Marketing Guidance for Michigan Medicare-Medicaid Plans

Contract Year (CY) 2022

Issued: August 19, 2021

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Introduction

The Centers for Medicare & Medicaid Service (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 Michigan 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; 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 Michigan. Information in this document is applicable to all marketing done for CY 2022 benefits.

Additional Guidance for Michigan MMPs

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

Formulary and formulary change notice requirements

Michigan MMPs should refer to the November 1, 2018 CMS memorandum, "Part D Communication Materials," for guidance on formulary and formulary change notice requirements. As noted in that memorandum, additional updates to reflect changes related to 42 CFR 423.120(b)(5), regarding notice of mid-year formulary changes and changes to the definition of an approved month's supply, will be incorporated into the Medicare Prescription Drug Benefit Manual in a future release. In addition, we note that Michigan MMPs are 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 (as described in Chapter 6 of the Prescription Drug Benefit Manual), regardless of whether or not the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan.

- Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on Michigan MMP websites.

Informational and enrollment calls

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

We clarify that in order to provide more than factual information, MMP outbound callers must be state-licensed (and, when required, appointed) marketing agents. MMPs must use state-licensed (and, when required, appointed) marketing agents for any activity that meets the definition of marketing.

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

We further clarify that telesales scripts are considered marketing, and MMPs must submit them in the Health Plan Management System (HPMS) Marketing Review Module.

Marketing MMP and non-MMP offerings

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

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

In addition, all marketing, advertising, and member education materials the MMP sends must include the MMP's Member Services toll-free phone and TTY numbers.

All marketing, advertising, and member education materials must use the term "care coordinator(s)" when discussing the individual who coordinates members' care. Terms such as care manager, case manager, or any other term used by the MMP to discuss the care coordinator are prohibited.

Use of MI Health Link logo

All use of the MI Health Link logo must meet the following requirements:

- The MI Health Link logo will not be used to imply sponsorship or endorsement on materials distributed by the MMP.

- The MI Health Link logo will not be used in any manner that may possibly disparage, bring into disrepute, or negatively reflect on MI Health Link or in connection with any products or services that may possibly diminish or damage the goodwill of the MI Health Link program or the Michigan Department of Health and Human Services.

- When the MI Health Link logo is used on materials, with the exception of materials related to rewards, incentives, promotional items, materials described in Appendix A of this document, and other materials subject to marketing review, the MMP will include the following disclaimer:

  > "The Michigan Department of Health and Human Services, MI Health Link program has not reviewed or endorsed this information."

- All materials referred to in Appendix A must contain the MI Health Link logo.

- MMPs may not include the MI Health Link logo on educational materials.

- MMPs may not use the MI Health Link logo on business cards.

- The MI Health Link logo appearance must not be altered. The MI Health Link logo must stand by itself so as to avoid unintended associations with any other objects, including, but not limited to, text, photographs, illustrations, borders, and edges.

- The width of the blank space surrounding the logo must be equal to 1/3 of the size of the symbol that is displayed (e.g., if the symbol is 30 pixels across, it must have 10 pixels of blank space above, below and on each side). The logo and the MMP's logo should retain their natural proportional size and should not appear stretched, distorted, or pixelated.

- The MI Health Link logo must not be used as a feature or design element, or be incorporated into any other service mark or logo.

- All materials that contain the MI Health Link logo, except the Member ID Card, must use the MI Health Link logo that includes the slogan "Linking Medicare and Medicaid for you." Furthermore, the Member ID Card must display the MI Health Link logo in the card's top right corner.

- Envelopes may, but are not required to, include the MI Health Link logo; however, consistent with Appendix B, envelopes are required to include the MMP's name or logo.

- Use of the MI Health Link logos is limited to the two versions (color and black/white – or reverse). The MI Health Link logo provided by the state to MMPs cannot be altered without the express permission of the Michigan Department of Health and Human Services.

- The MMP's logo must be displayed whenever the MI Health Link logo will appear on the MMP document(s) or material.

