Marketing Guidance for Texas 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.[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 Medicare-Medicaid Plans (MMPs) participating in the Texas capitated financial alignment 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 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 Texas. Information in this document is applicable to all marketing done for CY 2022 benefits.

Additional Guidance for Texas MMPs

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

Formulary and formulary change notice requirements

Texas 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

[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).

Prescription Drug Benefit Manual in a future release. In addition, we note that Texas 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, 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 Texas MMP websites.

Informational and enrollment calls

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.

Informational calls to plan call centers that become enrollment calls at the proactive request of the beneficiary must be transferred to the state's administrative services contractor. All enrollments into MMPs are submitted by the state's administrative services contractor since Texas MMPs are not allowed to market directly to individual potential enrollees.

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.

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.

In addition to the guidance in these provisions of the regulations, call centers must meet the following operating standards:

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

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

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

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 at least 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 all federal and state holidays except New Year's Day, as specified in the three-way contract, in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide 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.

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.

In addition, we clarify that the term "marketing, outreach, and member materials," defined as any informational materials for current and prospective enrollees in the three-way contract, is consistent with the definitions and explanations in 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. However, CMS and state marketing reviewers have standard operating procedures for ensuring materials are reviewed in a timely manner and differences in dispositions are resolved expeditiously. Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MMPs may obtain more information about the specific review parameters and timeframes for marketing materials in the HPMS Marketing Review Module and Users Guide.

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

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

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

MMPs submit these materials to the state via HPMS. The state adopts the same timeframes for review of these materials as applies to marketing materials ten (10) days for a model review and 45 days for a non-model review. MMPs submit provider materials to the state via the Data Management System (DMS) application within the Texas HHS Enterprise Portal at hhsportal.hhs.state.tx.us/iam/portal/Home/portalHome/.

We further clarify that MMPs must notify CMS and the state of any intent to implement an MMP-specific app. MMPs must submit any apps that are not health related, regardless of

whether they are targeted to current or potential enrollees, in HPMS subject to review by the state.

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 these subsections of the regulations. 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.

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

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

We further clarify that MMPs may use electronic media in marketing. For Texas MMPs, electronic media refers to television, radio, social media, and MMP-specific apps.[4]

[4] Refer to the Texas Health and Human Services Uniform Managed Care Manual, Chapter 4.13, for social media policy marketing requirements (www.hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/texas-medicaid-chip-uniform-managed-care-manual).

Prohibited terminology

422.2262(a), 423.2262(a)

In addition to the requirements in these provisions, Texas MMPs may not claim to be endorsed by Texas Medicaid or use the terms “Medicaid-approved” or “Medicare-Medicaid approved.”

Product endorsements

422.2262(b), 423.2262(b)

In addition to the requirements of these sections of the regulations, Texas MMPs must also adhere to the following requirements:

- An endorsement or testimonial by an individual cannot use any quotes by physicians or other health care providers.

- A contracted or employed physician or health care provider cannot provide an endorsement or testimonial.

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 administrative services contractor at least once in any marketing materials detailed in Appendix A of this guidance, as well as any materials that are provided prior to the time of enrollment and where an MMP’s customer service number is provided for enrollees to call.

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.

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

In addition to the requirements of these provisions, we clarify that any nominal gifts offered by MMPs:

- May not be provided to providers for the purpose of distributing to prospective or current members;
- May be provided to encourage prospective or current member attendance at MMP events; and
- May be provided to encourage current enrollees to participate in periodic surveys.

We also clarify that MMPs are allowed to accept promotional items from third-party sources and distribute to prospective or current enrollees as long as they are of nominal value, as governed by guidance published by the Office of Inspector General (OIG). Additionally, we clarify that MMPs may adhere their plan sticker to promotional items provided by third-party sources that MMPs distribute to prospective or current enrollees as gifts of nominal value.

Provide meals to potential enrollees

422.2263(b)(3), 423.2263(b)(3)

In addition to the requirements of these provisions of the regulation, we clarify that MMPs must not provide meals at any event at which a prospective enrollee will be in attendance, including educational events.

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 addition to the existing restrictions on marketing through unsolicited contact in these provisions of the regulations, we clarify that Texas MMPs may not initiate email contact with any prospective enrollees. Texas MMPs are prohibited from marketing through unsolicited contacts by conventional mail and other print media and by email. Potential members must initiate contact with the MMP and give permission to be called or contacted.

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 contact individuals who submit enrollment applications to conduct quality control and agent oversight activities.

