Final Contract Year (CY) 2018 Marketing Guidance for South Carolina Medicare-Medicaid Plans

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Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the Contract Year (CY) 2018 Medicare Marketing Guidelines (MMG), posted at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html, apply to Medicare-Medicaid plans (MMPs), also referred to as Coordinated and Integrated Care Organizations (CICOs), participating in the South Carolina capitated financial alignment model demonstration, except as noted or modified in this guidance document.[1]

This guidance document provides information only about those sections of the MMG that are not applicable or that are different for MMPs in South Carolina; therefore, this guidance document should be considered an addendum to the CY 2018 MMG. This MMP guidance is applicable to all marketing done for CY 2018 benefits. The table below summarizes those sections of the CY 2018 MMG that are clarified, modified, or replaced for South Carolina MMPs in this guidance.

Table 1: Summary of Clarifications, Modifications, or Replacements of MMG Guidance

Medicare Marketing Guidelines (MMG) Section	**Change in this Guidance Document**
Section 10 – Introduction	Adds guidance regarding the use of logos in marketing materials, terminology, formats, and materials that the South Carolina Department of Health and Human Services (SCDHHS) needs to review outside of the Health Plan Management System (HPMS).
Section 20 – Materials Not Subject to Marketing Review	Clarifies that there are several types of materials that the South Carolina Department of Health and Human Services (SCDHHS) must review and approve prior to use but that are not required to be submitted as marketing materials in HPMS. Provides one exception to the list of materials not subject to marketing review and submission processes in this section of the MMG.
Section 30.5 – Requirements Pertaining to Non-English Speaking Populations	Clarifies the requirements of this section for MMPs.
Section 30.6 – Required Materials with an Enrollment Form	Clarifies that the requirements of this section are not applicable to MMPs.

[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) in the MMG do not apply unless specifically noted in this guidance.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter	Replaces current guidance in the MMG with guidance for MMPs.
Section 30.8 – Enrollment Verification Requirements	Clarifies the requirements of this section for MMPs.
Section 30.10 – Star Ratings Information from CMS	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.10.1 – Referencing Star Ratings in Marketing Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 30.10.2 – Plans with an Overall 5-Star Rating	Clarifies that the requirements of this section are not applicable to MMPs.
Section 40.6 – Hours of Operation Requirements for Marketing Materials	Adds requirements for MMPs to current MMG requirements of this section.
Section 40.8 – Marketing of Multiple Lines of Business	Clarifies that organizations offering both MMP and non-MMP products in a service area may not market the non-MMP products in MMP marketing materials.
Section 40.8.1 – Multiple Lines of Business – General Information	Clarifies that MMPs may not send marketing materials to current 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.
Section 40.8.3 – Marketing Materials from Third Parties that Provide Non-Benefit/Non-Health Services	Clarifies that the requirements of this section do not apply to materials produced by the State and the State's enrollment broker.
Section 40.10 – Standardization of Plan Name Type	Clarifies the requirements of this section for MMPs.
Section 60.1 – Summary of Benefits (SB)	Replaces current guidance in this section with guidance for MMPs.
Section 60.2 – ID Card Requirements	Clarifies the requirements of this section for MMPs.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 60.4 – Formulary and Formulary Change Notice Requirements	Clarifies the requirements of this section for MMPs. Extends the requirements for formulary change notifications to Medicaid-covered drugs. Adds an option for MMPs to send a distinct and separate notice alerting enrollees how to access or receive the formulary.
Section 60.5 – Part D Explanation of Benefits	Clarifies the requirements of this section for MMPs.
Section 60.6 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)	Replaces current guidance in this section with guidance for MMPs.
Section 60.7 – Other Mid-Year Changes Requiring Enrollee Notification	Extends the requirements of this section to mid-year changes in Medicaid benefits.
Section 70.2 – Marketing Through Unsolicited Contacts	Clarifies that, in addition to the requirements of this section, South Carolina's enrollment broker's information should be included on marketing materials under certain circumstances.
Section 70.4.2 – Personal/Individual Marketing Appointments	Clarifies the requirements of this section for MMP agents/brokers.
Section 70.5 – Marketing in the Health Care Setting	Extends the flexibility for facilities to provide an explanatory brochure about contracted MMPs to long-term care facilities.
Section 70.5.4 – Comparative and Descriptive Plan Information Provided by a Non-Benefit/Non-Health Service-Providing Third Party	Clarifies that the requirements of this section vis-à-vis State agencies also apply to the State's enrollment broker.
Section 80.1 – Customer Service Call Center Requirements	Replaces current guidance in this section regarding permissible use of alternate call center technologies on weekends and holidays with guidance for MMPs.
Section 80.2 – Informational Scripts	Clarifies requirements in this section for MMPs.
Section 80.3 – Enrollment Scripts/Calls	Clarifies that the requirements of this section are not applicable to MMPs.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 80.4.1 – Telephonic Contact	Clarifies and modifies the requirements of this section for MMPs
Section 90 – The Marketing Review Process	Clarifies that references in this section (and subsections) to CMS in its role in marketing reviews also apply to the State.
Section 90.2.1 – Submission of Non-English and Alternate Format Materials	Clarifies that MMPs have state-specific MMP errata codes.
Section 90.2.3 – Submission of Multi-Plan Materials	Clarifies that the requirements of this section are not applicable to MMPs.
Section 90.3 – HPMS Material Statuses Section 90.5 – Timeframes for Marketing Review	Clarifies the requirements of these sections with respect to the lack of "deeming" for jointly reviewed materials.
Section 90.6 – File & Use Process	Clarifies the File & Use certification process for MMPs.
Section 100.2 – Required Content	Adds requirements for MMPs to current MMG requirements of this section.
Section 100.2.2 – Required Documents for All Plans/Part D Sponsors	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.3 – Electronic Enrollment	Clarifies that the requirements of this section are not applicable to MMPs.
Section 100.4 – Online Formulary, Utilization Management (UM), and Notice Requirements	Extends the formulary change notice requirements of this section to non-Part D drug formulary changes.
Section 110.2 – Marketing of Rewards and Incentives Programs	Clarifies that the requirements of this section, as well as those in CMS guidance regarding rewards and incentives programs, apply to MMPs.
Section 120.6 – Activities That Do Not Require the Use of State-Licensed Marketing Representatives	Clarifies that the requirements of this section are applicable to MMPs.
Section 150 – Use of Medicare Mark for Part D Sponsors	Clarifies the requirements of this section for MMPs.

