Medicare 101 - Marketing
HCCA Pre-Conference
December 7, 2008
Libby Easton-May

Overview, Enrollment & Disenrollment
Social Security Act of 1965

- Established Medicare to provide health and economic security to seniors
- Expanded in 1972 to cover younger beneficiaries with permanent disabilities
- Medicare was originally the responsibility of the Social Security Administration (SSA)
- 1977 - The Health Care Financing Administration (HCFA) was created under the Department of Health, Education, and Welfare to effectively coordinate Medicare and Medicaid
- 1980 - DHEW was divided into the Department of Education and the Department of Health and Human Services (HHS)
- 2001 - HCFA was renamed the Centers for Medicare & Medicaid Services (CMS)
- CMS still coordinates with the SSA to communicate Medicare information to seniors
Balanced Budget Act of 1997

- Created Medicare+Choice program (now Medicare Advantage) to offer beneficiaries more plan options
- Set federal reimbursement rates for Medicare+Choice organizations, on a per enrollee per month basis
  - Capped annual health plan reimbursement increases
- Increased number of covered preventive services
- Contained anti-fraud and anti-abuse provisions
  - Increased maximum amount of CMPs
- BBA introduced the requirement for M+C plans to have a compliance program as a condition of having a contract with CMS

Benefits Improvement and Protection Act (BIPA) of 2000

- Amended the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare, Medicaid and State Child Health Insurance Program
- Increased the minimum percentage increase in payment rates for Medicare+Choice organizations
- Created payment incentives for organizations to offer Medicare+Choice plans in rural areas
- Increased number of covered preventive services
- Established an independent external review process for all Medicare fee-for-service appeals
Medicare Modernization Act (MMA)

- Most significant changes to Medicare since 1965
  - Provides more choices and better benefits to Medicare recipients, including the Part D prescription drug benefit
  - Allows for competition among health plans to foster innovation and flexibility in coverage
  - Covers new preventive benefits

<table>
<thead>
<tr>
<th>2004</th>
<th>2005</th>
<th>2006</th>
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<tbody>
<tr>
<td>• Drug discount card&lt;br&gt;• Medicare + Choice became Medicare Advantage&lt;br&gt;• Moratorium on therapy capped until 1/1/06</td>
<td>• Drug discount card&lt;br&gt;• New preventive services&lt;br&gt;• Part B deductible increased to $170</td>
<td>• Prescription drug plans&lt;br&gt;• Two new Medigap policies&lt;br&gt;• Part B deductible increases with premium</td>
</tr>
</tbody>
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Medicare Improvements for Patients & Providers of 2008

- Passed July 15, 2008
- House & Senate both voted for Presidential veto override
- Largest changes to MMA to date
- Regulations released 9/15/08 with an additional rule released on 11/10/08 concerning sales compensation
- Effective dates vary, but marketing provisions are impacting CY 2009
- Law finalizes comment on May 8, 2008 NPRM and put various existing policies into law
- Further changes such as MIPPA expected in years to come based on current political environment
Medicare Improvements for Patients & Providers of 2008 (selected)

<table>
<thead>
<tr>
<th>MMA</th>
<th>MIPPA</th>
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<tbody>
<tr>
<td>• Funding for IME and Med Stabilization Fund</td>
<td>• Phase out of IME beginning in 2010 and elimination of MSF in 2013</td>
</tr>
<tr>
<td>• PFFS Plans do not require contracted provider network</td>
<td>• In most cases, PFFS plans will require contracted networks</td>
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<tr>
<td>• No QI Program Requirements for PFFS and MSA</td>
<td>• QI Programs now required for both PFFS and MSA</td>
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<tr>
<td>• Telemarketing to Medicare Beneficiaries Allowed</td>
<td>• No Unsolicited Contact allowed, including direct mail follow-up</td>
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<tr>
<td>• SNP Moratorium</td>
<td>• SNP Moratorium lifted/other reqts</td>
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<tr>
<td>• No specific Part D claims timeliness requirements</td>
<td>• Part D claims processing definitions and timeframes enacted</td>
</tr>
<tr>
<td>• E-prescribing not mandated or rewarded</td>
<td>• Incentives for 2009-2013 for e-prescribing and penalties in 2014 forward</td>
</tr>
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</table>

What is CMS?

• Centers for Medicare & Medicaid Services (CMS)
• Agency within the U.S Department of Health and Human Services (DHHS)
• Administers Medicaid and the State Children's Health Insurance Program (SCHIP) in addition to Medicare
• CMS:
  – Assures that the Medicaid, Medicare and SCHIP programs are properly run by its contractors and state agencies;
  – Establishes policies for paying health care providers;
  – Conducts research on the effectiveness of various methods of health care management, treatment, and financing; and
  – Assesses the quality of health care facilities and services and taking enforcement actions as appropriate.
Role of CMS in Medicare

- Oversight
- CMS is organized into the Central (more policy driven) and Regional Office structures
- Enforcement and penalties
  - Civil Monetary Penalties (CMPs) can be assessed by HHS
  - HHS can also impose “assessments,” an additional money payment in lieu of damages sustained by the government because of the violation
  - In some cases, CMS can also “freeze” new enrollments for plans in violation
  - The individual or entity violating the statute may be excluded from participating in the Medicare program
  - CMPs can reach $10,000 per item or service in noncompliance
  - Assessments can be three times the amount claimed for certain fraud violations

What is the OIG?

- Office of Inspector General (OIG) – An independent, objective oversight unit of HHS
- Mission is to protect the integrity of HHS programs, including Medicare, as well as the health and welfare of the beneficiaries of those programs
- OIG carries out this mission through a nationwide network of audits, investigations, and inspections
- Makes recommendations to the Secretary and Congress from findings
- The OIG is also the entity that issues Compliance Program guidance for MA Plans, Pharmaceutical Companies, Hospitals and other entities
- The OIG also enters into and oversees Corporate Integrity Agreements (CIA) with entities who have been found to be in violation of regulations (i.e. Kaiser of Hawaii)
Role of OIG in Medicare

• Oversight, Audit and Enforcement

  • It is important to review the OIG compliance program guidance, the annual work plan, and audit reports to incorporate those into compliance risk assessments and ongoing monitoring and auditing.

• Enforcement and penalties
  – OIG also has the power to impose CMPs
  – The OIG is authorized to seek different amounts of CMPs and assessments based on the type of violation
  – The OIG can also pursue criminal actions against violators
  – Examples of violations the OIG would investigate:
    • False and fraudulent claims
    • Kickbacks
    • Overcharging Medicare beneficiaries

What is the GAO?

