DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS for MEDICARE & MEDICAID SERVICES

CENTER FOR DRUG AND HEALTH PLAN CHOICE

DATE: September 18, 2009

TO: Medicare Advantage Organizations
Medicare Advantage-Prescription Drug Organizations
Cost-Based Contractors
Prescription Drug Plan Sponsors
Employer/Union-Sponsored Group Health Plans

FROM: Teresa DeCaro, Acting Director, Medicare Drug & Health Plan Contract Administration Group

RE: Issuance of the Final 2009 Medicare Marketing Guidelines and Clarification of Appeals Related Error in Annual Notice of Change/Evidence of Coverage (EOC) Templates

On August 10, 2009, CMS sent an HPMS memorandum announcing the issuance of the revised Medicare Marketing Guidelines as Chapters 3 and 2 of the Medicare Managed Care Manual and the Prescription Drug Benefit Manual, respectively. Since the release of the revised Medicare Marketing Guidelines, we have received a high volume of requests for clarification of several sections of the Guidelines. In this memorandum, we provide critical clarifications necessary for organizations and sponsors to prepare for the beginning of the contract year 2010 marketing season on October 1, 2009. Organizations and sponsors should view this guidance as an addendum to the current Medicare Marketing Guidelines. Please note, however, that we are already beginning our next revision of the Guidelines; that revision will contain the clarifications provided in this memorandum as well as additional clarifications and revisions for future implementation.

In addition, we issued the final 2010 ANOC/EOC templates for all plan types on July 31, 2009. We have since identified an error in the standardized language regarding appeals in section 4.1 of the PDP and MA-PD EOC templates. In this memorandum, we also provide corrected standardized language that these plan types must use in their 2010 EOCs.

Marketing Guidelines Clarifications

Section 20 - Definitions (Direct Mail), Section 90.6.1 - Materials Qualified for the File & Use Submission, and Section 90.19 - Specific Guidance on the Submission of General Advertising Materials

We have received a number of questions about whether direct mail and general advertising pieces are eligible for File & Use submission when they contain benefit and plan premium information. In order to clarify these questions, we are revising the definition of "direct mail" at section 20 of the Guidelines to read as follows:

"Direct mail pieces are primarily intended to attract or appeal to a potential enrollee and allow him/her to request additional information to make an educated decision about his/her health care options. Direct mail should possess one or more of the following characteristics: (1) pertains to rules or benefits of existing coverage or any other type of coverage offered, (2) contains more than three pages of content, and/or (3) has a salutation to a specific individual."

In addition, we wish to clarify sections 90.6.1 and 90.19 such that direct mail and general advertising materials may be submitted as File & Use provided the materials are not explanatory marketing materials that mention benefit and plan premium information, as detailed in section 50.5.3, and meet one or more of the three characteristics of direct mail as defined in section 20. Direct mail and general advertising materials that are explanatory marketing materials that mention benefit and plan premium information, as described in section 50.5.3, will not be eligible for File & Use regardless of whether they meet one or more of the three characteristics of direct mail as defined in section 20.

Section 30.7 – Requirements for Plan Sponsors with Non-English Speaking Populations or Populations with Special Needs

Section 30.7 currently states that plan sponsors "should make marketing materials available in any language that is the primary language of more than ten percent of a plan sponsor's PBP service area." We have received a number of questions regarding whether the provision of non-English materials is actually required when more than ten percent of the service area speaks that non-English language. We clarify that this is a requirement; sponsors must make marketing materials available in any language that is the primary language of more than ten percent of a plan sponsor's PBP service area.

Section 30.14 – Plan Ratings Information from www.medicare.gov and Section 30.9.1 – Required Materials in Enrollments Package (Pre-Enrollment)

Section 30.14 of the Guidelines requires plans to provide information about their plan or plans' ratings information to current and prospective enrollees by referring them to www.medicare.gov, by including the information in their pre-enrollment packet, and by making it available upon request. Section 30.9.1 of the Guidelines further reinforces this requirement by indicating that plan sponsor "enrollment kits" must include information about their plan ratings information. When we released the Guidelines, we alerted plans that we would provide more guidance about this requirement in subsequent guidance.

Plan sponsors must download their 2010 plan performance rating template from the Health Plan Management System (HPMS) Part D Performance Metrics Module using the following navigation path: HPMS Homepage > Quality and Performance > Part D Performance Metrics and Reports > Plan Ratings Template. Following selection of a contract number, plan sponsors will select the "Create PDF" link to generate their customized contract-specific template in PDF format, which may not be altered. Plan performance summary ratings for contract year 2010 will not be available until October 8, 2009. MA-PD plans will need to download separately plan performance ratings for MA and Part D, respectively. Therefore, beneficiaries requesting plan performance ratings for MA-PD plans will receive two documents.

Because plan ratings information is typically not finalized until after October 1st, the first day marketing for the following contract year is permitted, we clarify that the inclusion of the plan

ratings document in the enrollment kit is highly encouraged but optional for CY 2010. However, plan sponsors should ensure that they provide this information to current or prospective enrollees upon request using the HPMS generated plan ratings document for their contract. Please note that the HPMS generated plan ratings document may not be altered.

