Marketing Guidance for Ohio Medicare-Medicaid Plans

Contract Year (CY) 2023

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Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in 42 CFR Parts 422 and 423 as well as all MA-PD plan sponsor requirements in the Medicare Communications and Marketing Guidelines (MCMG), posted at www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines apply to Medicare-Medicaid Plans (MMPs) participating in the Ohio capitated financial alignment model demonstration, except as clarified or modified in this guidance document.[1] In addition, the Centers for Medicare and Medicaid Services (CMS) recently codified guidance on May 9, 2022,[2] which also applies to MMPs except as clarified in this document.

As defined in 42 CFR 422.2260 and 423.2260 prior to the implementation of the CMS-4182-F,[3] CMS continues to consider all Contract Year (CY) 2023 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 and MCMG that are not applicable or that are different for MMPs in Ohio. Information in this document is applicable to all marketing done for CY 2023 benefits.

Additional Guidance for Ohio MMPs

The following are additional Ohio MMP-specific modifications to the marketing regulations and MCMG.

Formulary and formulary change notice requirements

Ohio 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

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

[2] Refer to Contract Year 2023 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, which may be found in the Final Rule published on May 9, 2022 (https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and).

[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 Ohio MMPs are required to adhere to all new regulatory provisions and requirements.

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

- Formulary change notices must be sent for any negative formulary change (as described in Chapter 6 of the Prescription Drug Benefit Manual), regardless of whether or not the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan.

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

Informational and enrollment calls

We clarify that customer service staff may conduct activities that do not require the use of state-licensed marketing representatives.

We also clarify that informational calls to plan call centers that become enrollment calls at the proactive request of the beneficiary must be transferred to Ohio's enrollment broker. Plan customer service staff must remain on the telephone with the beneficiary until the transfer is complete. We also clarify that MMPs may not ask callers if they would like to receive information about other Medicare lines of business they offer. Such information may only be provided at the proactive request of a member.

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

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.

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 federal holidays in lieu of having live customer service representatives. For example, an MMP may use an interactive voice

response (IVR) system or similar technologies to provide the required information and allow individuals to leave a message (messages must be returned within one (1) business day). 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 2023 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 the CMS Required Materials and Content (422.2267(e)) section of this document.

Submission, Review, and Distribution of Materials

422.2261, 423.2261

General requirements

422.2261(a), 423.2261(a)

We clarify that MMPs are required to submit all plan websites for review, including those that are limited to content required under 422.2265 using the process described in the Submission of Required Websites section of the MCMG.

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 marketing 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 Financial Alignment Initiative capitated model demonstration. MMPs must include the "Medicare-Medicaid Plan" plan type terminology at the end of their plan name at least once on the front page or at the beginning of each marketing piece, excluding envelopes. Ohio also refers to MMPs as Medicare-Medicaid Plans and provides additional information about branding for the demonstration in the three-way contract. Thus, we clarify that MMPs must use the CMS standardized plan type, <plan name, including "MyCare Ohio"> (Medicare-Medicaid Plan), once in their materials.

We also clarify that MMPs in Ohio that offer Medicare Advantage products in the same service area as their MMPs may not use the same plan marketing name for both of those products. Thus, for example, an organization offering both 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)

The requirements of this section apply with the following modifications:

- MMP must provide hours and days of operation when a customer service number is provided on all marketing and communications materials in order to ensure that notice of the customer service contact information is adequate and not confusing or misleading. This does not apply to member ID cards.

Note: CMS requires MMP sponsors to list the days and hours of operation only once in conjunction with the customer service number and 1-800-MEDICARE listings.

- MMPs must also provide the phone and TTY numbers and days and hours of operation information for Ohio'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. The Ohio Medicaid Consumer Hotline (1-800-324-8680, www.ohiomh.com) operates from 7 a.m. to 8 p.m. ET Monday through Friday and 8 a.m. to 5 p.m. ET on Saturday.

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 SMID 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 the 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

Star Ratings

422.2263(c), 423.2263(c)

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)

We clarify that MMPs are permitted to initiate electronic communications with current enrollees **only**. MMPs must include a disclaimer regarding messaging rates in electronic communications.

These subsections of the regulations provide examples of unsolicited direct contact with current and prospective enrollees. We reiterate that marketing via conventional mail and other print media (e.g., advertisements, direct mail) is not considered unsolicited contact and, therefore, is permissible.