- The MI Health Link logo and the MMP's logo should appear next to each other wherever possible.

- The MI Health Link logo must appear in color whenever the MMP's logo is displayed in color on the same document or material.

- MMPs must submit materials that contain the MI Health Link logo in HPMS for state review.

- MMPs' downstream contractors and related entities may not use the MI Health Link logo unless the document meets all of the guidelines set forth in this document and has been approved through HPMS or the state approved process.

- The State of Michigan, through the Michigan Department of Health and Human Services, retains the right to change these guidelines at any time.

Use of Medicare Mark for Part D sponsors

We clarify that MMPs have been required to sign a licensing agreement to use the official Medicare Mark as part of the three-way contract rather than through the HPMS Contract Management Module.

Disclosure Requirements, Provision of Specific Information, Call Centers

422.111, 422.111(h)

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

Additionally, we clarify that MMPs must operate a toll-free call center during usual business hours. In light of the scope and nature of the services and benefits provided by MMPs, CMS interprets usual business hours for customer service call centers for both current and prospective enrollees as meaning at least 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. During this time period, current and prospective enrollees must be able to speak with a live customer service representative. MMPs may use alternative technologies on Saturdays, Sundays, and state and/or federal holidays (except New Year's Day) in lieu of having live customer service representatives. For example, an MMP may use an interactive voice response (IVR) system or similar technologies to provide 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 business day later. We also clarify that the remainder of 422.111(h) applies to MMPs.

Reward and Incentive Programs

422.134

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

Additionally, any rewards and incentives programs for current members must be consistent with the regulation with the following modifications:

- The state has the authority to impose limitations or deny an incentive that seems inappropriate for health prevention and promotion behaviors.

- Reward and incentive items cannot be items that are considered a health benefit (e.g., a free checkup) or be offered in the form of cash or other monetary rebates.

Definitions

422.2260, 423.2260

MMPs are generally subject to marketing and beneficiary communications applicable to Medicare Advantage plans in 42 CFR Parts 422 and 423, as well as those applicable to Medicaid managed care organizations in 42 CFR Part 438. We clarify that the definitions of communications and marketing as described in these sections of the regulations are not applicable to MMPs. CMS continues to consider all CY 2022 MMP materials to be marketing materials as stated in the "Introduction" in this document. For any other references to communications throughout 42 CFR Parts 422 and 423, the definition of marketing materials applies, and we provide additional details about materials in Appendix A and Appendix B of this document.

Submission, Review, and Distribution of Materials

422.2261, 423.2261

General requirements

422.2261(a), 423.2261(a)

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

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

CMS review of marketing materials and election forms

422.2261(b), 423.2261(b)

We clarify that, for purposes of MMP materials, there is no "deeming" of materials requiring either a dual review by CMS and the state or a one-sided state review, and materials remain in a "pending" status until the state and CMS reviewer dispositions match. Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MMPs

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

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

General Communications Materials and Activities Requirements

422.2262, 423.2262

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

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

MMPs may also use any state-specific plan type terminology in their marketing materials (e.g., a plan can state that Medicare-Medicaid Plans are also known as Integrated Care Organizations (ICOs) in Michigan), provided they comply with the guidance regarding use of the CMS standardized plan type.

We also clarify that MMPs in Michigan 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 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).

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 Michigan's enrollment broker at least once in any marketing materials that are provided prior to the time of enrollment and where a customer service number is provided for current and prospective enrollees to call.

Standardized material identification (SMID)

422.2262(d), 423.2262(d)

The provisions in these subsections of the regulations are modified as follows for MMPs:

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

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

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

General Marketing Requirements

422.2263, 423.2263

Offer gifts to beneficiaries

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

Under the Michigan demonstration, MMPs may **not** offer financial or other incentives, including private insurance, to induce enrollees or potential enrollees to enroll with the MMP or to refer a friend, neighbor, or other person to enroll with the plan. We clarify, however, that gifts of nominal value are permitted consistent with these subsections of the regulation.

