Draft CY 2013 Marketing Guidance for Massachusetts Medicare-Medicaid Plans (Integrated Care Organizations)

Released for Comment: March 29, 2012

Introduction

All Medicare Advantage-Prescription Drug (MA-PD) plan sponsor requirements in the CY 2013 Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf) apply to Medicare-Medicaid plans (MMPs), also referred to as Integrated Care Organizations (ICOs), participating in the Massachusetts Capitated Financial Alignment Demonstration, except as noted or modified in this guidance document.[1]

This guidance document provides information only about those sections of the Medicare Marketing Guidelines that are not applicable or that would be different for MMPs in Massachusetts; therefore, this guidance document should be considered an addendum to the CY 2013 Medicare Marketing Guidelines.

In addition, we clarify that all requirements applicable to independent agents/brokers throughout the Medicare Marketing Guidelines will be inapplicable to MMPs in Massachusetts, because the use of independent agents/brokers will not be permitted and all MMP enrollment transactions must be processed by the State enrollment broker.

We refer MMPs to the following available model marketing materials:

- MMP-specific model materials: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html. MMP-specific model materials tailored to MMPs in Massachusetts will be added to this website on a flow basis as they are finalized and will also be disseminated via the Health Plan Management System (HPMS).

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

- Part D appeals and grievances models in Chapter 18 of the Prescription Drug Benefit Manual: http://cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html.

- Part C appeals and grievances models in Chapter 13 of the Medicare Managed Care Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf.

[1] Note that any requirements for Special Needs Plan (SNPs), Private Fee-for-Service (PFFS) plans, Preferred Provider Organizations (PPOs), and Section 1876 Cost-Based Plans (cost plans) in the Medicare Marketing Guidelines do not apply unless specifically noted in this guidance.

- ANOC/EOC errata model: http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html

We expect to issue additional operational guidance – including final marketing codes for MMPs to use in submitting marketing materials in HPMS – as well as Massachusetts-specific MMP marketing model templates later this spring.

Following are the Massachusetts MMP-specific modifications to the Medicare Marketing Guidelines.

Section 10 – Introduction

The prohibition on marketing for an upcoming year prior to October 1 will only apply when the upcoming plan year begins on January 1. Given the mid-year demonstration start in Massachusetts, for CY 2013, MMPs may not begin marketing activity prior to May 1, 2013, or the month following execution of the three-way contract with CMS and EOHHS for the Demonstration, whichever is later.[2] Marketing activity for CY 2014 may begin no earlier than October 1, 2013 and must be consistent with the CY 2014 Medicare Marketing Guidelines (which will be released in final later this year), with the exceptions articulated in this guidance as appropriate.

Section 30.3 – Disclosure of National Committee for Quality Assurance's (NCQA) Approval Information

The guidance for special needs plans (SNPs) in this section also applies to MMPs.

Section 30.7 – Requirements Pertaining to Non-English Speaking Populations

The standard articulated in this section for translation of marketing materials into non-English language will be superseded to the extent that Massachusetts' standard for translation of marketing materials is more stringent. The Massachusetts translation standard – which requires translation of materials into "prevalent languages" (i.e., Spanish and any language that is the primary language of 5% or more of the ICO service area population) – exceeds the Medicare standard for translation in Massachusetts MMP services areas for CY 2013. For CY 2013, Massachusetts' standard requires translation of marketing materials into Spanish in all service areas. Therefore, the Massachusetts standard for translation will apply to Massachusetts MMPs for CY 2013.

Section 30.7.1 – Multi-Language Insert

We clarify that MMPs will need to include a Multi-Language Insert with their demonstration-specific Summary of Benefits (SB) and Annual Notice of Change (ANOC)/Evidence of Coverage (Member Handbook) documents, as is the case for other plan sponsor types with their Medicare Advantage and Part D SBs and ANOC/EOC documents. In addition to providing the Multi-Language insert in the languages required by Medicare, MMPs must also provide the insert in Cambodian, Haitian Creole and Laotian. We expect to release a Massachusetts-specific Multi-Language Insert model template later this spring.

[2] We note that MMPs with an executed contract can only market if they have also passed the CMS-State readiness review.

30.8 – Required Materials with an Enrollment Form

MMPs will not be required to include the Plan Ratings Information document when a beneficiary is provided with pre-enrollment information.

