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2013 Medicare Marketing Guidelines Present New Compliance Challenges

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On June 6, the Centers for Medicare & Medicaid Services released its final 2013 Medicare Marketing Guidelines-(Chapter 3 of the *Medicare Managed Care Manual*), which are applicable to marketing practices utilized by Medicare Plans, Medicare Advantage Plans, Prescription Drug Plans (referred to as Plans), and their contracted providers.

The 2013 Medicare Marketing Guidelines went through extensive revisions to make them less prescriptive. The most significant changes include new timeframe requirements for outbound enrollment and verification calls, revised disclaimers, website review submission, star rating marketing restrictions, and a new multi-language insert required to be included with certain marketing materials.

Medicare Marketing Guiding Principles

The following ''Guiding Principles'' were developed to provide a common sense approach to interpreting marketing requirements:

■ *Guiding Principle #1*—Plan sponsors are responsible for ensuring compliance with CMS's current marketing regulations and guidance, including monitoring and overseeing the activities of their subcontractors, downstream entities, and/or delegated entities.

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■ *Guiding Principle #2*—Plan sponsors are responsible for full disclosure when providing information about plan benefits, policies, and procedures.

■ *Guiding Principle #3*—Plan sponsors are responsible for documenting compliance with all applicable Medicare Marketing Guidelines requirements.

The first Guiding Principle is applicable to anything that the plan's and/or their designees conduct, including, but not limited to, marketing events, marketing materials, marketing material distribution, and collecting and disseminating information.

The Guiding Principle also applies to anyone that a Plan has delegated some responsibility to implement, including agents and brokers, third-party marketing organizations, providers, and pharmacy benefit managers.

The second Guiding Principle emphasizes the importance for Medicare beneficiaries to have complete information to make informed choices. Plans should use sound judgment to make sure that beneficiaries have enough information.

The third Guiding Principle was developed to ensure that Plans have systems and processes in place with all aspects of their marketing program, that Plans provide oversight of systems and processes, and that Plans have clearly defined processes and procedures.

The Guiding Principles should be used by Plan sponsors as guidance into how to structure marketing programs and plans.

Plan 5-Star Ratings Information from CMS

Plan Ratings information documents must be distributed with any enrollment form or Summary of Benefits and be available on plan websites.

Plan sponsors may only reference the contract's individual measures in conjunction with its overall performance rating in marketing materials Annually, plans

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will be required to use updated Plan Ratings information within 15 days of the release of new ratings.

Plan sponsors' marketing may not reference or include poor performance status information as a means to circumvent enrollment and disenrollment election period rules. Plan sponsors with an overall Five-Star rating have the option to include CMS's gold star icon on marketing materials.

Multi-Language Insert

The Multi-Language Insert is a document that contains the following statement translated into multiple languages:

■ *''We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at [1-xxx-xxx-xxxx]. Someone who speaks [language] can help you. This is a free service.''*

Plans must include the Multi-Language Insert with the Summary of Benefits (SB) and the Evidence of Coverage (EOC). Plan sponsors have the option to incorporate the Insert as part of these materials or to provide as a separate document.

The Multi-Language Insert cannot be modified except to include additional languages. If additional text is added to the insert, then the additional text must also be translated into multiple languages.

Plan Identification Card Requirements

Plans must provide member identification cards for each enrollees. Plan member identification cards must include:

- The Plan sponsor/plan website address
- The Plan sponsor's customer service number
- The phrase ''Medicare limiting charges apply'' (on MA PPO or PFFS cards only)
- The CMS contract and PBP number

The member identification care must also comply with the most recent version of the Workgroup for Electronic Data Interchange (WEDI) Health Identification Card Implementation Guide.

Nominal Gifts and Promotional Activities

Generally, nominal gifts are those used to attract attention of potential enrollees. Generally, promotional activities are those that are designed to attract the attention of prospective members and/or encourage retention of current members. Both nominal gifts and promotional activities must adhere to the nominal value, which is an individual item/service worth $15 or less.

Plan sponsors must track and document items given to current members. Plan sponsors are not required to track pre-enrollment items on a per-person basis; however, they may not willfully structure pre-enrollment activities with the intent to give people more than $50 per year.

Rewards and Incentives

Rewards and incentives may only be offered to a Plan's currently enrolled members for any Medicare-covered preventive service that has a zero dollar cost-share. Examples of preventive services that have a zero dollar cost share include screenings, immunizations, the welcome to the Medicare visit, and zero dollar cost share items listed on the CMS website. The $50 cap no longer applies to rewards and incentives.