Medicare Marketing Guidelines (MMG) Section	Change in this Guidance Document
Section 160.1 – When Prior Authorization from the Beneficiary is Not Required	Clarifies that MMPs may not send marketing materials to current 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.
Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received	Replaces current disclaimer in this section with a disclaimer for MMPs.
Appendix 5 – Disclaimers	Modifies and clarifies disclaimer requirements for MMPs.

Use of Independent Agents and Brokers

We clarify that all requirements applicable to independent agents/brokers throughout the MMG **are** applicable to MMPs in South Carolina.

Model Materials

We note that materials MMPs create should take into account the reading level requirements established in the three-way contract. Available model materials reflect acceptable reading levels. Current Part D models are acceptable for use as currently provided, and MMPs must add required disclaimers in Appendix 5 of this guidance and Appendix 5 of the MMG, 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 & Use materials.

We refer MMPs to the following available model materials:

- MMP-specific model materials tailored to MMPs in South Carolina, including a Summary of Benefits, Annual Notice of Change (ANOC), Evidence of Coverage (EOC) (Member Handbook), comprehensive integrated formulary, combined Provider and Pharmacy Directory, Member ID card, integrated denial notice, and welcome letter for opt-ins and passively enrolled individuals: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

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

- Required MMP Drug-Only EOB: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

- Part D appeals and grievances models (including those in Chapter 18 of the Prescription Drug Benefit Manual): https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html and https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/PlanNoticesAndDocuments.html.

- Part C appeals and grievances models (including those in Chapter 13 of the Medicare Managed Care Manual): http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Guidance.html and http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html.

- MMP-specific ANOC/EOC (Member Handbook) errata model: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. This MMP errata model, based on the Medicare Advantage errata model, may be helpful to MMPs in creating their own errata notices.

Provider and Pharmacy Directory Requirements

Guidance related to Provider and Pharmacy Directories is no longer included in the MMG and is, instead, available in Chapter 4 of the Medicare Managed Care Manual, the January 17, 2017 HPMS memorandum entitled, "Provider Directory Policy Updates," Chapter 5 of the Prescription Drug Benefit Manual, and the August 16, 2016 HPMS memorandum entitled "Pharmacy Directories and Disclaimers." This guidance on general, update, dissemination and timing, online directories, disclaimers, and submission requirements for directories applies to the MMP directory with the following modifications:

- MMPs are required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. However, as provided in section 110.2.1 of Chapter 4 of the Medicare Managed Care Manual, MMPs may print separate directories for primary care providers (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.

- MMPs must use the model Provider and Pharmacy Directory document provided to South Carolina MMPs by CMS and the State. The model will be consistent with directory requirements in the three-way contract. A non-model directory is not permitted.

- 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.

- The MMP Provider and Pharmacy Directory is considered a marketing material and must be submitted in the HPMS marketing module. MMPs may obtain more information about the specific review parameters and timeframes for the Provider and Pharmacy Directory under the South Carolina capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. In addition, we note that, the guidance in section 110.2.6 of Chapter 4 of the Medicare Managed Care Manual regarding submission of updates and/or addenda pages does not apply to South Carolina MMPs. South Carolina MMPs must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the South Carolina MMP Provider and Pharmacy Directory marketing code.

Compliance with Section 1557 of the Affordable Care Act of 2010

MMPs are subject to the disclosure requirements under Section 1557 of the Affordable Care Act. For more information, MMPs should refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557/.

Following are the South Carolina MMP-specific modifications to the MMG for CY 2018.

Section 10 – Introduction

Logos

For purposes of the South Carolina demonstration, MMPs are subject to following guidance for use of the Healthy Connections Prime logo (the logo):

- All marketing, advertising, media (including Internet and social media sites), and member education materials must contain the logo.

- Other educational materials not included above and third-party publications (e.g., CDC guidelines, dietary information, disease management) do not require the logo as long as the MMP's name, logo and/or telephone number are not present. However, the logo must be present if the MMP's logo and/or telephone number is present.

- The logo and the MMP's logo and associated telephone numbers must be proportional in size and location.

- Promotional materials, including items identified as "giveaways," which contain the MMP's logo must also contain the logo. If limited by dimensions of the promotional material, the plan and the Healthy Connections Prime logos do not need to be the same size.

- The first page of any material that includes the MMP's logo should also include the logo, but the logo is not required on subsequent pages.

- Envelopes may, but are not required to, include the logo; however, consistent with Appendix 5 of the MMG, envelopes are required to include the MMP's name or logo.

- The logo and the MMP's logo should be the same height and appear next to each other wherever possible.

- The MMP's logo should be on the left and the logo should be on the right when they appear next to each other, with the exception of the Member ID Card or any other model template document that specifically requires different placement. Logos that appear next to each other or on the same line of a page should be bottom-aligned (if the logos are approximately the same height) or center-aligned (if the logos are not approximately the same height).