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

This section is replaced with the following revised guidance:

> **30.9 – Required Materials for New and Renewing Members at Time of Enrollment and Thereafter**
>
> 42 CFR 422.111, 423.128, 422.2264, 423.2264
>
> The following materials must be received by enrollees at the time of enrollment and annually thereafter:
>
> - Annual Notice of Change/Evidence of Coverage (Member Handbook), or simply an Evidence of Coverage (Member Handbook), as applicable and described in the replacement guidance below for section 60.7 of the Medicare Marketing Guidelines.
>
> - A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and over-the-counter pharmacy drugs or products provided under the MMP.
>
> - A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits (required at the time of enrollment; see section 60.4 for additional information about provision of a directory post-enrollment).
>
> - A single identification (ID) card for accessing all covered services under the plan (required at the time of enrollment and as needed or required by the MMP post-enrollment).
>
> - For individuals enrolled through passive enrollment, a demonstration plan-specific Summary of Benefits (SB) containing a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, including co-pays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits (refer to the revised guidance for section 60.7 contained in this document for more information about when an MMP must send an SB to current enrollees post-enrollment).
>
> MMPs must provide enrollees who voluntarily opt-in the following materials no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever occurs first. For late month enrollment transactions (those for which CMS confirmation of enrollment is received less than 10 days before the end of the month prior to the effective date), MMPs must send these materials no later than ten (10) calendar days from receipt of CMS confirmation of enrollment. MMPs should

refer to the date of the Transaction Reply Report (TRR) that has the notification to identify the start of the ten (10) calendar day timeframe.

- A comprehensive integrated formulary
- A combined pharmacy/provider directory
- A single ID card

MMPs must provide enrollees who are passively enrolled the following materials no later than 20-25 days prior to the effective date of enrollment:

- A welcome letter consistent with a model developed jointly by CMS and the State
- A comprehensive integrated formulary
- A combined pharmacy/provider directory
- An SB

We specifically request comments about the proposed timeframe for receipt of the materials above.

In addition, MMP must provide enrollees who are passively enrolled a single ID card for receipt by the end of the month preceding the month the enrollment will take effect (e.g., the ID card must be received by a beneficiary by July 31 for an August 1 effective enrollment date). For late month enrollment transactions (those for which CMS confirmation of enrollment is received less than 10 days before the end of the month prior to the effective date), MMPs must send these materials no later than ten (10) calendar days from receipt of CMS confirmation of enrollment.

For both enrollees who are passively enrolled and enrollees who voluntarily opt-in, the Annual Notice of Change and Evidence of Coverage (Member Handbook) must be provided at the time of enrollment and annually thereafter consistent with the replacement guidance below for section 60.7 of the Medicare Marketing Guidelines.

Section 30.12 – Plan Ratings Information from CMS

This section does not apply to MMPs.

Section 30.12.1 – Referencing Plan Ratings in Marketing Materials

This section does not apply to MMPs.

Section 30.12.2 – Plans with an Overall Five-Star Rating

This section does not apply to MMPs.

Section 40.6 – Identification of All Plans in Materials

The guidance in this section is replaced with the following guidance:

> **Section 40.6 – Identification of All Plans in Materials**
>
> 42 CFR 422.2264, 423.2264, 422.2268, 423.2268
>
> Organizations offering both MMPs and non-MMP Medicare health plan options may only market MMP plan offerings in a service area in their MMP materials.

Section 40.8 – Hours of Operation Requirements for Marketing Materials

In addition to the requirements of this section, MMPs must also provide hours of operation information for the State enrollment broker in marketing materials where a customer service number is provided for current and prospective enrollees to call.

Section 40.11.3 – Non-Benefit/Non-Health Service-Providing Third Party Marketing Materials

In addition to the guidance in this section, CMS and the State clarify that materials produced by the State and its enrollment broker do not constitute non-benefit/non-health service-providing third party marketing materials. Therefore, such materials do not need to be submitted to the plan sponsor for review prior to their use. As indicated in the CMS "Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation rates and Medicare Advantage and Part D Payment Policies and Final Call Letter" released on April 2, 2012, CMS Medicare Marketing Guidelines do not apply to communication by State governments, and materials created by the State do not need to be reviewed or submitted in HPMS. However, CMS and the State agree to work together in the development of these materials.