• Government Accountability Office (GAO), formerly known as the General Accounting Office

• Studies the programs and expenditures of almost all parts of the federal government, including HHS

• Makes recommendations to Congress about ways to make government programs “more effective and responsive”

• Often referred to as the “investigational arm of Congress” or the “congressional watchdog”
Role of GAO in Medicare

- **Oversight**
  - The GAO investigates an issue, then presents its findings and recommendations in the form of a report and/or testimony before Congress
  - Also issues correspondence (letters), which are of a more limited interest and do not contain recommendations
  - Investigations are usually initiated at the request of members of Congress

- **Enforcement and Penalties**
  - The GAO regularly issues legal decisions and opinions on the use of federal funds, reports on major rules issued by federal agencies, and bid protest decisions that resolve challenges to government contract rewards
  - Assist in drafting legislation and review legislative proposals before Congress
  - Reviews and reports to Congress on proposed rescissions and deferrals of government funds

- It is also important to review GAO reports for incorporation into ongoing monitoring and auditing

State Agencies

- Medicaid is jointly funded between the Federal and State governments and is the provider of medical coverage for the poor and indigent population

- Individuals who are entitled to and members of both Medicare and Medicaid are known as “dual enrollees”
Code of Federal Regulations

- General and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government

- 50 titles that represent broad areas subject to Federal regulation
  - CFR can be found at http://www.gpoaccess.gov/cfr/index.html
  - Title 42, Chapter IV contains CMS regulations
  - 422 details MA and 423 details Part D
  - Updated regulations for MIPPA released 9/15/08, as CMS-4131 F & CMS-4138 IFC
  - Additional regulations outlining sales compensation published 11/10/08
  - CMS-4138 IFC2
  - Comments due for CMS-4138 IFC2 by 12/15/08

Policy Guidance - Program Manuals and Memoranda

- Part A and B Manuals
- Medicare Managed Care Manual
- Medicare Prescription Drug Benefit Manual
- Monitoring Review Guides
- Health Plan Letters and Memoranda (HPMS Memos)
- Operational Policy Letters (OPLs)
- Beneficiary Directed Materials
Part A and B Manuals

- These manuals are for Original Medicare contractors and providers such as:
  - Intermediary and Carrier Manuals
  - Hospital, ESRD, and SNF Manuals
  - The Coverage Issues Manual deals with difficult to find Medicare benefit topics that are often limitations to exclusions

- It is important to be familiar with these manuals because MA & Part D contractors must cover Original Medicare benefits and process those claims in the same manner as Medicare Contractors.

- These manuals also describe how claims are to be submitted by providers including the claim forms (UB-92 or HCFA 1450, HCFA 1500) and clinical coding to be used.

Medicare Managed Care Manual

- Contains CMS program instructions, policies, and procedures for Medicare Advantage organizations

- Can be found at http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS019326&intNumPerPage=10

- CMS is in the process of updating this manual and it is important to review and implement all released manual updates
Medicare Prescription Drug Benefit Manual

- Contains CMS program instructions, policies, and procedures for Medicare Part D (and MA-PD) sponsors
- Can be found at http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuels.asp
- CMS is in the process of updating this manual and it is important to review and implement all released manual updates

Monitoring Review Guide

- CMS uses the Review Guide as a way to assess if a Medicare Advantage and Part D organization is in compliance with federal requirements
- Review Guides do not cover every federal requirement, but organizations are still required to be compliant with all requirements
- Review Guides can be found in the Medicare HPMS system. Your plan should have HPMS access (by contract) and should be able to access these guides.
- These guides are one of the most important resources as it is used by CMS for monitoring audits
- The sections should be given to department heads so they understand their requirements
- The guide should also be used for any “mock audits” or monitoring activity
Health Plan Letters and Memoranda
HPMS Letters/Guidance

- Letters from CMS to managed care organizations, covering a variety of topics can be found at http://www.cms.hhs.gov/HealthPlansGenInfo/08_LettersandAnnouncements.asp
- Memos posted on HPMS are also a good way to get accurate and up to date information that might not have yet been incorporated into the Medicare Managed Care Manual or the Medicare Prescription Drug Manual.
- A history of the Part C HPMS memos can be found at http://www.cms.hhs.gov/HealthPlansGenInfo/PartCHPMS/list.asp
- A history of the Part D HPMS memos can be found at http://www.cms.hhs.gov/PrescriptionDrugCovContra/HPMSGH/list.asp

Operational Policy Letters (OPLs)

- Most OPLs have been deleted
  - Information is either obsolete or incorporated into the Managed Care Manual
- OPLs can still be valuable for history on a topic such as encounter data submission
CMS Call Letters

- CMS Call Letters are released in mid March each year and are excellent resources for preparing for the upcoming plan year.
- The Call Letters reference current CMS guidance and provide new information that clarifies or adds to existing CMS guidance.
- Attachments include new model documents, calendars and crosswalks
- The Call Letter has a section for MA plans and also one more specific to Part D plans.

Beneficiary Directed Materials

- There is value in becoming familiar with these materials as they are generally part of the MA sales presentation (i.e. basic Medicare benefits and then how KPSA can cover all of those and more)
- Materials can be found at http://www.medicare.gov
  - Medicare Handbook
  - Medicare & You
  - Search tools
    - Find a doctor
    - Compare hospitals
    - Find out what Medicare covers
    - Learn about prescription drug coverage options
Enrollment and Disenrollment

Enrollment/Disenrollment Overview

• In order to receive any Medicare benefits, a beneficiary must be properly enrolled in the Medicare program either through traditional Medicare or a Medicare Advantage organization.

• The MA organization has the responsibility for validating eligibility of the beneficiary to receive each type of Medicare benefit (Parts A, B, C and D).

• There are specific time frames for which a person may enroll in any Medicare program, these time periods are:
  - Initial Enrollment Period (IEP) - The period for which a new individual newly eligible for Medicare may elect to enroll in an MA.
  - Annual Enrollment Period (AEP) - A period spanning 11/15-12/31 of each year where eligible individuals may enroll (or disenroll) from an MA plan.
  - Special Enrollment Period (SEP) - A period specifically called for by the occurrence of certain events (i.e. change in residence, MA termination or violations)
  - Open Enrollment Period (OEP) - A specified open period of enrollment.
Entitlement to Parts A and B

- Who can join?
  - Anyone with Medicare Part A and/or Medicare Part B (regardless of age) can join a Medicare prescription drug plan offered in his or her area
  - Individuals must reside within the service area
  - For most people, joining now means they will pay a lower premium than if they waited to join until later

Entitlement to Parts A and B

- To be eligible to elect an MA plan, an individual must be properly entitled to Part A and enrolled in Part B as of the effective date of the coverage.
- It is not necessary for the individual to prove Part A entitlement or Part B enrollment at the time the election is completed; however, the election will be considered incomplete until such is verified.
- MA plans can use a number of different types of information to verify the entitlement to benefits, these include:
  - A Medicare Card
  - SSA Award Notice
  - Verification through a CMS system or data from CMS subcontractors
  - State documents (Part D)
End Stage Renal Disease (ESRD)

- An individual is not eligible to elect an MA plan if he/she has End Stage Renal Disease (ESRD).
- Medicare will assign ESRD status to a beneficiary as a result of a certification by the attending physician.
- Continuity of care issues prevalent with ESRD beneficiaries give rise to this exclusion.
- An MA must deny enrollment to any applicant that is determined to have ESRD aside from specific exclusions such as:
  - Members converting from a health plan to the MA plan of the same organization;
  - An individual who develops ESRD while enrolled in the MA; or
  - An individual who is certified as ESRD after the MA selection is signed and received by the MA.