- The MMP's logo should be above the logo when they appear above each other and should be center-aligned.

- The logo must be in color if the MMP's logo appears in color.

- The logo and the MMP's logo should retain their natural proportional size and should not appear stretched, distorted or pixelated. <u>The logos must be in the high resolution provided by the State. Lower resolution images are not allowed.</u> MMPs should check the resolution of the logos before finalizing materials.

Time Formats

The State has seen varying formats for showing hours of operations within the same paragraph or document and across documents. To standardize the formatting of times, please use: "XX x.m." when the time is on the hour and "XX:XX x.m." in all other instances (e.g., 8 a.m. to 5:30 p.m.)

MMP Member Services Toll-Free Number

All marketing, advertising, and member education materials the MMP sends (with the exception of envelopes) must include the MMP's Member Services toll-free number.

South Carolina Healthy Connections Medicaid References

In referencing Medicaid, MMPs must use "South Carolina Healthy Connections Medicaid" only in the first instance of each document. MMPs may use "Healthy Connections Medicaid" for all other instances in each document.

Other Terminology Preferences

MMPs must also:

- In referencing "Prime," use "Healthy Connections Prime"
- Use "member" instead of "enrollee"
- Use "primary care provider" instead of "primary care physician."
- Use "nursing home" instead of "nursing facility", unless it is in the context of a "skilled nursing facility."
- Use "initial health screen" instead of "health risk assessment."
- Choose between "care manager" and "care coordinator" and be consistent through the documents.
- Use "Medicare-Medicaid Plan" instead of "Medicare-Medicaid plan". This is a change to Healthy Connections Prime's approach in order to align with CMS's approach.

Section 20 – Materials Not Subject to Marketing Review

In addition to the guidance in section 20 of the MMG, we clarify that there are several types of materials that are not required to be submitted as marketing materials in HPMS but that the State must receive an electronic copy at least seven (7) business days prior to distribution. In the email, the MMP must certify that the materials comply with the MMG and the state marketing guidance. The South Carolina Department of Health and Human Services (SCDHHS) reserves the right to disapprove an item that is incomplete, incorrect, unclear, misleading or uncorrected, or contains disallowed content. If the disapproval is not provided within seven (7) business days, the MMP can proceed with the distribution. However, should the State disapprove after seven (7) business day, the MMP must halt distribution and revise the item immediately unless otherwise agreed upon by the State.

Materials covered by this section include:

- All provider-facing material that contains details about the Healthy Connections Prime program. (Member-facing material should go through HPMS whenever possible.) Examples include:
    - "Quick reference" sheets that contain Healthy Connections Prime-specific information about prior authorization, member/provider services numbers, appeals, etc.
    - Provider appeals and grievances information, since these business processes are likely to use different time frames than MMP standard Medicaid lines of business
    - Invitations to multi-disciplinary team meetings
- Training on multi-disciplinary teams (MDT)s or other aspects of Healthy Connections Prime. Note that general provider training material does not need to be submitted unless it addresses the Healthy Connections Prime program or members in particular
- Material for Member Advisory Committees or similar groups. This includes letters inviting members to serve on the committee, meeting presentations, etc. These materials can be submitted to the Healthy Connections Prime inbox.
    - Any items that use the Healthy Connections Prime logo. If the plan is only requesting a logo review, the MMP should state that in the email. Examples include:
        - Standard letters or other material where the only Prime-specific modification is the use of the Healthy Connections Prime logo.
        - Giveaway items (pens, mints, etc.) with the plan logo, and Healthy Connections Prime logo. If limited by dimensions of the giveaway items, the plan and the Healthy Connections Prime logos do not need to be the same size.

For these types of materials, MMPs should:

- Send them via email them to prime@scdhhs.gov and copy dustin.welch@scdhhs.gov
    - For Absolute Total Care, also copy brienne@ikasoconsulting.com
    - For First Choice VIP Care Plus and Molina Dual Options materials, also copy dvillamil@ikasoconsulting.com
- Use as the subject heading: **"[Plan name] NSR Submission: [item description]"**

General information for providers about doing business with the plan does not need to be submitted for review.

MMPs should feel free to ask SCDHHS directly if there are any questions about whether or not material is appropriate for submission. It is better to err on the side of caution.

In addition, we note that the requirements of section 20 of the MMG apply to MMPs with the following modification:

- The MMP Provider and Pharmacy Directory is considered a marketing material and must be submitted in the HPMS marketing module. MMPs may obtain more information about the specific review parameters and timeframes for the Provider and Pharmacy Directory under the South Carolina capitated financial alignment model demonstration in the Marketing Code Look-up functionality in the HPMS marketing module.

Section 30.5 – Requirements Pertaining to Non-English Speaking Populations

The standard articulated in this section for translation of marketing materials into non-English language will be superseded to the extent that South Carolina's standard for translation of marketing materials is more stringent. Guidance regarding the translation requirements for all plans, including MMPs, is released annually each fall. Required languages for translation for the MMP are also updated annually, as needed, in the HPMS Marketing Module. We expect that the South Carolina translation standard – which requires translation of materials into "prevalent languages" (i.e., Spanish and any language that is the primary language of 5% or more of the MMP service area population) – will again exceed the Medicare standard for translation in South Carolina MMP services areas for CY 2018.

> For more information on South Carolina's specific Section 1557 requirements, please refer to the Section 1557 communication on September 29, 2016 and a Guidance Update memos from Healthy Connections Prime released to MMPs on December 6, 2016, which can be found at https://msp.scdhhs.gov/SCDue2/sites/default/files/Healthy%20Connections%20Prime%20-%201557%20Guidance%20Update%20Memo%20%28Dec%206%202016%29.pdf

For South Carolina MMPs, required materials for translation are the SB, ANOC/EOC (Member Handbook), formulary (List of Covered Drugs), Provider and Pharmacy Directory, the distinct and separate notice alerting enrollees how to access or receive the directory described in Chapter 4 of the Medicare Managed Care Manual, the integrated denial notice, and the Part D transition letter.[2]

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 Module, at the time of request and on an ongoing basis thereafter.