MMPs may offer a nominal gift to the general population in the community, provided that such promotion and distribution of materials are directed at the entire population of the MMP's approved demonstration region and are not given in connection with enrollment.

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)

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.

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

"For information on <plan name> and other options for your health care, call Michigan ENROLLS at 1-800-975-7630 (TTY: 1-888-263-5897). Office hours are Monday through Friday, 8 AM to 7 PM."

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

Contact for plan business

422.2264(b), 423.2264(b)

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

- MMPs may not call current MMP enrollees to promote other Medicare plan types. Information about other Medicare plan types can only be provided at the proactive request of a current MMP enrollee.

- 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. Organizations that offer non-MMP and MMP products may call their current non-MMP members (e.g., those in Medicaid managed care products), including individuals who have previously opted out of passive enrollment into an MMP, to promote their MMP offerings.

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

Events with beneficiaries

422.2264(c), 423.2264(c)

Marketing or sales events

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

The provisions in these subsections of the regulations apply to Michigan MMPs with additional clarifications. MMPs may hold marketing events to persuade enrollees or potential enrollees to enroll with the MMP; however, the MMP may not discuss enrollment, disenrollment, or Medicaid eligibility. The MMP must refer all such inquiries to the state's enrollment broker. Advertisement of a health fair must be directed at the general population. An MMP's name may be used in health fair advertisements only if the state has approved the advertisement.

Personal marketing appointments

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

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

Websites

422.2265, 423.2265

General website requirements

422.2265(a), 423.2265(a)

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

Required content

422.2265(b), 423.2265(b)

In addition to the provisions in these subsections of the regulations, MMPs must also include on their website the contact information for the state's enrollment broker and must use the following language:

> "If you have questions about enrollment or disenrollment in MI Health Link, call Michigan ENROLLS toll-free at 1-800-975-7630. Persons with hearing and speech disabilities may call the TTY number at 1-888-263-5897. The office hours are Monday through Friday, 8 AM to 7 PM."

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

MMPs must also include information on the potential for contract termination (i.e., a statement that the MMP may terminate or non-renew its contract, or reduce its service area, and the effect any of those actions may have on MMP enrollees, as required under 42 CFR 422.111(f)(4)), and information that materials are available in alternate formats (e.g., large print, braille, audio).

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

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 by the state and/or distributed by its 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 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. Marketing materials must be available in languages appropriate to the beneficiaries being served within the demonstration region. All materials must be culturally appropriate and available in alternative formats in accordance with the Americans with Disabilities Act. The standard articulated in these subsections of the regulations regarding translation of marketing materials into non-English languages will be superseded to the extent that Michigan's standard for translation of marketing materials is more stringent. Guidance on the translation requirements for all plans, including MMPs, is released annually each fall via HPMS. Required languages for translation for the MMP are also updated annually, as needed, in the HPMS Marketing Module.

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

MMPs must have a process for ensuring that enrollees can make a standing request to receive the materials identified in this section, in alternate formats and in all non-English languages identified in this section 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 doesn't need to make a separate request for each material and how a member can change a standing request for preferred language and/or format.

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

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 guidance, 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 Michigan, 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, state-specific appeals notices, and welcome letters for opt-ins and passively enrolled individuals and other plan-delegated enrollment notices: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.

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

- Required MMP Drug-Only Explanation of Benefits (EOB): www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.

- Part D appeals and grievances models and notices (the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance) www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index and www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments, and www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Forms.

- Part C appeals and grievances models and notices (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 Michigan MMPs are in Appendix A and Appendix B of this document, which replace the requirements in 422.2267(e) and 23.2267(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, MMPs submit all materials in HPMS.