Residence Determinations

- An individual is eligible to elect an MA plan if he/she permanently resides in the service area of the MA plan.
- Proof of permanent residency is generally validated using documents such as statement of address; however, plans can request further proof such as voter’s registration, driver’s license, tax records or utility bills.
- Exceptions to the permanent residency requirement include:
  - Should an MA plan offer continuation of enrollment option to plan enrollees if they permanently move outside of the MA’s service area to a continuation area.
  - Individuals who are members of a health plan can enroll in the MA plan of that same organization during their IEP should they reside in the MA’s continuation area.
  - The MA plan for the area of residence was terminated or limited to where the residence lies outside of the reduced service area may be continued should there be no other MA plan serving that area, the MA offers the continuation option and the member agrees to receive services through the reduced provider network.
Enrollment Elections

- Individuals can elect the MA plan for which they wish to be covered. This election must take place for Medicare eligible persons even if they are currently enrolled in a health plan with that same MA carrier.
- A proper election must be made prior to the MA plan enrolling an individual in the MA plan, and the failure to make a complete election will preclude any enrollment in an MA plan.
- In order for an MA plan to accept an election from a currently enrolled member in same organization, the election must be made during one of the prescribed election periods: AEP, IEP, SEP or OEP.

Enrollment Administration

- Enrollment Forms
  - An enrollment form may be filled out by the individual or the individual’s legal representative
  - The enrollment form must be filled out completely with the requisite information to make the election (i.e. eligibility information, plan selection)
  - A completed form is a requirement for enrollment
- Enrollment Options
  - Telephone
    - An individual can enroll via telephone.
  - Auto-enrollment for dual eligibles
    - Full-benefit dual eligibles who are enrolled in an MA plan without drug coverage will be enrolled in an MA-PD automatically.
  - Internet
    - An individual can enroll via the internet provided that the MA plan has instituted CMS-based protective rules.
- Signature requirement
  - All election and enrollment forms must be signed by the applicant or the legal representative. Verification of the representative can be done should a question arise. Other enrollment methods can be verified systematically.
Enrollment Denials

• An MA plan may deny the enrollment of an applicant for prescribed reasons. Generally these reasons are the following:

  – Ineligibility
    • Should the individual attempting to enroll in the MA plan not be eligible to receive Medicare benefits, does not reside within the service area of the MA plan, or that MA plan is closed for new enrollments, then the enrollment may be denied.

  – Incomplete election of enrollment
    • Should the information provided by the individual on the election or enrollment forms be faulty, incomplete or unverifiable, the MA plan can deny enrollment should the deficiency not be cured within 21 calendar days or the end of the calendar month, whichever is later.

• Notice of Denial must be sent to the individual within 10 calendar days of the determination of denial.

When can individuals join?

• Individuals who currently have Medicare Part A and/or Part B can join a Medicare prescription drug plan between November 15 and December 31st of each year.

  – Drug plan coverage begins January 1 for individuals who join by December 31st of the prior year (January 1, 2009 for applications received on or before December 31, 2008).

• In general, individuals will be able to join or change plans and/or carriers once each year between November 15 and December 31.

• Anyone who joins after December 31st will receive coverage effective the first day of the month after the month joined.
Important Dates

- November 15th
  - Annual Election Period begins

- December 31st
  - Last day to join and begin coverage on January 1
  - Annual Election Period ends

- January 1st
  - Prescription and Medical coverage begins for those electing during AEP
  - Open Enrollment Period begins

- March 31st
  - Open Enrollment Period ends

Election Periods
Election Periods

- There are five distinct enrollment periods during which a Medicare eligible individual can enroll in an MA plan.
  - The Annual Election Period (AEP)
  - Initial Coverage Election Period (ICEP)
  - Open Enrollment Period (OEP)
  - Special Election Period (SEP)
  - Limited Open Enrollment (L-OEP) 2007 & 2008 Only

Annual Election Period

- During the Annual Election Period (AEP), an individual can enroll or disenroll from an MA plan or Part D plan.
- The AEP takes place every year from November 15 to December 31st for an effective date of January 1 of the following year.
- Should the individual make multiple elections during the AEP, the signature date of the last election made will be the election that takes effect.
Initial Coverage Election Period

- The Initial Coverage Election Period (ICEP) is the period in which a newly Medicare eligible individual can elect to enroll in an MA plan.
- This period starts three months before the individual’s entitlement to Parts A and B and ends the later of:
  - 7 month period surrounding Medicare entitlement (a.k.a. Part B initial enrollment period)
  - 3 months prior to entitlement to Part A and Part B (same as previous requirement)
- An individual can only make one election during the ICEP, and once the election is made and enrollment takes effect, the ICEP election is exhausted.

Open Enrollment Periods

- Every year Original Medicare provides for a prescribed Open Enrollment Period in which a beneficiary may make one enrollment election. This OEP is effective for MA plans as well.
- The yearly OEP is from January 1st to March 31st.
- OEP elections must be made to the same type of plan (MA-PD to MA-PD) or may involve a disenrollment from a PDP to enroll in an MA-PD or vice versa.
- An individual enrolled in an MA plan or original Medicare with no drug coverage can only enroll in an MA plan with no drug coverage; they may not enroll in an MA-PD or PDP during this period.
Special Election Periods

• Special Election Periods (SEPs) are those instances in which election and enrollment is allowed should certain special circumstances exist that would be an exception to the normal election periods.

• These special circumstances include generally:
  – Changes in permanent residence outside of the MA plan’s service and continuation area that causes the individual to no longer be eligible for that MA plan;
  – The termination of the MA plan’s contract by CMS in the area which the individual resides, or the MA plan notifies the individual of the pending termination of the MA plan in that area;
  – A demonstrated, material breach of the of the MA plan’s membership contract with the individual, or material misrepresentation during the marketing of the plan. (To be determined by CMS); and
  – Other CMS exceptions as to be determined.

• During an SEP, the individual can discontinue the election in the MA plan and elect another MA plan or original Medicare. The person can also elect another MA plan after enrolling in original Medicare as long as it is in the SEP.

• The SEP ends as soon as an election to a new MA plan is made or when the SEP timeframe has passed -- whichever comes first.