Final populated translations of all marketing materials must be submitted in HPMS (see section 90.2 of the MMG for more information about the material submission process).

[2] CMS will make available Spanish translations of the South Carolina MMP Summary of Benefits (SB), formulary, provider/pharmacy directory, and ANOC/EOC (Member Handbook). These are posted at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. CMS makes available a Spanish 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-Marketing-Materials.html.

For additional information regarding notice and tagline requirements, please refer to Appendix A and B to Part 92 of Section 1557 of the Patient Protection and Affordable Care Act.

Section 30.6 – Required Materials with an Enrollment Form

Because the Medicare-Medicaid Coordination Office (MMCO) is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, MMPs will not be required to include the Star Ratings Information document when a beneficiary is provided with any enrollment information. We further clarify that the responsibility for sending enrollment and disenrollment notices to enrollees will be delegated to South Carolina's enrollment broker, with the exception of any notices delegated to MMPs, as described in Appendix 5 of the MMP Enrollment and Disenrollment Guidance (see https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html).

Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter

This section is replaced with the following revised guidance:

> **Section 30.7 – Required Materials for New and Renewing Enrollees at Time of Enrollment and Thereafter**
>
> 42 CFR 422.111(c)(1), 423.128(c)(1), 422.2264(a), 423.2264(a)
>
> The following materials must be provided to enrollees at the time of enrollment and annually thereafter:
>
> - ANOC/EOC (Member Handbook), or a standalone EOC (Member Handbook), as applicable and described in the replacement guidance for section 60.6 of the MMG contained in this document.
>
> - A comprehensive integrated formulary (List of Covered Drugs) that includes Medicare and Medicaid outpatient prescription drugs and over-the-counter pharmacy drugs or products provided under the MMP, or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs.
>
> - A combined Provider and Pharmacy Directory that includes all providers of Medicare, Medicaid and additional benefits, or a distinct and separate notice alerting enrollees how to access or receive the directory (required at the time of enrollment and annually thereafter).
>
> - A single Member ID Card for accessing all covered services under the plan (required at the time of enrollment and as needed or required by the MMP post-enrollment).
>
> - For individuals enrolled through passive enrollment, a demonstration plan-specific SB containing a concise description of the important aspects of enrolling in the

plan, as well as the benefits offered under the plan, including copays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits. Because the EOC (Member Handbook) may not be received until just prior to the effective date of a passive enrollment, the SB must be received by individuals enrolled through passive enrollment prior to receipt of the EOC (Member Handbook) to ensure that they have sufficient information about plan benefits to make an informed decision prior to the passive enrollment effective date. Refer to the revised guidance for section 60.6 of the MMG contained in this document for more information about when an SB must be received by current enrollees post-enrollment.

MMPs must send enrollees who opt in to the demonstration the following materials for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever occurs later. 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. For late-month enrollment transactions (those for which CMS confirmation of enrollment is received less than ten (10) calendar days before the end of the month prior to the effective date), MMPs must send enrollees these materials for receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment. 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.

- A welcome letter, which must contain 4Rx information, consistent with a model developed jointly by CMS and the State

- A comprehensive integrated formulary (List of Covered Drugs), or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs)

- A combined Provider and Pharmacy Directory, or a distinct and separate notice alerting enrollees how to access or receive the directory, consistent with the requirements in Chapter 4 of the Medicare Managed Care Manual

- A single Member ID Card

- An EOC (Member Handbook)

MMPs must send enrollees who are passively enrolled the following materials for receipt no later than 30 calendar days prior to the effective date of enrollment:

- A welcome letter, which must contain 4Rx information, consistent with a model developed jointly by CMS and the State

- A comprehensive integrated formulary (List of Covered Drugs), or a distinct and separate notice alerting enrollees how to access or receive the formulary (List of Covered Drugs)

- A combined Provider and Pharmacy Directory, or a distinct and separate notice alerting enrollees how to access or receive the directory, consistent with the requirements in Chapter 4 of the Medicare Managed Care Manual

- An SB

In addition, MMPs must provide enrollees who are passively enrolled an EOC (Member Handbook) and a single Member ID Card for receipt by the end of the month preceding the month the enrollment will take effect (e.g., the Member ID Card and EOC (Member Handbook) must be received by a beneficiary by January 31 for a February 1 effective enrollment date).

After the time of initial enrollment for both enrollees who are passively enrolled and enrollees who opt in to the demonstration, the ANOC and EOC (Member Handbook) must also be provided annually consistent with the replacement guidance for section 60.6 of the MMG contained in this document.

Additional informational materials related to plan benefits or operations may be included in these required mailings to new and current enrollees – both at the time of enrollment and annually thereafter, consistent with the requirements of section 60.3 of the MMG.

The following tables summarize the requirements of this section.

