DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS for MEDICARE & MEDICAID SERVICES

CENTER FOR DRUG AND HEALTH PLAN CHOICE

DATE: February 19, 2010

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

FROM: Danielle Moon, J.D., M.P.A
Director, Medicare Drug & Health Plan Contract Administration Group

RE: Issuance of the Revised Draft 2011 Medicare Marketing Guidelines

Included with this memorandum are CMS' draft revisions to the Medicare Marketing Guidelines for Medicare Advantage organizations; prescription drug plan sponsors; section 1876 cost-based contractors; demonstration plans; and employer and union-sponsored group plans, including employer/union-only group waiver plans for contract year 2011. (Chapters 3 and 2 of the Medicare Managed Care Manual and the Prescription Drug Benefit Manual, respectively.) The draft revision of the Guidelines will also be available on the marketing page of the CMS website at: http://www.cms.hhs.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp#TopOfPage. We are releasing these draft revisions to obtain public comment, which we will consider carefully before finalizing the Guidelines later this year.

In drafting our proposed revisions for marketing requirements for contract year 2011, we have focused primarily on incorporating recent policy clarifications and on streamlining operational guidance for the benefit of both plans and Regional Office marketing reviewers. We have also made minor editorial changes throughout the document and renumbered certain sections from the current Guidelines as part of our efforts to streamline requirements. We will separately issue technical and procedural clarifications regarding CMS marketing models for contract year 2011. In order to facilitate review of our proposed changes to the Guidelines, we provide below a high-level summary of the most significant changes in the draft. We ask that commenters focus primarily on our proposed changes and not on established policy issues. We have noted in bold, italicized text in the draft revised Guidelines those areas that have been modified or added relative to the 2010 Guidelines so that reviewers can easily identify our changes. In our review of comments, we will focus primarily on the specific areas we are proposing to revise.

Summary of Significant Changes

- Clarified guidance related to requirements for plan sponsors with non-English speaking or special needs populations (section 30.7).
- Added guidance related to material status and date stamp for file & use materials (section 40.1).

- Clarified guidance related to customer service hours of operation requirements and added a new section on agent/broker customer service number requirements (sections 40.11 and 40.11.1).
- Significantly restructured and consolidated disclaimer requirements (section 50).
- Clarified and restructured guidance related to advertising/explanatory marketing requirements (sections 50.1 and 50.1.1).
- Clarified plan mailing statements (section 50.2; formerly section 50.6).
- Clarified the responsibility for the summary of benefits review on the comprehensive statement in section 4 regarding accuracy of SNP benefits (section 60.1).
- Clarified guidance related to provider and pharmacy directory mailing requirements (sections 60.4.1 and 60.4.2).
- Clarified that door hangings are considered unsolicited contacts (section 70.4).
- Revised our policy with regard to outbound enrollment verification (OEV) requirements, including applicability of OEV requirements to enrollment changes within organizations and to agents when acting as customer service representatives only, operational timeframes, and guidance on recording and retaining verification calls. We also added Medicare Medical Savings Account OEV requirements to this section (sections 70.6 & 70.6.1).
- Restructured and revised guidance regarding educational events and sales/marketing events to encompass relevant topics or examples from current Guidelines sections 70.7.1-70.8.3 (sections 70.7 and 70.8; formerly 70.8 and 70.9).
- Added guidance on resubmitting previously disapproved marketing pieces (section 90.4).
- Revised the submission of template materials (section 90.10)
- Extended website requirements to Part C organizations and to social networking sites (section 100.1).
- Added requirements regarding the prohibition of charging additional marketing fees (section 120.5.4.1).
- Added and clarified requirements with respect to the charge back for agents and brokers (section 120.5.6).
- Clarified that the Medicare Mark will be incorporated in the contract management module in HPMS and that further guidance will be forthcoming as part of the annual contracting process (section 150).
- Added previously released policy guidance on the use of Federal funds and the use of Medicare beneficiary information obtained from CMS requirements (sections 160 and 170).

We appreciate your feedback and comments on our proposed changes to the draft revision of the Guidelines as described above. Comments on the draft revisions must be received by CMS no later than 5 PM (EST), March 5, 2010. Comments received after this date may not be considered for this update. Please submit all comments using the attached Excel spreadsheet via e-mail to Marketingpolicy@cms.hhs.gov with "Comments on Marketing Guidelines" in the subject line of the email. We thank you in advance for your careful review and comments on these draft Medicare Marketing Guidelines.