• The SEP timeframe is associated with the reason for the SEP
  – Changes in Residence
    • The SEP begins the month prior to the move and includes the month of the move and two months after the move.
  – Contract Violations
    • The SEP will commence once CMS determines a violation has occurred. The SEP ends if the individual elects a new MA plan or three months after enrolling in Original Medicare prior to election of a new MA plan.
  – Contract Terminations
    • The MA plan is required to give 60 days notice of termination and the SEP will commence two months prior to the termination date and ends one month after the month in which the termination took place.
MA-OEP Enrollment Requests

<table>
<thead>
<tr>
<th>Current Coverage</th>
<th>Can use OEP to get</th>
<th>Cannot use OEP to get</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage with prescription drug coverage (MA-PD)</td>
<td>A different MA-PD or Original Medicare + PDP or MA-only PFFS + PDP</td>
<td>MA-only or Original Medicare only (cannot drop drug coverage)</td>
</tr>
<tr>
<td>Medicare Advantage with no prescription drug coverage (MA-only)</td>
<td>A different MA-only or Original Medicare only</td>
<td>MA-PD or Original Medicare + PDP (cannot add drug coverage)</td>
</tr>
<tr>
<td>MA-only PFFS + PDP</td>
<td>MA-PD or different MA-only PFFS and same PDP or Original Medicare and same PDP</td>
<td>MA-only or Original Medicare cannot drop drug coverage)</td>
</tr>
<tr>
<td>Original Medicare and a prescription drug plan (PDP)</td>
<td>MA-PD or MA-PFFS and the same PDP</td>
<td>MA-only or a different PDP to use with Original Medicare (cannot drop drug coverage)</td>
</tr>
<tr>
<td>Original Medicare only</td>
<td>MA-only</td>
<td>MAPD or Original Medicare + PDP (cannot add drug coverage)</td>
</tr>
</tbody>
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Effective Date of Coverage

- The effective date is the date on which benefits are available and coverage payable by the elected MA plan.
- To determine the correct effective date, the appropriate election period must be ascertained. For SEPs, the effective date can vary depending on the specific date of the special circumstances that give rise to the SEP.
- For Initial Coverage Election Periods (ICEP) the effective date would be:
  - The first day of the month of entitlement to Parts A and B; or
  - The first of the month following the month the election was made after entitlement has occurred.
- For Annual Election Periods (AEP) the effective date would be:
  - January 1st of the following year
Effective Date of Coverage (2)

- For Open Enrollment Periods (OEP) the effective date would be:
  - The first of the month after the month the MA plan receives the election.

- For Special Election Periods (SEP) the effective date would be:
  - Variable, depending on the circumstances surrounding the SEP.

- If an election takes place during a period where more than one of the four periods apply, the MA plan must allow the individual to select their own effective date. If unsuccessful, use following hierarchy:

  Ranking of Election Periods: (1 = Highest, 4 = Lowest)
  1. ICEP/IEP-D
  2. SEP
  3. AEP
  4. OEP / OEPNEW / OEPI/MA-OEP

Disenrollment
Disenrollment

- Disenrollment from an MA plan is handled in a similar manner as enrollments. Disenrollments are generally allowed in specific time periods and allow for special circumstances.
- There are two distinct types of disenrollments:
  - Voluntary
    - The member elects to terminate his/her membership in the MA plan.
  - Involuntary
    - Given the occurrence of limited circumstances, the MA plan can unilaterally disenroll a member from the MA plan.
- A voluntary disenrollment must take place in certain time periods while involuntary disenrollments may take place at any time.
- An MA plan may not request or encourage a member to voluntarily disenroll.

Voluntary Disenrollment

- A member may only voluntarily disenroll from an MA plan during three election periods:
  - The Annual Election Period (AEP)
  - Special Election Period (SEP)
  - Open Election Period (OEP)
- The same time period rules apply for these election periods as are in effect for enrollment elections.
- A member may voluntarily disenroll from an MA plan using the following methods:
  - Giving or faxing a signed written notice of disenrollment election to the MA plan;
  - Submitting a disenrollment request via the Internet to the MA plan (if available); or
  - By calling the Medicare (800) number.
- A disenrollment request will only be valid if it is done inside the applicable time periods and effectuated using one of the three acceptable methods.
Voluntary Disenrollment

- If the voluntary disenrollment request is written, it must be signed by the member or legal representative. The same signature rules apply to disenrollment as with enrollment election signatures.
- The effective date of the disenrollment is dependent on the period in which the request was made.
  - For disenrollment requests made during the AEP, the effective date is January 1st of the following year;
  - For disenrollment requests made during the OEP, the effective date is the first day of the month after the month the MA plan receives the completed disenrollment request; and
  - For disenrollment requests during the SEP, the effective date varies depending on the circumstances surrounding the SEP.

Voluntary Disenrollment

- Notice Requirement
  - After the member submits a request for disenrollment, the MA plan must provide a notice of disenrollment within 10 calendar days of receipt of the disenrollment. This notice must include the following:
    - An explanation of the lock-in restrictions for the period in which the member remains enrolled in the MA plan; and
    - The effective date of the disenrollment.
  - For disenrollment elections received by means other than written notice from the member (i.e. Medicare (800) number), the MA plan must send the notice of disenrollment to the member within 10 calendar days of the availability through the Transaction Reply Report (TRR).
  - For denials of voluntary disenrollment requests, the denial notice must be sent within 10 calendar days of the denial determination and must include the reason for denial/
Required Involuntary Disenrollments

- Required Involuntary Disenrollments are circumstances in which the MA plan must disenroll a member based upon the rules set out by Medicare. The circumstances that call for a required involuntary disenrollment are as follows:
  - A change in residence makes the member ineligible to remain enrolled in the plan;
  - The member loses entitlement to either Medicare Part A or B;
  - The member dies; or
  - The MA plan contract is terminated or discontinues offering the plan in the member’s area with no continuation area.

- Disenrollment, given these circumstances, is required and must be made immediately given the appropriate notice timeframes.

Required Involuntary Disenrollment

- Notice Requirements
  - In cases of involuntary disenrollment (except those due to death or loss of entitlement), the following must be included in the notice:
    - Statement advising the member of the decision to disenroll the member and why it is taking place; and
    - An explanation of the member’s right to a hearing under the MA plan’s grievance procedures.
  - This notice must be mailed to the member prior to the disenrollment being submitted to CMS for processing.
Change of Residence

- An MA plan must disenroll a member if:
  - He/She moves permanently out of the service area and not into a continuation area;
  - The member’s temporary absence from the service area exceeds six consecutive months; or
  - The member moves out of the service area, yet into a continuation area, but chooses not to enroll in the local MA plan.