Table 2: Required Materials for New Members

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	30 calendar days prior to the effective date of enrollment
	• Member ID Card • EOC (Member Handbook)	No later than the day prior to the effective date of enrollment
Opt-in enrollment (with enrollment confirmation received more than 10 calendar days before the end of the month)	• 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)	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)	• 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)	No later than 10 calendar days from receipt of the CMS confirmation of enrollment

Table 3: Required Materials for Renewing Members

Required Materials for Renewing Members	Timing of Beneficiary Receipt
• ANOC/EOC (Member Handbook) • Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary) OR • ANOC • SB • Formulary (or a distinct and separate notice alerting enrollees how to access or receive the formulary)	September 30 The ANOC, SB, and List of Covered Drugs (Formulary) must be posted on plan websites by September 30. The EOC (Member Handbook) must only be posted by September 30 if it is sent with the ANOC.
If only the ANOC, SB, and formulary are sent by September 30: • EOC (Member Handbook)	December 31 The EOC (Member Handbook) must be posted on plan websites by December 31. The ANOC, SB, and formulary (List of Covered Drugs) must still be posted by September 30.
Member ID Card	As needed
Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory)	September 30. The plan website's directory must be kept up-to-date consistent with Chapter 4 of the Medicare Managed Care Manual. The Provider and Pharmacy Directory must be posted on plan websites by September 30.

Section 30.8 – Enrollment Verification Requirements

We clarify that we consider an Medicare Advantage (MA) to MMP plan change, even if within the same parent organization, to be a plan switch that triggers the outbound enrollment and verification requirements described in section 30.8 of the MMG.

Section 30.10 – Star Ratings Information from CMS

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this section does not apply to MMPs.

Section 30.10.1 – Referencing Star Ratings in Marketing Materials

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this section does not apply to MMPs.

Section 30.10.2 – Plans with an Overall 5-Star Rating

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this section does not apply to MMPs.

Section 40.6 – Hours of Operation Requirements for Marketing Materials

In addition to the requirements of this section, MMPs must also provide the phone and TTY/TTD numbers and days and hours of operation information for South Carolina'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.

Section 40.8 – Marketing of Multiple Lines of Business

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.

Section 40.8.1 – Multiple Lines of Business – General Information

We clarify that MMPs may not send marketing materials to current 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. Such materials may only be sent when a current enrollee proactively makes a request for information about other Medicare products.

Section 40.8.3 – Marketing Materials from Third Parties that Provide Non-Benefit/Non-Health Services

In addition to the guidance in this section, CMS and the State clarify that materials produced by the State and distributed by South Carolina's enrollment broker do not constitute non-benefit/non-health service-providing third-party marketing materials. Therefore, such materials do not need to be submitted to the plan for review prior to their use. As indicated in section 20 of the MMG, the MMG do not apply to communications by State governments, and materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials.

Section 40.10 – Standardization of Plan Name Type

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,

consistent with the requirements of section 40.10 of the MMG. South Carolina also refers to MMPs as Medicare-Medicaid Plans and has provided additional information about branding for the demonstration.

To reduce beneficiary confusion, we also clarify that MMPs in South Carolina that offer Medicare Advantage products, including special needs plans (SNPs), in the same service area as their MMPs may not use the same plan marketing name for both 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).

Section 60.1 – Summary of Benefits (SB)

This section is replaced with the following revised guidance. We also note that Appendix 4 of the MMG does not apply to MMPs.

> **Section 60.1 – Summary of Benefits (SB)**
>
> 42 CFR 422.111(b)(2), 423.128(b)(2)
>
> MMPs must use the Summary of Benefits (SB) model document provided by CMS and the State. A non-model SB is not permitted. 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.

Section 60.2 – ID Card Requirements

MMPs are required to meet the Member ID card content requirements in sections 60.2, 60.2.1 and 60.2.2 of the MMG. We clarify, however, that 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. MMPs must use the model Member ID Card document provided by CMS and the State. A non-model Member ID Card is not permitted.

Section 60.4 – Formulary and Formulary Change Notice Requirements

The requirements of section 60.4, 60.4.1, 60.4.2, 60.4.3, 60.4.4, 60.4.5, and 60.4.6 of the MMG apply to MMPs with the following modifications:

- 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;

- MMPs are only permitted to make available a comprehensive, not abridged, formulary (List of Covered Drugs);

- MMPs must use the model formulary (List of Covered Drugs) document provided by CMS and the State (a non-model formulary (List of Covered Drugs) is not permitted); and

- Formulary change notices must be sent for any negative formulary change (as described in section 30.3.3, “Midyear Formulary Changes,” and section 30.3.4, “Provision of Notice

Regarding Formulary Changes," of Chapter 6 of the Prescription Drug Benefit Manual), regardless of whether the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan. Consistent with the guidance in the MMG, this notice must be provided to affected enrollees at least 60 calendar days prior to the change.

We note that the new option available to all Part D sponsors in section 60.4 of the MMG to send either a hard copy formulary (List of Covered Drugs) or a distinct and separate notice (in hard copy) describing where enrollees can find the formulary (List of Covered Drugs) online and how enrollees can request a hard copy formulary also applies to South Carolina MMPs starting with Contract Year 2018. MMPs should refer to section 60.4 of the MMG for additional detail about these requirements.

Section 60.5– Part D Explanation of Benefits

MMPs are required to meet the Part D Explanation of Benefits (EOB) requirements in section 60.5 of the MMG. We clarify, however, that MMPs must meet this requirement by using the South Carolina-specific MMP Drug-Only EOB model provided by CMS and the State.

Section 60.6 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

This section is replaced with the following revised guidance:

Section 60.6 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) (Member Handbook)

42 CFR 417.427, 422.111(a)(3), 422.111(d)(2), 423.128(a)(3)

MMPs are required to send an ANOC summarizing all major changes to the plan's covered benefits from one contract year to the next prior to the beginning of the second contract year of the demonstration and annually thereafter. The MMP may send the ANOC and EOC (Member Handbook) as a combined document or separately, as provided below. South Carolina MMPs must use the model ANOC and EOC (Member Handbook) documents provided by CMS and the State.