Section 40.16 - Standardization of Plan Name Type

Section 40.16 states that model documents do not require inclusion of the plan name throughout the entire document, but that plans must include the plan type on the front page of the model document or at the beginning of the model document. We have received a number of questions about whether this same guidance applies to non-model documents. We clarify that neither model nor non-model documents must include the plan type throughout the document. Plan sponsors must ensure that they include the plan type on the front page or at the beginning of the model or non-model document to comply with our plan name type requirements.

Section 40.16 also provides that plan logos that include a plan name must include the plan type in the logo. We understand that plan sponsors have existing stock of letterhead including plan logos that include a plan name but not the plan type and have been asked to clarify whether they would be permitted to use existing stock for some period of time. We clarify that we are providing some operational flexibility to plan sponsors in this situation. Prior to January 1, 2010, we will permit plan sponsors to use existing stock provided they mention the plan type on the front page or the beginning of the document that includes the logo. After January 1, 2010, any logo a plan sponsor uses that includes the plan name must include the plan type in the logo.

In addition, CMS will allow organizations and plan sponsors to either spell out the plan name type or abbreviate on materials that are not generated from the Health Plan Management System (HPMS). For example, use of "either "Acme Medicare HMO" or "Acme Health Maintenance Organization." We remind plan sponsors that HPMS auto-generated plan name types cannot be altered or changed.

Section 50 – Disclaimers

A number of plan sponsors have expressed concerns about the new disclaimers required in section 50 of the Guidelines, particularly given previous Regional Office approvals of marketing materials that did not include those disclaimers. We clarify that plan sponsors that have already received approval for marketing materials that do not include the new disclaimers established in the final Medicare Marketing Guidelines will not be required to resubmit their materials to their CMS Regional Office for approval. However, plan sponsors must add the appropriate disclaimer to the already approved marketing material to be compliant with the disclaimer requirements in section 50. Plan sponsors submitting marketing materials for review and approval after the release of the Guidelines must include the appropriate disclaimers in their submitted materials. Plan sponsors found not to include the appropriate disclaimers in their marketing materials may be subject to compliance action.

Section 50.6 - Plan Mailing Statements on Envelopes/Mailing Itself

We have received a number of questions about both the requirements in section 50.6 and their implementation timing. As provided in section 50.6, all mailings to beneficiaries must include a statement on the envelope or mailing itself to identify the type of plan mailing. We clarify that the second statement in section 50.6 regarding plan information should read "Important plan

information" instead of "Important plan information about your enrollment." We further clarify that all mailings must include one of the three mailing statements – a mailing must either be categorized as an advertising, plan information, or health and wellness mailing. If a mailing is not an advertisement or a health and wellness mailing, sponsors should categorize it as a plan information mailing. Plan sponsors may not create additional statement categories.

Plan sponsors have asked whether they may use their existing stock of envelopes for some transitional period while they implement this requirement. We clarify that we will provide some operational flexibility to plan sponsors in this situation. Prior to January 1, 2010, we will permit plan sponsors to use their existing stock of envelopes provided they make a good faith effort to comply with our requirements by using alternate methods of conveying this statement (e.g., by the use of stickers or stamps). After January 1, 2010, all plan envelopes or mailings must include one of the three statements provided in section 50.6 and this guidance.

Section 70.6 - Outbound Education and Verification Calls to All New Enrollees

CMS has received a number of questions about the requirements in section 70.6 of the Guidelines, particularly as concerns our intended implementation timeframes. CMS is currently evaluating these questions and will issue further guidance in the near future.

Section 70.9 - Marketing/Sales Events

As provided in section 70.9, plan sponsors must upload an event no later than the 30th of the month preceding the event. Amendments to marketing/sales events (e.g., cancellations, updates and edits) must be updated in HPMS at least 48 hours prior to the scheduled event. We have heard from a number of plan sponsors that this cut-off date limits their flexibility to schedule marketing events. We clarify that plan sponsors are permitted to add new marketing/sales events after the 30th of the month as long as the marketing/sales events are entered into HPMS prior to the occurrence of the actual event.

EOC Clarification

We have identified an error in the standardized language describing certain appeals requirements in section 4.1 of the PDP and MA-PD EOC templates. This language currently reads as follows:

> "If [the plan] says no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal." However, as provided in sections (70.9.1 and 70.9.2 of Chapter 18 of the Prescription Drug Benefit Manual), it is not correct that a Level 1 appeal is automatically forwarded to the IRE; rather, the beneficiary must submit the request within 60 days of the plan's decision and can do so using a CMS model request for reconsiderations. Appeals are automatically forwarded only if the plan did not provide a response within the timeframes set forth by CMS.

Sponsors of MA-PD plans and PDPs should replace the language cited above with the following corrected, standardized language:

> "If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal."

We hope this memorandum provides useful guidance to plan sponsors as they prepare to market their 2010 Medicare health plan products. Plans sponsors should contact their local CMS Regional Office Account Manager or Marketing Reviewer with additional questions.