Loss of Entitlement

- Should a member lose their entitlement to coverage under Parts A or B of the Medicare program, they must be disenrolled from the MA plan.
- The MA plan will be notified by CMS if the member has lost his/her entitlement and CMS will make the disenrollment effective the first day of the month following the last month of entitlement to either Part A or B.
- The MA plan must disenroll the member even if they only lose entitlement to either one of Parts A or B. The MA plan cannot offer Parts A or B equivalents to the member, nor charge them a premium for similar coverage.
- Notice from the MA plan is suggested, but not required. CMS is the ultimate arbitrator of entitlement and the member must seek redress for erroneous disenrollments from CMS.
Death

- A member who is deceased will be disenrolled from the MA plan effective the first day of the month after the month of the member’s death.
- Organizations may not submit disenrollment transactions to CMS in response to the apparent death of a member. In anticipation of official notification from CMS via the TRR, organizations may, at their discretion, make note of the reported death in internal plan systems in order to suppress premium bills and member notices.
- Following receipt of a CMS notification (via TRR) of disenrollment due to death, CMS strongly suggests that a notice be sent to the member or the estate of the member so that any erroneous disenrollments can be corrected as soon as possible.

Terminations/Non-renewals

- The MA plan must disenroll a member from the plan should the MA plan’s contract with CMS be terminated or if the plan discontinues offering coverage in any portion of the area where that member resides.
- Should a member be disenrolled due to these circumstances, they will be entitled to an SEP to elect another MA plan.
- Beneficiaries affected by these types of terminations may request an effective date of the month after notice is given, or up to two months after the effective date of the termination. However, the effective date may not be earlier than the date the new MA organization receives the enrollment election.
- Notice Requirements
  - The MA plan must provide each effected member a written notice of the effective date of the disenrollment due to termination or non-renewal and include a discussion of the alternatives for obtaining benefits under the Medicare program. This notice must be provided to effected members at least 60 days prior to the date of termination.
Optional Involuntary Disenrollment

• MA plans have the option of disenrolling members from the plan when certain circumstances arise. The decision to disenroll these members are under the MA plan’s discretion only and are not controlled by CMS.

• An MA plan may disenroll a member if:
  – Premiums are not paid on a timely basis;
  – The member engages in disruptive behavior; or
  – The member provides fraudulent information on an election form or permits abuse of the enrollment card in the MA plan.

• Notice Requirements
  – In situations where the MA plan disenrolls a members based on the above reasons, a notice must be sent with the following elements:
    • Advising the member of the plan to disenroll him/her;
    • The effective date of termination; and
    • An explanation of the member’s right to a hearing under the MA plan’s grievance procedures.

Disenrollment for Failure to Pay Premiums (Optional)

• MA organizations may:
  – Do nothing, i.e., allow member to remain enrolled
  – Disenroll member after grace period (no less than 1 calendar month) and proper notice; or
  – Reduce coverage from premium level plan to a lower level of coverage

• MA organizations may not:
  – Involuntarily disenroll members for failure to pay premiums when in premium withhold status

• There is no SEP available for individuals disenrolled for failure to pay premiums.
Disenrollment for Disruptive Behavior

- Disruptive Behavior = substantially impairs ability to arrange or provide for care
- MA must make effort to resolve problem
- CMS review – Includes clinician/expert
- Request by MA to decline future enrollment
- Reasonable Accommodations

Oversight and Audit
Oversight and Audit of Enrollment Functions

- Oversight and audit of enrollments and disenrollments are required to ensure that the organization is not exposed to compliance risk for inaccurate determinations or untimely processes.
- For enrollments, adequate notice requirements must be closely followed as these are the only communications between the plan and the individual during the enrollment process.
- The compliance department, as part of its oversight, should monitor the complaint and grievance logs dealing with enrollment decisions. Any determination regarding enrollments or disenrollments should be documented and then reviewed to ensure that the proper steps were taken and appropriate notice provided.
- Processes and review protocol for disenrollments must be implemented and reviewed.

Questions?
Sales & Marketing Overview

Definitions - General

- Marketing – Steering, or attempting to steer, an undecided potential enrollee towards a plan or limited number of plans, and for which the individual or entity performing marketing activities expects compensation directly or indirectly from the plan for such marketing activities.

- Education – Informing a potential enrollee about MA or other Medicare programs generally or specifically, but not steering or attempting to steer a potential enrollee toward a specific plan or limited number of plans.

During the Marketing process, sales agents should provide the enrollee (using a combination of verbal and written material) with enough information to make an informed enrollment decision.
Definitions - General

- Marketing Materials – Any informational materials that perform one or more of the following:
  - Promote an Organization
  - Provide enrollment information for an Organization
  - Explain the benefits of enrollment in an Organization
  - Describe the rules that apply to enrollees in an Organization
  - Explain how Medicare services are covered under an Organization, including conditions that apply to such coverage
  - Communicate with the individual on various membership operational policies, rules, and procedures

- Explanatory Materials – A subset of marketing materials primarily intended to explain the benefits, operational procedures, cost sharing, and/or other features of an organization to current members or those considering enrollment. Explanatory materials are further subdivided into pre- and post-enrollment materials.

Definitions - General

- Promotional Activities – Activities intended to educate potential enrollees or to assist potential enrollees in enrollment.

- Value Added Items and Services (VAIS) – Items and services offered to plan members that do not meet the definition of benefits under the Medicare program and involve only administrative or minimal cost. VAIS may not be funded by Medicare program dollars and are subdivided into Health-Related VAIS and Non Health-Related VAIS.
Definitions – Marketing Materials

◆ Pre-Enrollment Marketing Materials – Materials that provide more detail on the Organization than what is provided in an advertisement and are generally used by prospective enrollees to decide whether or not to enroll in an Organization. Organization rules and benefits are among the information included in such materials.

◆ Post-Enrollment Marketing Materials – Materials used by an Organization to convey benefits or operational information to enrolled plan members.

◆ Advertising Materials – Materials intended to attract or appeal to a potential Organization enrollee. Such materials are intended for quick view and do not contain the same level of detail expected in other marketing materials. The purpose is to allow recipients the opportunity to request additional information that will assist them in making an informed enrollment decision.

Types of Marketing Materials

◆ Advertising Materials
  • Television Ads
  • Radio Ads
  • Outdoor Advertising (billboards, signs attached to transportation vehicles, etc.)
  • Banner/Banner-like Ads
  • Print Ads (newspapers, magazines, flyers, brochures, posters, etc.)
  • Direct Mail without enrollment forms (postcards, self mailers, reply cards, etc.)
  • Event Signage
  • Internet Advertising
  • Windows Stickers
  • Post Stands and Free Standing Inserts
Types of Marketing Materials

- Pre-Enrollment Materials
  - Sales Scripts
  - Sales Presentations
  - Direct Mail that includes an Enrollment Form

- Post-Enrollment Materials
  - Annual Notice of Change/EOC
  - Evidence of Coverage (stand-alone)
  - Summary of Benefits
  - Provider Directories
  - Pharmacy Directories
  - Appeals and Grievance Letters
  - Enrollment/Disenrollment Forms and Letters
  - Member Handbooks