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

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

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

Events with beneficiaries

422.2264(c), 423.2264(c)

Educational events

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

In addition to the guidance in these subsections of the regulations, we clarify that the following requirements apply to MMP educational events:

- Events may only focus on health and program education.

- Events may be hosted by MMPs but must be held in public venues. Events must be physically accessible to all current or potential enrollees, including persons with disabilities and persons using public transportation.

- Events cannot be held at in-home or one-on-one settings, in or around public assistance offices, or in the common areas of provider offices.

- MMPs may not charge members for goods or services distributed at educational events.

- MMPs may offer free health screenings to potential members at educational events as long as they are **not** conditioned upon enrollment into the MMP. The health screenings cannot be used to identify and discourage less healthy potential members from enrolling in the MMP.

We also clarify that, as included in the three-way contract, the state may request that Texas MMPs provide current schedules of all educational events conducted for current or prospective enrollees.

Marketing or sales events

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

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

- Maintain sign-in sheets;

- Assist individuals with completing enrollment forms; and

- Charge members for goods or services distributed at events.

Personal marketing appointments

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

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

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

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

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

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 Users Guide for instructions about submitting websites and webpages for review.

MMPs should submit their websites via links on a document. State reviewers should be able to review the information as it will be displayed on the website. The link may provide access to a live website or a test website, provided that the test site displays information as it will appear to the beneficiary or 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 their 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. MMPs must resubmit webpages for review when changes are made to plan benefits, premiums, or cost sharing.

MMPs may make the website available for public use during the state review period; however, MMPs 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, MMPs must submit the revision to HPMS within 20 days.

MMPs are not required to resubmit materials that have received prior approval for posting on their 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, MMP websites must:

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

We clarify that MMPs must also include on their websites:

- Information on how to contact the state's administrative services contractor to enroll in

the MMP.

- Information on the potential for contract termination, as required under 42 CFR 422.111(f)(4).

- Information that materials are published in alternate formats (e.g., large print, braille, audio).

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

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

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 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 and the distribution and collection of enrollment forms in common areas of a health care setting.

Provider-initiated activities

422.2266(c), 423.2266(c)

In addition to the requirements of this section, we clarify that MMPs must ensure that contracted providers are aware that they are not to assist beneficiaries with enrollment decisions. Providers may only inform beneficiaries of benefits, services, and specialty care services offered through the plans with which they contract. Providers must follow the Texas Provider Marketing Guidelines that became effective in July 2014 per SB 8 (refer to www.hhs.texas.gov/services/health/medicaid-chip/provider-information/texas-medicaid-chip-communications-resources). Contracted providers also may not:

- Make any oral or written statements that any MMP is endorsed by CMS, a federal or state governmental agency, or similar entity.

- Display marketing materials for any MMP anywhere in the provider office, including common areas.

- Recommend one MMP over another or assist a beneficiary in deciding to select a specific MMP.

- Induce or accept a current or prospective member's enrollment in or disenrollment from an MMP.

- Assist an enrollee with enrollment forms.

- Portray any MMP in a negative manner.

- Provide nominal gifts on behalf of an MMP to current or prospective members, or condition nominal gifts on enrollment with an MMP.

- Use terms that would influence, mislead, or cause prospective members to contact the MMP, rather than the state's administrative services contractor, for enrollment in the MMP.

- Discriminate against current or prospective member based on race, creed, age, color, religion, national origin, ancestry, marital status, sexual orientation, physical or mental disability, health status, or existing need for medical care.

- Use telephone number "2-1-1" for enrollment purposes to promote enrollment in an MMP.

We also clarify that referring patients to other sources of information such as the "State Medicaid Office" also applies to materials produced by the state and/or distributed by its administrative services contractor.

Plan-initiated provider activities

422.2266(d), 423.2266(d)

In addition to the requirements of this section, we clarify that MMPs may have agreements with providers in connection with plan activities and should ensure that those agreements address marketing activity in a manner consistent with Medicare and Texas Medicaid regulations. These requirements are discussed throughout this section. MMPs may not cobrand or conduct plan marketing activities in health care settings.

MMPs may not use providers to make available, distribute, and/or display plan marketing materials, communications, and/or enrollment forms. Providers may distribute or display general health promotion materials/health-related materials for all contracted MMPs. Providers are not required to distribute or display all general health promotion materials provided by each MMP with whom they contract. Providers can choose which items to distribute or display, as long as they distribute/display one (1) or more items from each contracted MMP without giving the appearance of supporting one (1) MMP over another. Providers that choose to display MMP stickers must display a sticker for each plan that provides one (1), or the provider may choose to display none at all. MMPs may provide health-related display posters and materials for providers to display in common areas, subject to the following requirements:

- Health-related posters cannot be larger than 16" x 24".