Rewards and incentives items must be offered in connection with the whole service, be offered to all members without discrimination, must have a monetary cap not to exceed $15 per reward item (which is based on the retail value of that item), must be tracked and documented during the contract year, and must comply with all relevant fraud and abuse laws, anti-kickback stature, and civil monetary penalty prohibiting inducements to beneficiaries.

Additionally, reward items cannot be items that are considered a health benefit; for example, a free checkup. They cannot be items that consist of lowering or waiving co-pays, must not be offered in the form of cash or other monetary rebates, or be used to target potential enrollees.

For example, they cannot be used in enrollment advertising, marketing or promotion of Plans. They cannot be structured to steer enrollees to particular providers, practitioners or suppliers, and they cannot be tied directly or indirectly to the provision of any other covered item or service.

Outbound Enrollment and Verification Requirements

All plan sponsors must verify enrollments facilitated by independent and employed agents or brokers. Plans must ensure that enrolling beneficiaries understand the plan rules. These calls should be made after the sale and not at the point of sale. Plans may not use an automated calling technology for this call.

Plan sponsors must make a minimum of three documented attempts to contact the applicant by phone within fifteen calendar days of receipt of the application. However, the first two attempts must be made within the first 10 days.

If the enrollment application is incomplete, plan sponsors should concurrently conduct the outbound enrollment and verification process while obtaining the missing information needed to complete that application.

Plan sponsors that do not reach the beneficiary on the first or second attempt must send the applicant an enrollment verification letter in addition to trying to make that third outbound verification call within the 15-day timeframe.

Submission of Plan Websites for Review

All Plans must submit their websites annually for review by CMS. The websites may be available for public use during the CMS review period. If any portion of the website is disapproved, the plan sponsor must remove the disapproved portion immediately.

Submission of the Plan website through HPMS will be achieved through links through the website and not through screen shots or text documents. CMS Guidance for Plan websites has been consolidated into Section 100 of the Medicare Marketing Guidelines. There is a section on general website requirements and there is another section dedicated to the required content of Plan websites.

Plan sponsors are allowed to use social/electronic media such as Facebook and Twitter; however, such tools are considered marketing materials and, as such, are subject to the Medicare Marketing Guidelines.

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Reporting of Terminated Agents

When a plan sponsor discovers incidents of unlicensed agents or brokers submitting applications, they must terminate that agent or broker, report them to the authority in the state which the application was submitted, and notify beneficiaries enrolled by the unqualified agent to advise of that agent's status.

Plan sponsors are also required to report the reason for the termination. Beneficiaries affected by this may request to make a Plan change. Plan sponsors must notify CMS annually whether they intend to use independent agents or brokers for the upcoming plan year and the amounts they will pay them.

Plan sponsors must pay independent agents/brokers an amount that is at or below the adjusted fair market value cut off amounts released each spring by CMS.

Marketing Materials Not Subject to Review

CMS has added new items to the list of materials not subject tor review. They now include ad-hoc enrollee communication materials, OMB forms, VAIS materials, and mid-year change enrollee notification as those not subject to review. The referenced materials should not be uploaded in HPMS and they do not require a unique material ID on them.

Required Materials with an Enrollment Form

When an enrollment form is distributed, the Plan must also give the beneficiary the Plan ratings document, which is commonly referred to as the star ratings document, a summary of benefits, and the Multi-Language Insert. Prior to online enrollment, Plan sponsors must make available online the Plan ratings, summary of benefits and Multi-Language Insert.

Required Materials for New and Renewing Members at Time of Enrollment and Thereafter

The following materials must be provided at the time of enrollment: (1) the annual notice of change/evidence of coverage; (2) the comprehensive formulary or abridged formulary; (3) pharmacy directory; (4) provider directory as applicable, and (6) membership identification card.

Every member must receive the above-referenced materials at the time of enrollment. Thereafter, Plan sponsors have the option of mailing the materials to either every member or every address where up to four members reside.

Marketing Material Identification

The marketing material identification is made up of two parts. The first being the Plan's contract number, and the second being a series of alpha numeric characters chosen by the Plan.

Plans have the option, but they're not required to include the date on materials as part of the marketing material identification. All marketing materials must have the marketing material identification number with the following exceptions:

- The member ID card (although PDP or MA-PD member ID cards must include the CMS contract number and PBP number on them)
- Envelopes
- Radio advertisements
- Outdoor advertisements
- Banner or banner-like ads
- Social media comments and posts

Providing Materials in Different Media Types

CMS does allow Plan sponsors to provide materials in alternate media, such as electronic or portable media like email, CDs or DVDs). If a Plan sponsor chooses to exercise this option, they must receive beneficiary consent prior to providing material in this format. A beneficiary must opt in to receiving materials in different media types, not opt out.