Materials Required at Point of Sale

- Cover letter with contact information
- Enrollment instructions and forms
- Summary of Benefits
- Written explanation of processes: exceptions, grievances, appeals, contract termination
  - Also a good idea to use for reference:
    - Pharmacy directory
    - Formulary
    - Evidence of Coverage
- Written notice regarding refusal rights, possibility of service area reductions and potential member disenrollment from plan if contract is terminated.
Marketing Materials
Rules for Production and Distribution
• ALL materials must:
  – Be approved by CMS prior to use
  – Be unchanged from what was approved by CMS (unless information was bracketed)
  – Be at least size 12-point font
  – Include a statement that the MA plan is contracted with CMS
  – Include contact information (toll-free #, TTY/TDD #, hours to call, website)
  – Only be used within the defined service area
  – Important:
    • Marketing pieces should have the CMS Material ID number and approval date printed on them, and if they don’t, they shouldn’t be used
    • All sales presentations, scripts (including in-person), and telemarketing are also subject to CMS review

Marketing Materials
Availability of Alternative Formats
• Plans must provide a disclosure on pre-enrollment materials and post enrollment EOC indicating documents are available in alternative formats (e.g. foreign languages, large print, etc.).
• Plans must make marketing materials available in any language that is the primary language of than 10% of beneficiaries in the geographic area.
• Materials must be available for visually impaired.
• CMS requires use of standardized language in all materials. For example, plans translating materials into Spanish or Cantonese should use a standard Spanish or Cantonese language resource (e.g., “Real Academia Espanola” Royal Spanish Academy, the most widely-recognized institution responsible for regulating the Spanish language.)
Marketing Materials
Summary of Benefits

- If the MA Plan includes additional information about covered benefits in Section 3 (freeform text area), they may include a page reference to this information the appropriate box in the benefit comparison matrix using the language:
  - “See page <> for additional information about (Enter the benefit category exactly as it appears in the left column)”. Additional language makes it non-model and subject to longer reviews by CMS.
- CMS will allow the option to use the prior year’s Medicare premium and deductible amounts instead of waiting for CMS to issue the new information. Plans should use a “2009 Benefits” placeholder sentence.
- SB does not need to be sent with the ANOC.
- Summary of Benefits hard-copy changes are only permitted to correct inaccurate or misleading information generated by SB/PBP software. HC changes must be requested by organization and approved by CMS. These changes will not be reflected in Medicare Options Compare nor will they be noted in the PBP.

Marketing Materials Combined
ANOC/EOC

- Combined/standardized document – first use 2009
- Submit via “file & use certification”
- ANOC/EOC is due to all members by 10/31
  - Plans must indicate actual mail date in HPMS within 3 days of mailing
  - Plans must issue upon enrollment and at least annually
- Plans must send new members an EOC no later than when the plan confirms the member’s enrollment
- LIS Riders and abridged or comprehensive formularies are due to MA-PD and PDP members by 10/31
- CMS strongly urges plans to have post their EOCs on plan websites
- Area of compliance focus and CMS attention
Marketing Materials Provider Directory

- Provide at the time of enrollment and at least annually thereafter
- Non-model, but might become so in 2010
- Plans can combine Pharmacy & Provider Directories or keep as separate documents
- Must include:
  - Number, mix and distribution of providers including addresses.
  - Providers available through out-of-network coverage or POS options
  - PCP, specialist, SNF, hospital, outpatient mental health providers, and pharmacies (if applicable)
  - Lock-in information
  - Plan service area description
  - Customer Service contact information
  - Instructions re: non-contracting provider billing
  - Information re: OOA & ER coverage
  - Prior authorization rules
  - Disclaimer re: directory being current

Marketing Materials – ID Cards

Front of Card
- Each member must be provided ID card at time of enrollment
- Font size 8 point or larger for mandatory elements
- Cardholder’s ID which cannot be the SSN or HICN
- Cardholder’s first name, middle initial (if available) and last name
- No co-branded logos (exclusion SPAP and specific provider network logos)

- Back of Card
  - Font must also be 8 point or larger
  - Claims submission name & address
  - Customer Service numbers and Customer Service TTY/TDD number
  - Bar coding, when required by state law
  - Optional elements:
    - Medicare Contact Information (1-800-MEDICARE)
    - PO Box/Address to return lost cards
    - Benefit Administrator web site information

- OPTIONAL: MA PPOs and PFFS plans recommends language indicating “Medicare limiting charges apply” and “Provider should bill the PPO or PFFS organization and not original Medicare.”
Marketing Materials Not Subject to Review

• Privacy notices (but are subject to enforcement by the Office for Civil Rights)
• Press releases
• Newsletters (unless sections used to enroll, disenroll and communicate with members on membership operations policies, procedures, rules, etc.)
• Blank letterhead/fax coversheet
• General health promotion materials that do not contain marketing materials
• Customer service correspondence that addresses issues unique to individual members
• Materials used in education of beneficiaries
• Coordination of Benefits survey

Marketing Materials Can’t Say / Must Say

• Can’t Say
  – Health Plan/Sponsor is endorsed by CMS, Medicare or DHHS
  – The Plan is for seniors / 65+ / retirees
  – No claims or paperwork

• Must Say
  – Health Plan/Sponsor has a contract with Medicare to provide drug coverage
  – The Plan is available to anyone eligible for Medicare
  – Medicare beneficiaries might qualify for various types of subsidies to help pay for this coverage
  – Generally, members must use network providers and pharmacies to receive benefits
Marketing Materials
Employer/Union

- CMS may waive or modify marketing requirements that “hinder the design of, the offering of, or the enrollment in” employer-sponsored group plans (Social Security Act Sections 1857(l) and 1860D-22(b))
- CMS has waived certain marketing requirements for all employer-sponsored MA-PD plans
- CMS will waive certain disclosure and dissemination requirements when Organizations that offer employer/union-only group plans provide attestations that the employer or union sponsor is subject to alternative disclosure requirements and the plan complies with such alternatives
- MA organizations and PDPs that offer employer/union-only group plans may merge their existing member ID cards in order to provide enrollees with one combination member ID card; however, co-branding is not allowed on ID cards.

