the MMP, including applicable copays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.<br>. |

| Summary of Benefits | |
|---|---|
| *Translation Required:* | Yes. |

| Welcome Letter | |
|---|---|
| *To Whom Required:* | Must be provided to all new enrollees of MMP. |
| *Timing:* | • Must send to enrollees who opt in to the MMP for receipt no later than eight (8) calendar days from receipt of CMS confirmation of enrollment or by last day of the month prior to the effective date, whichever is later.<br>• Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. |
| *Method of Delivery:* | Hard copy. |
| *HPMS Timing and Submission:* | Refer to the HPMS Marketing Review Module and Users Guide. |
| *Format Specification:* | Rhode Island MMP model required for CY. |
| *Guidance and Other Needed Information:* | • Must contain 4Rx information consistent with the model.<br>• National Enrollment/Disenrollment Guidance for States & MMPs, section 30.5.1. |
| *Translation Required:* | 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**

| Enrollment Mechanism | Required Materials for New Members | Timing of Beneficiary Receipt |
|---|---|---|
| Passive enrollment | • Welcome letter<br>• Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary)<br>• Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory)<br>• SB | 30 calendar days prior to the effective date of enrollment |
| Passive enrollment | • Member ID Card<br>• EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC) | No later than the day prior to the effective date of enrollment |

**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 eight (8) calendar days before the end of the month)[5] | • Welcome letter<br>• Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary)<br>• Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory)<br>• Member ID Card<br>• EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC) | No later than the last day of the month prior to the effective date |
| Opt-in enrollment (with enrollment confirmation received less than eight (8) calendar days before the end of the month)[5] | • Welcome letter<br>• Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary)<br>• Provider and Pharmacy Directory (or separate notice alerting enrollees how to access or receive the directory)<br>• Member ID Card<br>• EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC) | No later than eight (8) calendar days from receipt of the CMS confirmation of enrollment |

[5] We clarify that this group of enrollees who opt in includes individuals who are eligible for passive enrollment but select a different health plan or initiate an earlier enrollment date than their passive enrollment effective date. The MMP should refer to the date of the Daily Transaction Reply Report (DTRR) that has the notification to identify the start of the eight (8) calendar-day timeframe.

## Appendix B. State-specific MMP Disclaimers

We clarify that the MMP must include specific disclaimer language in the table below. We also clarify that, as applicable, the MMP must include additional disclaimers contained in subsections 422.2267(e) and 423.2267(e) of the regulations. In addition, we clarify that the MMP is 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 Rhode Island 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, "*Translation required:* Yes." |
| Non-plan and Non-health Information | Neither Medicare nor Rhode Island Medicaid has reviewed or endorsed this information. | Required on non-plan and non-health related information once prior authorization from the enrollee is granted to receive materials. |

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