We also clarify that MMPs may not make unsolicited direct contact with prospective enrollees using electronic communications (e.g., email). If a prospective enrollee provides permission to be contacted, the contact must be event-specific and may not be treated as

open-ended permission for future contacts. In addition to the provisions of these subsections of the regulations, MMPs conducting permitted unsolicited marketing activities, such as conventional mail and other print media, are required to include the following disclaimer on all materials used for that purpose:

> "For information on <plan name> and other options for your health care, call the Ohio Medicaid Hotline at 1-800-324-8680 (voice) or 1-800-292-3572 (TTY), or visit www.ohiomh.com."
>
> 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:

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

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

Events with beneficiaries

422.2264(c), 423.2264(c)

Educational events

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

We clarify that, as provided under the three-way contract, the state may request that Ohio MMPs provide current schedules of all educational events conducted for current or prospective enrollees.

Personal marketing appointments

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

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

Websites

422.2265, 423.2265

Required content

422.2265(b), 423.2265(b)

In addition to the provisions in these subsections of the regulations, MMPs must also include on their websites a direct link to the following website: www.ohiomh.com. MMPs must also include information on the potential for contract termination (as required under 42 CFR 422.111(f)(4)), and information that materials are published in alternate formats (e.g., large print, braille, audio).

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

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 Ohio MMPs may not allow contracted providers to answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information. In addition, we clarify that the guidance in this section about referring patients to other sources of information such as the "State Medicaid office" also applies to materials produced and/or distributed by Ohio's enrollment broker.

Required Materials and Content

422.2267, 423.2267

We clarify that, unless otherwise modified and/or specifically indicated in this section of the document, these sections of the regulations and all of their subsections apply to 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 section. To the extent that Ohio's standard for translation of marketing materials into non-English languages is more stringent than the standard articulated in this section of the regulation, the Ohio standard will supersede that standard. The Ohio translation standard – which requires translation of materials into "prevalent

languages" (i.e., Spanish and any language that is the primary language of five (5) percent or more of households of Medicaid managed care enrollees in the plan's service area) – typically exceeds the Medicare standard for translation in Ohio MMP service areas. Guidance regarding translation requirements for all plans, including MMPs, is released annually each fall via HPMS. Required languages for translation for MMPs are also updated annually, as needed, in the HPMS Marketing Review Module.

We expect the Ohio standard for translation will likely be the more stringent (and, therefore, applicable) standard for Ohio MMPs for CY 2023. CMS and the state have designated materials that are vital and, therefore, must be translated into non-English languages.[4] This information is located in the CMS Required Materials and Content (422.2267(e)) section 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 does not need to make a separate request for each material and how a member can change a standing request for preferred language and/or format.

Model materials

422.2267(c), 423.2267(c)

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

We note that materials MMPs create should take into account the average reading level established in the three-way contract. Available models reflect acceptable average reading levels. Current Part D models are acceptable for use as currently provided, and MMPs must add required disclaimers included in the State-specific MMP Disclaimers section 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 Ohio, including an Annual Notice of Changes (ANOC), Summary of Benefits (SB), 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,

[4] CMS makes available Spanish translations of the Ohio 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.

integrated denial notice, notice of appeals decision, and welcome letters 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 materials, including the Excluded Provider Letter, Prescription Transfer Letter, and Transition Letter: https://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.

- 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/index, 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 (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 Ohio MMPs are included below and replace the requirements in 422.2267(e) and 423.2267(e) unless otherwise specifically indicated. We further clarify that the Pre-Enrollment Checklist referenced in 422.2267(e)(4) and 423.2267(e)(4) is not applicable to MMPs since the state's enrollment broker submits all enrollments. As stated in the "Introduction" in this document, CMS continues to consider all CY 2023 MMP materials to be marketing materials. As a result, MMPs submit all materials in HPMS.

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 User Guide. • Must be submitted prior to mailing ANOCs.
Format Specification:	• Ohio 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 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 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. Refer to the annual Health Plan Management System memo "Issuance of Contract Year Model Materials" and "Contract Year Annual Notice of Change and Evidence of Coverage Submission Requirements and Yearly Assessment "memos.
Translation Required:	Yes.