- Materials may include the MMP's name, logo, and contact information.

- MMP stickers may not be larger than 5" x 7" and may not indicate anything more than MMP is accepted or welcomed here.

Providers may choose whether to display items such as pens or pencils provided by each contracted MMP. Providers can choose which items to display as long as they display one (1) or more from each contracted MMP. Items may only be placed in common areas.

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

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

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 Texas' standard for translation of marketing materials is more stringent. Guidance regarding the translation requirements for all plans, including MMPs, is released annually each fall via HPMS. Required languages for translation for each MMP are also updated annually, as needed, in the HPMS Marketing Review Module. We expect that the standard for CY 2022 will remain unchanged and that Texas MMPs must translate all required marketing materials into Spanish for all service areas.

CMS and the state have designated materials that are vital and, therefore, must be translated into specified non-English languages.[5] This information is located in Appendix A of this document. MMPs are also required to make required materials available in alternate formats upon request (e.g., large print, braille, audio).

MMPs must have a process for ensuring that enrollees can make 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.

[5] CMS makes available Spanish translations of the Texas 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.

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 Texas, 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 for passively-enrolled individuals and welcome letter for individuals who voluntarily enrolled: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.

- 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.

- 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 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. Texas MMPs have the option to use either model to meet the requirement to send a Part D EOB.

- Part D appeals and grievances models and notices (including those in 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 Texas 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. 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 administrative services contractor 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, MMPs submit all materials in HPMS.

Agent, Broker, and Other Third Party Requirements

422.2274, 423.2274

The state's administrative services contractor continues to process all MMP enrollments.

The requirements applicable to independent agents and brokers in these sections of the regulations are applicable to Texas MMPs. We 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.

We also clarify that Texas MMPs are permitted to compensate independent agents and brokers in two scenarios, as described in Appendix C of this document. MMPs may compensate independent agents or brokers in situations where individuals opt in to MMPs offered by the same parent organization as their previous coverage (e.g., a Dual Eligible Special Needs Plan or D-SNP) and an independent agent or broker facilitated enrollment into the previous coverage. This situation can occur in the middle of the initial compensation year or in a subsequent year in which the agent or broker is receiving a renewal compensation for retention in that Medicare Advantage (MA) plan.

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

We further clarify that the state does not provide annual specifications for training and testing

criteria and documentation requirements. In addition, 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 Texas 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, MMPs may not change their decisions related to agent or broker type until the next plan year.

Appendix A. Required Materials and Instructions for MMPs

The tables on the following pages contain required materials for Texas 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 Users 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)	
To Whom Required:	Must be provided to current enrollees of plan, including those with October 1, November 1, and December 1 effective dates.
Timing:	• MMPs must send for enrollee receipt no later than September 30 of each year. (**Note**: ANOC must be posted on MMP website by October 15.) • Enrollees with October 1, November 1, and December 1 enrollment effective dates must receive the ANOC for the upcoming year by one (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. • Must be submitted prior to mailing ANOCs.
Format Specification:	• Texas MMP model required for current CY. • 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. 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 "Marketing Materials AMD/Beneficiary Information" section of the HPMS Marketing Review Module and Users Guide. (**Note:** 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.) • Plans may include the following with the ANOC: o Summary of Benefits o Provider and Pharmacy Directory o EOC (Member Handbook) o Formulary (List of Covered Drugs) o Notification of Electronic Documents • 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. • ANOC errata must be submitted by October 15. • EOC (Member Handbook) errata must be submitted by November 15.
Format Specification:	Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	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. **Note:** Any mid-year changes, including but not limited to mid-year legislative benefit additions or removals and changes in enrollment policies, should be communicated to current enrollees consistent with the "Mid-Year Change Notification" guidance in this section. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to plan error. Instead plans 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. • 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:	Other 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. • 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. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current 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.
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. • Submitted prior to October 15 of each year.
Format Specification:	• Texas MMP model required for current CY. • 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, or • Texas MMP specific model - standardized model • A non-model document is not 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. • 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. • 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:	• 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. • OTC items and/or supplemental benefits that are in excess of Medicaid requirements may not be included in this document. • MMPs are 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:	• Texas MMP model required for current CY. • 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 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. • Must send to enrollees who are passively enrolled for receipt by the end of the month preceding the month the enrollment will take effect (e.g., must be received by a beneficiary by March 31 for an April 1 effective enrollment date). • Must also be provided to all enrollees if information on existing card changes.
Method of Delivery:	Must be provided in hard copy. In addition to hard copy, MMPs 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:	• MMPs must issue a single Member ID Card meeting these requirements for all services offered under the plan. • Separate pharmacy and health benefits Member ID cards are not permitted.
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. • National Coverage Determination (NCD) changes announced or finalized less than 30 days before effective date, notification required as soon as possible. • 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. • Medicare Managed Care Manual - Chapter 4. • 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. • 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:	• Texas MMP model required for current CY. • 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. • 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). • Additional NR/SAR notice information can be found in the annual CMS memorandum, "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models." • For terminations, relevant notice requirements are provided in 42 CFR 422.506, 422.508, and 422.512.
Translation Required:	Yes.