Section 40.13. – Standardization of Plan Name Type

As is the case for other Medicare health plans, MMPs will be required to include the plan type in each plan's name using standard terminology consistent with the guidance provided in this section. CMS has created the standardized plan type label "Medicare-Medicaid Plan" to refer generically to all plans participating in a Capitated Financial Alignment Demonstration. CMS is unable to create State-specific plan type labels in HPMS for each State's demonstration plans; therefore all MMPs will include the standardized plan name type "Medicare-Medicaid Plan" in CMS' external communications– e.g., the Medicare & You handbook and the Medicare Plan Finder tool on www.medicare.gov. MMPs may also use any State-specific plan type terminology in their marketing materials (e.g., a plan can state that Medicare-Medicaid Plans are also known as Integrated Care Organizations in Massachusetts), provided they comply with the guidance regarding use of the CMS standardized plan type.

Section 50.1 – Federal Contracting Disclaimer

This section is replaced with the following revised guidance:

> **Section 50.1 – Federal and State Contracting Disclaimer**
>
> 42 CFR 422.2264, 423.2264

All marketing materials must include the statement that the MMP contracts with both the Federal and the State government. The following statement must be used:

> "<Plan's legal or marketing name> is a health plan that contracts with both Medicare and <name of [state] Medicaid program> to provide benefits of both programs to enrollees."

NOTE: Banner and banner-like ads, outdoor advertising, radio, television and Internet banner ads do not need to include the Federal and State contracting disclaimer.

Section 50.2 – Disclaimers When Benefits are Mentioned

This section is replaced with the following revised guidance:

Section 50.2 – Disclaimers When Benefits Are Mentioned

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

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

> For summary documents like the Summary of Benefits: "This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Member Handbook."
>
> "Limitations [, copays,] and restrictions may apply. For more information, call <plan name> <Member Services> [or read the <plan name>Member Handbook.]"
>
> "Benefits, List of Covered Drugs, pharmacies and provider networks [and/or copayments] may change on January 1 of each year."

Section 50.3 – Disclaimers When Plan Premiums are Mentioned

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

Section 50.4 – Disclaimer on Availability of Non-English Translations

This section is replaced with the following revised guidance:

Section 50.4 – Disclaimer on Availability of Non-English Translations

42 CFR 422.2264, 423.2264

Plan sponsors that meet either: (1) Medicare's five (5) percent threshold for language translation (Refer to section 30.7); or (2) the relevant Medicaid translation standard must place the following alternate language disclaimer on all materials as required.

"You can get this information for free in other languages. Call <toll-free number>. The call is free."

The alternate language disclaimer must be placed in both English and all non-English languages that meet the more stringent of either the Medicare or the Medicaid translation standard. The non-English disclaimer must be placed below the English version and in the same font size as the English version.

Section 50.6 – Dual Eligible SNP Materials

This section is replaced with the following revised guidance:

Section 50.6 – MMP Materials Including Part D Benefit Information

42 CFR 422.2, 422.4(a)(1)(iv), 422.111(b)(2)(iii), 422.2264, 423.2264

The following disclaimer must be on any MMP materials that mention Part D benefits, unless the plan charges $0 copays for <u>all</u> Part D drugs:

"Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details."

Section 50.12 – Disclaimer for Plans Accepting Online Enrollment Requests

This section does not apply to MMPs, as the Online Enrollment Center on the Medicare Plan Finder website will not be available to MMPs.

Section 50.13 – Disclaimer When Using Third Party Materials

This section applies to MMPs with the following modification to the disclaimer language:

"Neither Medicare nor MassHealth has reviewed or endorsed this information."

Section 50.14 – Disclaimer When Referencing Plan Ratings Information

This section does not apply to MMPs.

Section 60.1 – Summary of Benefits

This section is replaced with the following revised guidance:

Section 60.1 – Summary of Benefits

42 CFR 422.111(b)(2), 422.111(f), 423.128(b)(2)

MMPs must use the Summary of Benefits (SB) model document provided to Massachusetts MMPs by CMS and the State. The SB must contain a concise description of the important

aspects of enrolling in the plan, as well as the benefits offered under the plan, including applicable co-pays, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.

The Multi-Language Insert must be included with the SB.

Section 60.2 – ID Card Requirements

MMPs are required to meet the ID card content requirements in sections 60.2, 60.2.1, and 60.2.2. We clarify, however, that MMPs must issue a single ID card meeting these requirements for all services offered under the plan. Separate pharmacy and health benefits ID cards will not be permitted. MMPs must use the model ID card document provided to Massachusetts MMPs by CMS and the State.