Promotional Activities and Guidelines
Promotional Activity Guidelines

- Promotional activities must comply with all relevant Federal and state laws (e.g. anti-kickback statutes, civil monetary penalty prohibiting inducements)
- Any promotional activities or items (not including VAIS) offered by Organizations, including those that will be used to encourage retention of members, must be
  - Of nominal value
  - Offered to all eligible members without discrimination
  - Not in the form of cash or other monetary rebates
- Organizations may not offer pre- or post-enrollment promotional items that in any way compensate beneficiaries based on their utilization of services or influence their decision to enroll

Types of Promotional Activities

- Nominal Gifts
  - Promotional gifts cannot exceed a nominal value of $15 based on the retail purchase price of the item.
- Drawings/Prizes/Giveaways
  - Free gifts and prizes cannot be used to induce enrollment and must have a value less than $15. Statements regarding these promotional items must include a “no obligation to enroll” disclaimer.
  - Gifts that can be converted to cash are not allowed, even if gift is under $15.
- Hold Time Messages
  - Messages should only discuss health-related features and other operational or general information.
- Referral Programs
  - Organizations can ask for referrals from active members, including names and addresses, but cannot request phone numbers.
Types of Promotional Activities

- Door-to-Door Solicitation
  - Prohibited unless invited by the beneficiary
- Unsolicited E-mail Policy
  - Beneficiary must agree to receive e-mails
- Outbound Telemarketing
  - Starting 1/1/09, outbound telemarketing is prohibited (MIPPA). Contact with potential enrollees is only allowed if the enrollee initiates the action.
- Direct Mail Marketing
  - Starting 1/1/09, plans cannot call potential enrollees directly to inquire about interest in direct sales materials mailed without the enrollee’s request
- No Cross-Marketing
  - Prospective enrollees must know and agree to scope of products discussed at sales meetings.
  - Sales staff must obtain written documentation of agreement of scope

Promotional Events – Sales Events

- Sole-Sponsor
  - Referring to a single-sponsor for an event
  - If offered, door prizes/raffles cannot exceed the $15 limit each
- Multi-Sponsor
  - More than one sponsor for an event. It may consist of the MA-PD and one or more participants who are not contracting providers with the MA-PD
  - Door prizes/raffles can exceed the $15 limit if a MA-PD contributes to a pool of cash for prizes or contributes to a pool of prizes such that the prize(s) is not individually identified with the MA-PD, but is identified with a list of contributors
  - Anyone who attends must be eligible for the prize

- Starting in 2009, CMS will allow no sales activities to take place at Health Fairs.
Drawings / Prize Giveaways

- Free gifts and prizes cannot be given as an inducement for enrollment
- Any gratuity must be made available to all participants whether or not they enroll
- The value of any gift should be less than $15 and cannot be anything that can be converted to cash (even if under $15)
- Statements made concerning drawings/prize giveaways must include that there is no obligation to enroll in the Plan
  - Example: “Eligible for a free drawing and prizes with no obligation”
- No meals at presentations – light snacks allowed

Health Fairs

- Beginning 9/18/08, educational events cannot include sales activities
- No marketing materials may be distributed
- Can discuss educational information about Medicare program
- Disclaimer required on event advertising materials that event is educational only
- Can be sponsored by the plan, outside entity
Provider Promotional Activity

• Generally, providers must only provide assistance in enrollment and education in their capacity as a member of the MA-PD’s network and only in coordination with the MA-PD. MA-PD activities and materials in the health care setting:
  
  – Sales presentations and information materials cannot be distributed in a health care setting. Enrollment forms cannot be handed out.
  
  – Sales presentations cannot be conducted in areas where patients primarily intend to receive health care services, such as long-term care facilities, an exam room, waiting rooms, and/or pharmacy counter areas.
  
  – Sales & Marketing activities may be held in a common area.
  
  – Again, sales and marketing is not allowed at health education events including health fairs.

The “Cannot Do!”

• Sales Reps and Brokers/Agents cannot / may not:
  
  – “Cherry pick” – Some agents may be in a unique position to enroll healthier beneficiaries into specific health plans
  
  – Discriminate against any eligible person
  
  – Make unsolicited contact with potential enrollees
  
  – Make outbound telemarketing calls
  
  – Rent an email list to distribute information about MA or Part D
  
  – Acquire email addresses through any type of directory
  
  – Solicit Medicare beneficiaries door-to-door for health related or non health related services and/or benefits prior to receiving an invitation from the beneficiary
Scope of Appointments

• Recent regulations state that MA or Part D plans may not conduct marketing for any products beyond the scope agreed upon by the beneficiary.
• Agreement of scope must be documented (CMS Model Scope of Sales Confirmation Form now available).
• Applies to any personal/individual meeting.
• Documentation of agreed to scope of appointment must be in writing, in the form of signed agreement by member, or via recorded oral agreement.
• Documentation should be obtained prior to meeting, or at the very least, an agent must get the beneficiary to sign the form at the beginning of the appointment.
• Bene can sign a Scope form at a group sales presentation for a follow-up appointment without a 48 hour waiting period applying.

Audits and Monitoring Activities
Audits and Monitoring Activities – Elements of a Compliant Sales & Marketing Plan

- This plan should be in place and be overseen by the Head of Marketing/Sales, but Medicare Compliance should have input into the plan.

- There should also be defined handoffs with regard to how Medicare Compliance will be involved with oversight, investigation of complaints, and progressive discipline.

- The Sales/Marketing compliance plan should also have detailed policies and procedures that describe how the staff will be trained, tested, and overseen by Department Heads and Medicare Compliance.

- Both the Compliance plan and the P&Ps should specify how any brokers or agents will be overseen as “delegated” sales reps of the health plan.

- Sales Compensation compliance is now a big focus as a result of MIPPA

Audits and Monitoring Activities

During an audit, health plan must demonstrate that:

- There is oversight/management of all individuals who sell Medicare plans (marketing representatives, agents, and brokers).

- There are procedures in place to determine understanding of the Medicare program by all individuals selling the plan.

- There are procedures in place to monitor activities of all individuals who are selling the plan (e.g. ride-alongs, pop-ins, silent monitoring of telemarketers).

- There are personnel evaluations to determine where marketing emphasis is placed (e.g. numbers enrolled versus accuracy of enrollments, “charge back” program for rapid disenrollments.)

- There is effective training and testing for all individuals selling the plan (the training is deemed effective if a Medicare beneficiary is able to make an informed decision regarding enrollment).

- Sales compensation is administered per MIPPA requirements and to reflect method filed with CMS.
Sales and Brokerage Oversight
Direct Sales Agent = Broker/Agent

CMS expects the same level of compliance for directly employed sales agents as it does for contracted broker/agents. CMS marketing guidelines applies to both the direct sales agent and the broker.

Sales & Brokerage Oversight

- CMS expects plans to ensure a significant oversight role on both direct sales and broker/agent sales activities.
- CMS increased oversight activities based on inappropriate/misleading marketing practices at 7 of the large PFFS plans in May, 2007
- CMS guidance was released and then put into law on July 15, 2008 through the MIPPA legislation
- New sales/marketing guidance released as part of MIPPA reform and subsequent regulations released 11/10 to provide more detail on sales compensation
- Oversight of these areas and functions will be a key audit area and one that will be constantly monitored by Regional and Central CMS Office staff.
Sales & Brokerage Oversight
Sales Presentations, Unsolicited Contacts & Training

- Must use CMS approved sales presentations
- Must use PFFS disclaimer language
- No door-to-door solicitation
- Must NOT do unsolicited calling (telemarketing)
- Must report sales meetings monthly through HPMS
- Must perform internal “secret shopping” and audit
- Sales Training Programs
  - CMS approved modules recommended
  - Written with 85% pass rate
  - Initial Certification and Yearly Re-Certification or “no sell”
- Must use state licensed agents and abide by state licensure laws
- Must maintain licensure and training databases so that plans can report on compliance to CMS and State in these areas

Sales & Broker Oversight
PFFS Sales Language Disclaimer

- CMS has revised the PFFS Disclaimer language subsequent to the May 25, 2007 guidance to all PFFS plans. This language must be prominently displayed on all materials including but not limited to, advertisements, enrollment-related materials, web-based information, materials used at sales presentations by agents and brokers in all meetings with beneficiaries.