MMPs must send the ANOC for member receipt by September 30 each year. The EOC (Member Handbook) may be sent as a standalone document as follows:

- MMPs must send new enrollees (whether they opt in to the demonstration or are passively enrolled) an EOC (Member Handbook) for member receipt by the end of the month preceding the month the enrollment will take effect (e.g., the document must be received by a beneficiary by June 30 for a July 1 effective enrollment date). For late-month enrollment transactions (those for which CMS confirmation of enrollment is received less than ten (10) calendar days before the end of the month prior to the effective date), MMPs must send these materials for member receipt no later than ten (10) calendar days from receipt of CMS confirmation of enrollment.

- After the time of initial enrollment, MMPs must annually send an EOC (Member Handbook) for member receipt by December 31. MMPs choosing

this option (rather than a combined ANOC/EOC (Member Handbook) by September 30) must also send an SB with the ANOC.

New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current contract year, as well as a combined ANOC/EOC (Member Handbook) document for the upcoming contract year. We clarify that, for these members, the combined ANOC/EOC (Member Handbook) for the upcoming year, as well as the formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the formulary), and the Provider and Pharmacy Directory (or distinct and separate notice alerting enrollees how to access the directory online or obtain a hard copy) for the upcoming year, must be received by one month after the effective date of enrollment, but not later than December 15th.

Additional informational materials beyond the materials required to be sent with the ANOC/EOC (Member Handbook) or separate ANOC and EOC (Member Handbook) may be included with the ANOC, EOC (Member Handbook), or ANOC/EOC (Member Handbook) mailings consistent with the requirements of section 60.3 of the MMG.

We remind MMPs that they must upload in HPMS either (1) a standalone ANOC and a standalone EOC (Member Handbook), or (2) a combined ANOC/EOC (Member Handbook). MMPs should only use the combined ANOC/EOC (Member Handbook) material code if they are sending enrollees a combined document. Otherwise, MMPs should use both the standalone EOC and the standalone ANOC codes. Submitting materials under both standalone and combined ANOC/EOC (Member Handbook) codes will impact CMS' ANOC and EOC (Member Handbook) timeliness and accuracy monitoring efforts and may subject MMPs to compliance action.

To ensure timely mailing of their annual ANOC/EOC (Member Handbook), plans must indicate the actual mail date (AMD) and the number of enrollees who were mailed the documents in HPMS within fifteen (15) calendar days of mailing. This includes mail dates for alternate materials. We remind MMPs that they should enter AMD information in HPMS for mailings to current members only. Plans should not enter AMD information for October 1, November 1, or December 1 effective dates, or for January 1 effective dates for new members. MMPs that mail in waves should enter the AMD for each wave. MMPs may enter up to ten waves of mailings. MMPs that use a standalone ANOC and a standalone EOC (Member Handbook) must enter AMD information for one to ten mailing waves, as applicable, separately for both materials. MMPs that use a combined ANOC/EOC (Member Handbook) should enter AMD information for one to ten mailing waves, as applicable, only for the combined ANOC/EOC. For instructions on meeting this requirement, refer to the *Update AMD/Beneficiary Link/Function* section of the Marketing Review Users Guide in HPMS.

Note: For a single mailing to multiple recipients, as allowed under section 30.7.1 of the MMG, MMPs should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed.

MMPs must use an errata notice to notify enrollees of certain plan errors in their original mailings. We clarify that errata notices should only be used to notify enrollees of plan errors in MMP materials. 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 section 60.7 of this guidance and section 60.7 of the MMG. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to plan error.

Section 60.7 – Other Mid-Year Changes Requiring Enrollee Notification

The notification requirements for mid-year Medicare benefit changes described in this section are also applicable to mid-year Medicaid or required demonstration additional benefit changes.

Plans must provide written notification of mid-year changes to enrollees and providers as well as publication on the plan website at least 30 days before the intended effective date of the change. We note that this requirement is separate from the requirement to provide notice of formulary changes in section 60.4 of this guidance.

Section 70.2 – Marketing Through Unsolicited Contacts

Section 70.2 of the MMG provides 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, both here and in section 70.2 of this guidance that MMP marketing to current enrollees (including those enrolled in other product lines such as its Medicaid managed care product) is not considered unsolicited direct contact and, therefore, is permissible.

In addition to the requirements of section 70.2, MMPs conducting permitted unsolicited marketing activities such as conventional mail and other print media are required to include the unsolicited marketing materials disclaimer in Appendix 5 of this guidance on all materials used for that purpose. For purposes of this section, enrollment materials sent to passively enrolled individuals are not considered marketing through unsolicited contact.

Section 70.4.2 – Personal/Individual Marketing Appointments

The provisions of this section apply to MMPs, with the following modifications for appointments with agents/brokers:

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

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

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

Section 70.5 – Marketing in the Health Care Setting

The flexibility provided in the last paragraph of this section for long-term care facility staff to provide residents meeting the eligibility criteria for an Institutional Special Needs Plan (I-SNP) with an explanatory brochure for each I-SNP with which the facility contracts is also

applicable to MMPs.

Section 70.5.4 – Comparative and Descriptive Plan Information Provided by a Non-Benefit/Non-Health Service-Providing Third Party

We clarify that the guidance in this section referring to materials provided by a "State agency" also applies to materials produced by the State and/or distributed by South Carolina's enrollment broker.