Hours of Operation Requirements for Marketing Materials

Hours of operation must be listed on all materials where a customer service number is provided for current and prospective enrollees to call. Hours of operation must be listed once, not every time a customer service or other phone number is provided.

Disclaimers

Marketing materials are grouped into two distinct categories: (1) Materials directed to potential enrollees; and (2) Communications to existing members. Unless otherwise noted on a specific disclaimer, all disclaimers are required on all marketing materials created by the Plan.

Many of the CMS mandated disclaimers were updated to incorporate plain language principles; however, Plans are not required to resubmit existing materials to reflect such changes.

Directories

Plan sponsors must send a Provider and Pharmacy Directory at the time of enrollment and at least every three years after that. Change pages no longer required. Plans must make directories available upon request and websites must contain current directories at all times.

Plans must continue to provide written notice of termination for providers and pharmacists to members that use them. Plans must also provide written notice regarding significant changes to the provider/pharmacy network.

Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)

Except as described below, all members must get their ANOC/EOCs by Sept. 30 of each year. Dual Special Needs Plans (DSNPs) have a couple of options. First, they can send their ANOC with an SB for receipt by Sept. 30 and then send the EOC for receipt by Dec. 30 or send a combined ANOC/EOC for receipt by Sept. 30 and then the Plan does not have to send an FB.

Cost plans without Part D have to send the ANOC/EOC for receipt by Dec. 1. Cost plans with Part D have to send their ANOC/EOC for receipt by Sept. 30. Employer group plans must send the ANOC/EOC for receipt no later than 15 days before the employer union open enrollment period.

Educational Events

Educational events may not have marketing, including plan specific benefits. If Plan sponsors hold member-only events, they may not conduct enrollment

or sales activities at these events. Additionally, any marketing of these events must be done in a way that reasonably targets only existing members (e.g., direct mail flyers), and not the mass marketplace (e.g., radio or newspaper ad).

Notifying CMS of Scheduled Marketing Events

Previously, HPMS did not allow a plan to cancel an event in the system up to the day of an event. As such, plans were required to notify their regional office account manager of any cancellations.

HPMS was recently updated and enhanced to allow plans the ability to cancel an event in the system up to the same day of the event. Now, Plans must notify the regional office only if they are unable to cancel the event directly in HPMS.

Customer Service Call Center Requirements

From Oct. 1 through Feb. 14 plan sponsors must have live customer service representatives available seven days a week from 8 a.m. to 8 p.m. in the time zones for the regions in which they operate. Plans may use alternative technologies on Thanksgiving and Christmas Day.

From Feb. 14 through Sept. 14 plan sponsors must have live customer service representatives Monday through Friday available from 8 am to 8 p.m. according to the time zones for the regions in which they operate. Plans may use alternative technologies Saturday, Sunday, and on federal holidays.

In addition, CMS added the requirement that plans must inform customers that call in that interpreter services are available for free.

HPMS Updates

The 2013 Medicare Marketing Guidelines make numerous updates to the HPMS. The HPMS user guide was updated and it describes in detail all of the changes made.

It has an overview of the updates and all functionality changes are described in the guide with screen prints. Plans should carefully review the HPMS user guide to understand and implement the HPMS updates.

Conclusion

Medicare marketing compliance should be part of a larger strategic plan that is determined in advance of open enrollment season. If the organization does not have a well developed and managed marketing plan, compliance with the Medicare Marketing Guidelines may be difficult.

However, if Plans read and understand the Guiding Principles, and design their marketing processes accordingly, compliance will be easy to achieve.

A Medicare Marketing compliance plan should include the following:

- *Sales Force Training*. Plans will need to be even more active in monitoring, training and enforcing their employees, agents and brokers' compliance with Medicare marketing requirements.
- *Sales Force Oversight*. Plan Agent, Broker, Field Marketing Organization oversight should include monitoring and audits such as a secret shopper program; audit scopes of appointment; conduct appointment ''ride-alongs;'' audit Agent, Broker compensation; monitor enrollment verification calls; monitor rapid disenrollments and cancellations; investigate sales allegations; and document and adhere to enforcement standards.
- *Annual Update of Marketing Materials*. Plans need to update marketing materials to include the new disclaimers and new marketing guidelines.
- *Annual Update of Marketing Policies and Procedures*. Updated Medicare Marketing policies and procedures need to be developed quickly since 2013 marketing begins on Oct. 1.

The consequences for violating any of the new marketing rules are substantial, as CMS can levy penalties of up to $25,000 for each enrollee affected, or likely to be affected, by any violation.

References

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