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan’s terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan’s terms and conditions on our website at [insert link to PFFS terms and conditions].
Sales & Brokerage Oversight
Misrepresentation

Direct sales agents and brokers must not:

• Provide false or misleading information about the Medicare MA or Part D plans including benefits, provider rules and all other plan information.
• Lead beneficiaries to believe they are purchasing a stand-alone PDP rather than a PFFS (or other MA) plan.
• Say that a PFFS plan (or other MA plan) is the same as Original Medicare.
• Lead beneficiaries to believe that a Medicare PFFS Plan (or other MA plan) is a Medicare supplement plan or use terms such as “Medicare Supplement replacement.”
• Lead beneficiaries to believe that the broker or agent works for Medicare, CMS or any government agency.
• Claim that Medicare, CMS, or any government agency endorses or recommends the Medicare MA or Part D plan.

Health Plan/Sponsor Enforcement
Actions
Related to Marketing Abuses

• CMS requires MAOs to conduct “secret shopper” visits to a sample of sales and outreach activities
  – CMS is now doing this across the United States with mixed results
• MAOs must establish penalties for brokers and agents who engage in verified misconduct. Penalties for brokers should include:
  – Withholding commissions
  – Re-training
  – Suspension of marketing
  – Termination
  – Reporting conduct to State DOI
• MAO sales compensation structure must:
  – Avoid incentives to mislead, cherry pick or churn beneficiaries between plans
  – Withdraw compensation if member rapidly disenrolls (60/90 days)
CMS Enforcement Actions Related to Marketing Abuses

- CMS oversees MAO/Part D plan sponsor compliance with Medicare sales and marketing rules.
- CMS’ monitoring includes “secret shopper” visits to a sample of sales and outreach activities for each sponsor based on the events reported through HPMS monthly.
- Plan sponsors are subject to CMS penalties for non-compliance that include:
  - Corrective Action Plans (CAPs)
  - Suspension of marketing and enrollment
  - Monetary penalties
  - Contract terminations
- In other words, CMS is constantly auditing and monitoring these activities and expects plan sponsors to have internal controls and processes to ensure on-going compliance.

CMS Oversight & Enforcement Additional Resources

- www.Medicare.gov
- Medicare Marketing Guidelines (look for update to this 2006 document soon!)
- CMS Guidance for Eligibility, Enrollment and Disenrollment for MA Plans, including MA-PD plans
- 2009 Call Letter – Section C – Marketing/Beneficiary Communications
Questions?

Marketing Material Development/Review
Submission Process

- All marketing materials must be submitted to CMS accordingly:
  - MA marketing material must be submitted through either the Health Plan Management System (HPMS) Marketing Module tool, or by mail, fax, or email to the Regional Office

Time Frames for Review

- Organizations may not distribute marketing materials or enrollment forms, or make them available unless:
  - The materials have been submitted to CMS for review 45 days prior to distributions
  - CMS has not disapproved the materials
- This rule applies to materials submitted where:
  - No standardized or model language is available
  - Available model language is not being used without modification
- Materials may be distributed before 45 days have passed if prior approval has been granted by CMS
45-Day Review Exception

• When an organization follows CMS model language without modification, CMS must review the material within 10 days (as opposed to the usual 45)
  – CMS model language must be used verbatim
  – Must also follow the sequence of information provided in the model
• CMS must make a determination within 10 days, or the material is deemed approved on the 11th day
• Organization must indicate on its submission that it has followed the CMS model without modification and is requesting the 10 day review

Material Disposition Definitions

• Approval
  – Material is compliant and approved for use
  – Remains approved until material is altered or conditions change such that the material is no longer accurate
• Disapproval
  – Material is not compliant
  – CMS will provide a specific reason for disapproval and, when possible, provide specific citations to the requirement with which the material was non-compliant
• Deemed
  – Materials subject to the 45/10-day review period will be given the status of “Deemed” approved on the 46th/11th day
• Withdrawn
  – An organization can choose to withdraw a submission prior to CMS acting upon it
File and Use Overview: Certification and Eligibility

- File & Use Certification - Organizations can certify that they followed all applicable Marketing Guidelines or use certain CMS models without modification when a model is available as specified by CMS.

- File & Use Eligibility – No longer used per MIPPA changes.

File & Use Certification

- All plans qualify to use file and use certification. If not already qualified (pre-MIPPA), plans must have submitted a one-time certification form.

- File & Use Certification marketing materials must be submitted to CMS 5 calendar days prior to distribution and certify they comply with Marketing Guidelines.

- Model language must be used without modification, if available.

- Organizations are required to submit at least 90% of materials that qualify for File & Use Certification under this process.
Materials Qualified for File & Use Certification

- Advertising materials
- Provider and/or pharmacy directories (model)
- Formularies
- Certain CMS model letters utilized without modification
  - Enrollment/disenrollment
  - Claims
  - Organization determinations
  - Appeals/grievances
  - Exception process
- 2009 Combined Standardized ANOC/EOC

Materials Not Qualified for File & Use Certification

- Any material that poses greater risk to a Medicare beneficiary if it is inaccurate in any way
  - Summary of Benefits
  - Member Handbook
  - Member ID card
  - Mid-year Benefit Enhancement Notice
  - Individual Enrollment Form
  - Abbreviated Enrollment Form
  - Disenrollment Form
  - PFFS Terms & Conditions (Model) – by 1/1/09
- Materials not qualified for File & Use Certification will remain under the 45/10 day review process
- For full listing, see Marketing Code Look-up in HPMS
Retrospective Monitoring Review

- CMS selects a random sample of qualified materials for review
- Review is conducted semi-annually for materials submitted for the previous 6 months
- Marketing complaints are investigated to verify if they are valid marketing violations
- CMS may order the organization to prepare an addendum or reissue any marketing materials if they are found not to comply
- Failing to comply may result in corrective action

CMS Increased Emphasis on Marketing Materials

- Due to number or errors in plan materials and in plan submission process, CMS will more closely monitor plan compliance starting in CY 2009.
- CMS has disclosed these areas of increased focus:
  - HPMS will be improved to document all revisions to submitted materials;
  - Materials will be rejected for substantive grammatical errors;
  - CMS reviewers will be re-trained on Medicare Marketing Guidelines (including changes to the MG because of MIPPA);
  - Retrospective reviews of file and use materials will continue;
  - Secret shopping of sales events;
  - Reviews of CTM marketing complaints;
  - Reviews of materials currently in marketplace; and
  - Compliance actions for significant violations of CMS marketing requirements.