Section 80.1 – Customer Service Call Center Requirements

This section is replaced with the following revised guidance:

> **Section 80.1 – Customer Service Call Center Requirements**
>
> 42 CFR 422.111(h)(1), 423.128(d)(1)
>
> MMPs must operate a toll-free call center for both current and prospective enrollees seven (7) days a week, at least from 8 a.m. to 8 p.m. ET, except as provided below. During this time period, current and prospective enrollees must be able to speak with a live customer service representative (CSR). MMPs may use alternative technologies on Saturdays, Sundays and State and 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 the required information listed below, and/or allow a beneficiary to leave a message in a voice mail box. A CSR must then return the call in a timely manner, no more than one business day later.
>
> The use of a call center and the provision of information through a call center are mandatory for all MMPs.
>
> Call centers must meet the following operating standards:
>
> - Provide information in response to inquiries outlined in sections 80.2-80.4 of the MMG. If callers are transferred to a third party for provision of the information listed in sections 80.2 and 80.4 of the MMG, all other requirements in this section apply to the services as performed by the third party.
>
> - Follow an explicitly defined process for handling customer complaints.
>
> - Provide interpreter services to all non-English speaking, limited English-proficient, and hearing impaired beneficiaries.
>
> - Inform callers that interpreter services are "free." Interpreters should be available within eight (8) minutes of reaching the CSR.
>
> - Provide TTY service to all hearing impaired beneficiaries. CSRs through the TTY service should be available within seven (7) minutes of the time of answer.

- Limit average hold time to two (2) minutes. The average hold time is defined as the time spent on hold by the caller following the IVR system, touch-tone response system, or recorded greeting and before reaching a live person.

- Answer eighty (80) percent of incoming calls within thirty (30) seconds.

- Limit the disconnect rate of all incoming calls to five (5) percent. A disconnected call is defined as a call that is unexpectedly dropped by the MMP.

Hold time messages (messages played when an enrollee or prospective enrollee is on hold when calling the plans) that promote the MMP or include benefit information must be submitted in HPMS for review as marketing materials (see section 90.2 of the MMG for more information about the material submission process). MMPs are prohibited from using hold time messages to sell other products.

For Pharmacy Technical Help or Coverage Determinations and Appeals Call Center requirements, refer to Appendix 3 in the MMG.

Section 80.2 –Informational Scripts

We clarify that informational calls to plan call centers that become sales/enrollment calls at the proactive request of the beneficiary must be transferred to South Carolina's enrollment broker. 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.

MMPs should refer to section 120.6 of this guidance, as well as section 120.6 of the MMG, for clarification of the types of activities conducted by a plan customer service representative that do not require the use of State-licensed marketing representatives. MMPs must use a State-licensed (and, when required, appointed) marketing agent for any activity that meets the definition of marketing in Appendix 1 of the MMG.

Section 80.3 – Enrollment Scripts/Calls

This section does not apply to MMPs because enrollment requests must be transferred to South Carolina's enrollment broker.

Section 80.4.1 – Telephonic Contact

The requirements of section 80.4.1 of the MMG 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.

- Consistent with section 80.4.1 of the MMG, 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 enrollees (for example, 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 Insurance Counseling Assistance and Referrals for Elders (I-CARE) program (I-CARE is the State Health Insurance Assistance Program in South Carolina, and contact information is provided in Chapter 2 of the Member Handbook) for information and assistance.

- MMPs may call enrollees who are in the process of disenrolling before the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes. This is consistent with South Carolina Healthy Connections Medicaid policy in other program areas and allows contact with members solely for the purpose of learning the reasons for disenrollment. It is not permissible to engage in discussions to change the enrollee's choice to disenroll.

Section 90 – The Marketing Review Process

Any references in this section of the MMG, and in all subsections thereunder, to CMS in its role in reviewing marketing materials are also references to the State for purposes of MMP marketing material review.

Section 90.2.1 – Submission of Non-English and Alternate Format Materials

The requirements of this section apply without modification. We note, however, that MMPs should use state-specific MMP errata codes. For more information about errata codes, MMPs should consult the Marketing Code Look-up functionality in the HPMS marketing module.

Section 90.2.3 – Submission of Multi-Plan Materials

This section does not apply to MMPs.

Section 90.3 – HPMS Material Statuses

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 under the South Carolina capitated financial alignment demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. All other guidance in this section of the MMG and its subsections applies.

Section 90.5 – Timeframes for Marketing Review

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 under the South Carolina capitated financial alignment demonstration in the Marketing Code Look-up functionality in the HPMS marketing module. All other guidance in this section of the MMG and its subsections applies.

Section 90.6 – File & Use Process

We clarify that the File & Use certification process for MMPs is included in the three-way contract. All other guidance in section 90.6 of the MMG and all its subsections applies.

Section 100.2 – Required Content

In addition to the requirements outlined in this section, MMPs must also include on their website a direct link and the phone number for the options counselors known as SC Thrive, and/or the State enrollment broker. MMPs must also include information on the potential for contract termination (i.e., a statement that the MMP may terminate or non-renew its contract, or reduce its service area, and the effect any of those actions may have on MMP enrollees, as required under 42 CFR 422.111(f)(4)), and information that materials are published in alternate formats (e.g., large print, braille, audio).

Section 100.2.2 – Required Documents for All Plans/Part D Sponsors

The requirements of this section apply with the following modifications:

- MMPs will not be required to post the low-income subsidy (LIS) Premium Summary Chart as this document will not be applicable to MMPs.

- Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, MMPs are not required to post a CMS Star Ratings document on their websites.

Section 100.3 – Electronic Enrollment

This section is not applicable to MMPs. The Online Enrollment Center is not enabled for MMPs, and MMPs are not permitted to directly enroll individuals through a secure Internet website. All enrollments are processed via South Carolina's enrollment broker.

Section 100.4 – Online Formulary, Utilization Management (UM), and Notice Requirements

Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on MMP websites as required in this section. All other guidance in this section applies without modification.

Section 110.2 – Marketing of Rewards and Incentives Programs

MMPs may market rewards and incentives to current enrollees, as provided in section 110.2 of the MMG. Any rewards and incentives programs must be consistent with section 100 of Chapter 4 of the Medicare Managed Care Manual.