Comprehensive Medication Review Summary	
To Whom Required:	Provided to enrollees in a plan's Medication Therapy Management (MTM) program after receiving a comprehensive medication review (CMR)
Timing:	May be provided to enrollee immediately following a CMR, or if distributed separately, materials should be sent out within 14 calendar days.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 423.2267(d).
HPMS Timing and Submission:	Not applicable.
Format Specification:	Standardized OMB-approved Format (Form CMS-10396, OMB Control Number 0938-1154). The Format cannot be modified, but the specific content to populate the Format must be tailored to address issues unique to the individual enrollee and may be customized for the Part D plan and MTM program.
Guidance and Other Needed Information:	See https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM for CMR Standardized Format and detailed implementation instructions and Annual MTM Program Submission Instructions memo. **Note:** MTM program materials should not include any marketing or promotional messages.
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:	• Ohio MMP model for notice of appeals decision - 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, 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 Notice of Electronic Documents; or electronically if enrollee has opted into receiving electronic version.
HPMS Timing and Submission:	• Refer to the HPMS Marketing Review Module and User Guide. • Submitted prior to October 15 of each year.
Format Specification:	• Ohio 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/fraud/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:	• Part D EOB model - modifications permitted. • Ohio 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 Notification 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 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 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 User Guide.
Format Specification:	• Ohio 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 earlier than fifteen (15) calendar days prior to the effective enrollment date. • 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, MMPs may 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. • Must include MMP's website address, customer service number, and contract/plan benefits package number. • May not use social security number (SSN). • The front of the card must include the Medicare Prescription Drug Benefit Program Mark.
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 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 User Guide.
Format Specification:	Ohio 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 model 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). • MMPs must provide a NR/SAR notice to beneficiaries who enroll in a non-renewing plan on October 1, November 1, or December 1 of the current contract year (e.g., less than 90 days before the effective date of the non-renewal). • Additional NR/SAR notice information can be found in the annual CMS memorandum, "Non-Renewal and Service Area Reduction Guidance and Enrollee Notification Models" issued through HPMS.
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 and Disenrollment Guidance for States and MMPs.
Timing:	Varies; must follow required timeframes as outlined in National Enrollment and Disenrollment Guidance for States and 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:	• Ohio MMP model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• MMPs must follow specifications in the Marketing Review Module, along with the Enrollment/Disenrollment Guidance and Ohio Enrollment Guidance Appendix 5, 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 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 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 Notification 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 User Guide.
Format Specification:	• Ohio 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.
	• Ohio MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the Ohio MMP Provider and Pharmacy Directory.
	• Ohio MMPs' online directories must be updated as frequently as specified in the regulation for those providers types not on the Ohio Department of Medicaid (ODM) list of required provider types specified in the three-way contract. For ODM-required providers, Ohio MMPs must:
	  ○ Add new providers to their online directory within one (1) week of submitting them to the Managed Care Provider Network (MCPN) database, and
	  ○ Remove providers deleted from the MCPN database from the online directory within one (1) week of notification by provider to the MMP.
	• 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.

Safe Disposal Information	
To Whom Required:	Provided to enrollees in a plan's MTM program as part of the CMR, targeted medication review, or other MTM correspondence or service.
Timing:	At least once annually beginning on January 1, 2022.
Method of Delivery:	Hard copy, or electronically if enrollee has opted into receiving electronic version as permitted in 422.2267(d) and 423.2267(d).
HPMS Timing and Submission:	Not applicable.
Format Specification:	No model required. This information must comply with all requirements of 422.111(j).
Guidance and Other Needed Information:	See https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM for Annual MTM Program Submission Instructions memo.
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 MMP website by October 15 of each year.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	• Refer to the HPMS Marketing Module User Guide. • Submitted prior to October 15 of each year.
Format Specification:	• Ohio 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:	Ohio 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 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	The 15th of the month 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 Members	Timing of Beneficiary Receipt
Opt-in enrollment (with enrollment confirmation received more than ten (10) calendar days before the end of the month)[5]	• 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. The Member ID Card must be received no earlier than 15 calendar days prior to the effective date.
Opt-in enrollment (with enrollment confirmation received less than ten (10) calendar days before the end of the month)[5]	• 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. The Member ID Card must be received no earlier than 15 calendar days prior to the effective date.

[5] 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.

State-specific MMP Disclaimers

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

Disclaimer	Required MMP Disclaimer Language	MMP Disclaimer Instructions
Federal Contracting	<Plan's legal or marketing name> is a health plan that contracts with both Medicare and Ohio 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)
Multi-language insert	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.	Per 422.2267(e)(31) required in Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese and applicable non-English languages in those models in the CMS Required Material and Content section for which the last row of the table indicates, "*Translation required:* Yes"
Non-plan and Non-health Information	Neither Medicare nor Ohio 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.

Agent, Broker, and Other Third Party Requirements

422.2274, 423.2274

We clarify that Ohio does not permit the use of independent agents and brokers. Ohio's enrollment broker processes all MMP enrollments. We also clarify that CMS does not regulate compensation of employed agents. 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 broker or agent.

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 Ohio 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 422.2274 and 423.2274 does not apply to MMPs.

Appendix 1. Standardized Pre-Enrollment Checklist

This appendix does not apply to MMPs since all enrollments are submitted by the Ohio enrollment broker.

Appendix 2. Model Summary of Benefit Instructions

This appendix does not apply to MMPs in Ohio since they are required to use the model developed for the demonstration.

Appendix 3. Employer/Union Group Health Plans

This appendix does not apply to MMPs in Ohio.

Appendix 4. Use of Medicare Mark for Part D Sponsors

We clarify that MMPs have been required to sign a licensing agreement to use the official Medicare Mark as part of the three-way contract rather than through the HPMS contracting module. All other guidance in Appendix 4 of the MCMG applies.