Section 60.4 – Directories

The pharmacy and provider directory requirements in sections 60.4, 60.4.1, 60.4.1.1, 60.4.2, and 60.4.3 apply to MMPs with the following modifications:

- MMPs are required to issue a single, combined pharmacy/provider directory. Separate pharmacy and provider directories will not be permitted;

- The combined pharmacy/provider directory must include all network providers and pharmacies, regardless of whether they provide Medicare, Medicaid, or additional benefits; and

- MMPs must use the model pharmacy/provider directory document provided to Massachusetts MMPs by CMS and the State.

Section 60.5 – Formulary and Formulary Change Notice Requirements

The requirements of section 60.5, 60.5.1, 60.5.2, 60.5.3, 60.5.4, 60.5.5, and 60.5.6 apply to MMPs with the following modifications:

- MMPs must provide a comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the plan;

- MMPs will only be permitted to provide comprehensive formularies, not abridged formularies;

- MMPs must use the model formulary document provided to Massachusetts MMPs by CMS and the State; and

- Formulary change notices must be sent for any non-maintenance formulary change, regardless of whether the change is coverage is to an item covered under Medicare or Medicaid, or as an additional benefit under the plan. Consistent with the guidance in the Medicare Marketing Guidelines, this notice must be provided at least 60 days prior to the change.

Section 60.7 – Annual Notice of Change (ANOC) and Evidence of Coverage

This section is replaced with the following revised guidance:

> **Section 60.7 – Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) (Member Handbook)**
>
> 42 CFR 422.111(a)(3), 422.111(d)(2), 423.128(a)(3)
>
> MMPs are required to send an Annual Notice of Change (ANOC) summarizing all major changes to the plan's covered benefits from one contract year to the next prior to the beginning of the second contract year of the demonstration and annually thereafter. The MMP may send the ANOC and EOC (Member Handbook) as a combined document or separately, as provided below.
>
> MMPs must send the ANOC for member receipt by September 30 each year. The EOC (Member Handbook) may be sent as a standalone document as follows:
>
> - MMPs must send new enrollees (whether they voluntarily opt-in or are passively enrolled) an EOC (Member Handbook) for member receipt by the end of the month preceding the month the enrollment will take effect (e.g., the document must be received by a beneficiary by June 30 for a July 1 effective enrollment date). For late month enrollment transactions (those for which CMS confirmation of enrollment is received less than 10 days before the end of the month prior to the effective date), MMPs must send these materials no later than ten (10) calendar days from receipt of CMS confirmation of enrollment.
>
> - After the time of initial enrollment, MMPs must annually send an EOC (Member Handbook) for member receipt by December 31. MMPs choosing this option (rather than a combined ANOC/EOC (Member Handbook) by September 30 must also send an SB with the ANOC.
>
> New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current contract year, as well as a combined ANOC/EOC (Member Handbook) document for the upcoming contract year.
>
> To ensure that MMPs are mailing their annual ANOC/EOC (Member Handbook) in a timely manner, plan sponsors must indicate the actual mail date in HPMS within three (3) days of mailing. MMPs that mail in waves should enter the actual date for each wave. For instructions on meeting this requirement, refer to the *Update Material Link/Function* section of the Marketing Review Users Guide in HPMS.
>
> MMPs must use the ANOC/EOC (Member Handbook) errata model to notify enrollees of any errors in their original mailings.

Section 60.8 – Mid-Year Changes Requiring Enrollee Notification

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

Section 70.1 – Nominal Gifts

Under the Massachusetts demonstration, MMPs may not offer financial or other incentives, including private insurance, to induce enrollees or potential enrollees to enroll with the MMP or to refer a friend, neighbor, or other person to enroll with the plan. Therefore, the guidance in section 70.1 does not apply, because MMPs will not be permitted to offer nominal gifts.

Section 70.2 – Promotional Activities

Under the Massachusetts demonstration, MMPs may not offer financial or other incentives, including private insurance, to induce enrollees or potential enrollees to enroll with the MMP or to refer a friend, neighbor, or other person to enroll with the plan. Therefore, the guidance in section 70.2 regarding promotional items does not apply, because MMPs will not be permitted to offer nominal gifts or financial incentives.

Section 70.3 – Rewards and Incentives

Under the Massachusetts demonstration, MMPs may not offer financial or other incentives, including private insurance, to induce enrollees or potential enrollees to enroll with the MMP or to refer a friend, neighbor, or other person to enroll with the plan. Therefore, the guidance in section 70.3 regarding rewards and incentives does not apply, because MMPs will not be permitted to financial or other incentives.