Part D Transition Letter	
To Whom Required:	Must be provided when a beneficiary receives a transition fill for a non-formulary drug.
Timing:	Must be sent within three (3) days of adjudication of temporary transition fill.
Method of Delivery:	Hard copy.
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:	Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4.10.
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 plan.
Timing:	• Must be sent to current enrollees of MMP for receipt by October 15 of each year. Must be posted to MMP website by October 15 of each year. • 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. • Must send to enrollees who are passively enrolled for receipt no later than 30 calendar days prior to enrollment. • Must be provided to current enrollees upon request, within three (3) business days of the request. • Must update directory information any time they become aware of changes. All updates to the online provider and pharmacy directories are expected to be completed within 30 days of receiving information. Updates to hard copy provider and pharmacy directories must be completed within 30 days; however, hard copy directories that include separate updates via addenda are considered up-to-date.
Method of Delivery:	Hard copy or via Electronic Notice of Documents, 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:	• Texas MMP model required for current CY. • Standardized model; a non-model document is not permitted.

Provider and Pharmacy Directory	
Guidance and Other Needed Information:	• 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. • The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits. • For 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. • Texas MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the Texas MMP Provider and Pharmacy Directory. • 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 (SOA)	
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.
Guidance and Other Needed Information:	• The following requirements must be on the scope of appointment (SOA) form or on the recorded call: o Product types to be discussed o Date of appointment o Beneficiary and agent contact information o Statement stating there is no obligation to enroll, current or future Medicare enrollment status will not be impacted, and automatic enrollment will not occur. • A new SOA is required if, during an appointment, the beneficiary requests information regarding a different plan type than previously agreed upon.
Translation Required:	Yes.

Summary of Benefits (SB)	
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. • 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. • Submitted prior to October 15 of each year.
Format Specification:	• Texas MMP model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• The SB must contain a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including applicable copays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. .
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 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. • 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:	Texas MMP model required for CY.
Guidance and Other Needed Information:	• Must contain 4Rx information consistent with the model. • National Enrollment/Disenrollment Guidance for States and 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 Enrollees	Timing of Beneficiary Receipt
Passive enrollment	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • SB	30 calendar days prior to the effective date of enrollment
Passive enrollment	• Member ID Card • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC)	No later than the day prior to the effective date of enrollment

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

Enrollment Mechanism	Required Materials for New Enrollees	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received more than ten (10) calendar days before the end of the month)[6]	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC)	No later than the last day of the month prior to the effective date
Opt-in enrollment (with enrollment confirmation received less than ten (10) calendar days before the end of the month)[6]	• Welcome letter • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) • Provider and Pharmacy Directory (or separate notice alerting enrollees how to access or receive the directory) • Member ID Card • EOC (Member Handbook) (or a distinct and separate notice alerting enrollees how to access or receive the EOC)	No later than ten (10) calendar days from receipt of the CMS confirmation of enrollment

[6] We clarify that this group of enrollees who opt in includes individuals who are eligible for passive enrollment but select a different MMP or initiate an earlier enrollment date than their passive enrollment effective date. 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 Texas 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 Texas 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 Texas 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.

Appendix C. Permissible Options for Compensating Independent Agents or Brokers

Information in the table below describes the two scenarios for which Texas MMPs are permitted to compensate independent agents or brokers when a member opts in to an MMP that is offered by the same parent organization as their previous coverage. In the initial compensation scenario in the table's first row, consistent with information in subsection 422.2274(d)(2) of the regulation, the MA plan would be required to pro-rate the compensation paid to the agent for the months the enrollee was no longer enrolled in the MA plan.

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