Section 120.6 – Activities That Do Not Require the Use of State-Licensed Marketing Representatives

Consistent with section 120.6 of the MMG, 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 in Appendix 1 of the MMG.

Section 150 – 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 section 150 of the MMG and all its subsections applies.

Section 160.1 – When Prior Authorization from the Beneficiary Is Not Required

We clarify that MMPs may not send marketing materials to current 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. Such materials may only be sent when a current enrollee proactively makes a request for information about other Medicare products.

Section 160.4 – Sending Non-Plan and Non-Health Information Once Prior Authorization Is Received

The disclaimer described in this section should be modified as follows:

> "Neither Medicare nor South Carolina Healthy Connections Medicaid has reviewed or endorsed this information."

Appendix 5 – Disclaimers

The disclaimers in Appendix 5 of the MMG apply to MMPs except as modified or clarified below.

Federal Contracting Disclaimer

This disclaimer is replaced with the following revised MMP-specific disclaimer:

> **Federal and State Contracting Disclaimer**
>
> 42 CFR 422.2264(c), 423.2264(c)
>
> All marketing materials must include the statement that the MMP contracts with both the Federal and the State government. The MMP should include the contracting statement either in the text or at the end/bottom of the piece. The following statement must be used:
>
> > "<Plan's legal or marketing name> is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees."

NOTE: In addition to the exceptions noted in section 50 of the MMG, radio television, and internet banner ads do not need to include the Federal and State contracting disclaimer.

Benefits Are Mentioned

These disclaimers are replaced with the following revised MMP-specific disclaimers:

Benefits Are Mentioned

42 CFR 422.111(a) and (b), 422.2264, 423.128(a) and (b), 423.2264

The following disclaimers must be used when benefit information is included in marketing materials:

> Only for summary documents like the SB: "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 refer to the Member Handbook."
>
> "Limitations [, copays,] and restrictions may apply. For more information, call <plan name> <Member Services> or refer to the <plan name> Member Handbook."
>
> "Benefits [and/or copays] may change on January 1 of each year."

Plan Premiums Are Mentioned

This disclaimer does not apply to MMPs, as MMPs are not permitted to assess plan premiums, and States will pay Medicare Part B premiums on behalf of Medicare-Medicaid enrollees in MMPs.

Availability of Non-English Translations

This disclaimer is replaced with the following revised MMP-specific disclaimer:

Availability of Non-English Translations

42 CFR 422.2264(e), 423.2264(e)

South Carolina must place the following non-English language disclaimer on the materials identified as required for translation into non-English languages in section 30.5 of this guidance: The non-English disclaimer must be placed below the English version and in the same font size as the English version.

> "If you speak <insert language of the disclaimer>, language assistance services, free of charge, are available to you. Call <insert Member Services toll-free phone and TTY/TDD numbers, days and hours of operation>. The call is free."

The non-English language disclaimer must be included in Spanish and any other non-English languages that meet the more stringent of either the Medicare or and/or state thresholds for translation.

For more information on South Carolina's specific Section 1557 requirements, please refer to the Section 1557 communication on September 29, 2016 and a Guidance Update memos from Healthy Connections Prime released to MMPs on December 6, 2016, which can be found at https://msp.scdhhs.gov/SCDue2/sites/default/files/Healthy%20Connections%20Prime%20-%201557%20Guidance%20Update%20Memo%20%28Dec%206%202016%29.pdf

Referencing NCQA Approval

We clarify that the prohibition on discussion of numeric Special Needs Plan (SNP) approval scores in marketing materials or press releases also applies to MMPs. MMPs may only include the following information related to their National Committee for Quality Assurance (NCQA) Model of Care approval:

> "<Plan name> has a Model of Care approved by the National Committee for Quality Assurance (NCQA) and Healthy Connections Medicaid until <last contract year of NCQA and State approval of Model of Care> based on a review of <plan name>'s Model of Care."

Mentioning Cost-Sharing Information on D-SNP Materials

This disclaimer is replaced with the following revised MMP-specific disclaimer:

> **Mentioning Cost-Sharing Information on MMP Materials**
>
> 42 CFR 422.2, 422.4(a)(1)(iv), 422.111(b)(2)(iii), 422.2264, 423.2264
>
> The following disclaimer must be on any MMP materials that mention Part D benefits unless the plan charges $0 copays for all Part D drugs:
>
> > "Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details."

Plans Accepting Online Enrollment Requests

This disclaimer does not apply to MMPs, as the Online Enrollment Center on the Medicare Plan Finder website is not available to MMPs.

Referencing Star Ratings Information

Because MMCO is in the process of developing a Star Ratings system for MMP performance, MMPs will not be subject to the Star Ratings requirements in the MMG. Therefore, this disclaimer does not apply to MMPs.

Pharmacy/Provider Network and Formulary

This disclaimer is replaced with the following revised MMP-specific disclaimer:

> **Provider and Pharmacy Network and Formulary (List of Covered Drugs)**

42 CFR 422.111(a) and (b), 423.128(a) and (b)

The following disclaimer must be included on materials whenever the formulary (List of Covered Drugs) or provider and pharmacy networks are mentioned: “The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.”

Unsolicited Marketing Materials

This disclaimer is replaced with the following revised MMP-specific disclaimer:

Unsolicited Marketing Materials

In addition to required disclaimers in Appendix 5 of the MMG and Appendix 5 of this guidance, the following additional disclaimer is required for MMPs.

As provided in section 70.2 of this guidance, 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 South Carolina Healthy Connections Choices Customer Service Center at (877) 552-4642, TTY (877) 552-4670, from <hours and days of operation>, or visit www.scchoices.com.”

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