Agent, Broker, and Other Third Party Requirements

422.2274, 423.2274

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

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

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

Appendix A. Required Materials and Instructions for MMPs

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

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

Annual Notice of Changes (ANOC)	
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 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 User Guide. • Must be submitted prior to mailing ANOCs.
Format Specification:	• Michigan 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 "Manage Material AMD/Beneficiary Information" section of the HPMS Marketing Review Module and User 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 Form allowing enrollees to "opt in" to receiving their upcoming ANOC and EOC via e-mail. • 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 User 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
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 User Guide.
Format Specification:	• Michigan MMP models - standardized model; a non-model document is not permitted. • Other CMS models - modifications permitted.
Guidance and Other Needed Information:	Three-way contract, Parts C & D Enrollee Grievances, and 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 month after the effective date of enrollment, but not later than December 15.
Method of Delivery:	Hard copy EOC (Member Handbook) or via Notice of Electronic 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 Uses Guide. • Submitted prior to October 15 of each year.
Format Specification:	• Michigan 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 User Guide.
Format Specification:	Model provided; modifications permitted.
Guidance and Other Needed Information:	oig.hhs.gov/exclusions.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 User Guide.
Format Specification:	Michigan MMP specific model - standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	Three-way contract and 423.2267(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 User 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 10 (ten) days in advance of any adverse
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 User Guide.
Format Specification:	• Michigan 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 the hard copy, plans may also provide a digital version (e.g., app).
HPMS Timing and Submission:	Refer to the HPMS Marketing Review Module and User 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 User 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 Decisions (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 User Guide.
Format Specification:	• Michigan 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 User Guide.
Format Specification:	Model provided; modifications permitted.
Guidance and Other Needed Information:	Medicare Prescription Drug Benefit Manual, Chapter 6.
Translation Required:	Yes.

Plan Delegated Enrollment and Disenrollment Notices	
To Whom Required:	Must be provided as outlined in National Enrollment/Disenrollment Guidance for States & MMPs.
Timing:	Varies; must follow required timeframes as outlined in National Enrollment/Disenrollment Guidance for States & MMPs.
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 User Guide.
Format Specification:	• Michigan MMP model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• National Enrollment/Disenrollment Guidance for States & MMPs. • Michigan Enrollment Guidance Appendix 5. • MMPs must follow specifications in the HPMS Marketing Review Module, along with the enrollment/disenrollment guidance, to determine how to submit appropriately.
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 User 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 his or her 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 Plan for receipt by October 15 of each year. Must be posted to 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. • 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 User Guide.
Format Specification:	• Michigan 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. • Michigan MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the Michigan MMP Provider and Pharmacy Directory. • As applicable, refer to the language and guidelines issued in the CMS memorandum, dated August 16, 2016, HPMS memo, "Pharmacy Directories and Disclaimers" for the pharmacy portion of the combined directory.
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. • 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 plan website by October 15 of each year.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	• Refer to the HPMS Marketing Review Module and User Guide. • Submitted prior to October 15 of each year.
Format Specification:	• Michigan 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 User Guide.
Format Specification:	Michigan MMP model required for CY.
Guidance and Other Needed Information:	• Must contain 4Rx information consistent with this model. • 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 • 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 • Provider letter[5]	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

[5] A provider letter is for enrollees to take with them when they go to appointments. It explains the enrollee's new benefit plan, continuity of care requirements, instructions for the provider to bill for services, and information on how to join the MMP's provider network. A model provider letter will be provided to MMPs by the state.

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 10 (ten) 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) • Provider letter[7]	No later than the last day of the month prior to the effective date
Opt-in enrollment (with enrollment confirmation received less than 10 calendar days before the end of the month)[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) • Provider letter[5]	No later than 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.

[7] A provider letter is for enrollees to take with them when they go to appointments. It explains the enrollee's new benefit plan, continuity of care requirements, instructions for the provider to bill for services, and information on how to join the MMP's provider network. A model provider letter will be provided to MMPs by the state.

Appendix B. State-specific MMP Disclaimers

We clarify that MMPs include specific disclaimer language in the table below. We also clarify that, as applicable, MMPs include additional disclaimers contained in subsections 422.2267(e) and 423.2267(e) of the regulations. In addition, we clarify that MMPs are not required to include disclaimers on the following material types: 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 Michigan 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 Michigan 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.