Section 70.6 – Marketing Through Unsolicited Contacts

In addition to the requirements of section 70.6, MMPs conducting permitted unsolicited marketing activities such as mail and other print media are required to include the following disclaimer on all materials used for that purpose:

> "For information on <Plan name> and other options for your health care, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648), or visit [www.mass.gov/masshealth/oneprogram].

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

Section 70.8 – Outbound Enrollment and Verification Requirements

Since all enrollments into MMPs will be submitted by the State enrollment broker, the requirements of this section do not apply.

Section 70.10.2 – Personal/Individual Marketing Appointments

The provisions of this section apply to MMPs, with the following modifications:

- MMP sales agents are not permitted to conduct personal/individual appointments. To the extent an MMP offers Individual appointments, they must be staffed by trained Customer Service staff.

- An individual appointment must only be set up at the request of the member or his/her authorized representative. An MMP can offer an individual appointment to a member that has contacted the MMP to request assistance or information. However, MMPs are prohibited from making unsolicited offers of individual appointments.

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

We specifically request comments on these proposed modifications.

Section 70.12 – Marketing in the Health Care Setting

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

Section 70.12.5 – Comparative and Descriptive Plan Information Provided by a Non-Benefit/Non-Health Service-Providing Third Party

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

Section 70.12.6 – Providers/Provider Group Websites

This section is replaced with the following revised guidance:

70.12.6 – Providers/Provider Group Websites

42 CFR 422.2268, 423.2268

Provider websites may not provide links to MMP enrollment applications or to the CMS Online Enrollment Center (which will not be enabled for MMPs). Providers may include a link to the State enrollment broker's website.

Section 80.1 – Customer Service Call Center Requirements

In addition to the guidance in this section specifying the permissible dates for the use of alternative call center technologies on Saturdays, Sundays, and Federal holidays, we clarify that MMPs are not permitted to use alternative technologies for the two months preceding, and the month following, a wave of passive enrollment into a plan, as well as during any initial voluntary opt-in period at the beginning of the demonstration.

Section 90 – The Marketing Review Process

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

Section 90.2.3 – Service Area/Low-Income Subsidy Materials Functionality (SA/LIS) – Multiple Submissions of Materials

This section does not apply to MMPs.

Section 90.3 – Material Dispositions

We clarify that, for purposes of MMP materials, there will be no "deeming" of materials requiring a dual review by CMS and the State. All other guidance in this section and its subsections applies.

90.5 – Time Frames for Marketing Review

We clarify that, for purposes of MMP materials, there will be no "deeming" of materials requiring a dual review by CMS and the State. All other guidance in this section and its subsections applies.

90.6 – File & Use Program

We clarify that the File & Use program certification program for MMPs will be handled through the three-way contract. All other guidance in section 90.6 and all its subsections applies.

Section 100.2 – Required Content

In addition to the requirements outlined in this section, MMPs must also include a direct link to the State enrollment broker website on their website.

Section 100.2.1 – Required Documents for All Plan Sponsors

MMPs will not be required to post a CMS plan ratings document on their websites.

100.2.2 – Required Documents for Part D Sponsors

MMPs will not be required to post the LIS Premium Summary Chart, as this document will not be applicable to MMPs.

Section 100.3 – Online Enrollment

This section is not applicable to MMPs. The Online Enrollment Center will not be enabled for MMPs, and MMPs will not be permitted to directly enroll individuals through a secure Internet website. All enrollments will be processed via the State enrollment broker.

Section 100.5 – Online Formulary and Utilization Management (UM) Requirements

Formulary changes notices applicable to all formulary changes (not just Part D drug changes) must be maintained on MMPs' websites as required in this section.

Section 120 – Marketing and Sales Oversight and Responsibilities

The provisions in this section and all its subsections applicable to independent agents/brokers does not apply to MMPs since the use of independent agents/brokers will not be permitted. All MMPs enrollments will be processed by the State enrollment broker.

Section 150 – Use of Medicare Mark for Part D Plans

We clarify that MMPs will be required to sign a licensing agreement to use the official Medicare Mark as part of the three-way contract, rather than through the HPMS contracting module. All other guidance section 150 and all its subsections applies.

Section 160.4 – Sending Non-plan and Non-health Information Once Prior Authorization is Received

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

> "Neither Medicare nor MassHealth has reviewed or endorsed this information."