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2016 Medicare Marketing Guidelines Significant Changes

Presented by Medicare Compliance Solutions
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Introduction

- CMS released the updated Medicare Marketing Guidelines (MMG) in July 2015.
- The MMG is effective upon release of the CY2016 marketing materials (which have been released).
- The HPMS memo does not include all updated information and new guidance.
- CMS made the noteworthy revisions in red text. CMS also streamlined some MMG sections for clarity, and the information remains in **black text** because there is no change in policy.
- The following information is provided by the MMG sections.

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Section 10--Introduction

Failure to comply with MMG may result in intermediate sanctions (intermediate sanctions, civil monetary penalties)

- CMS always had this authority; they are simply stating that they may begin using it for marketing violations.

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Section 20—Materials Not Subject to Review

- **Clarification**: enrollee newsletters where no plan-specific info is included (e.g., benefits, cost-sharing, network, plan rules)
- **New exclusions**:
  - State materials
  - Password-protected websites accessible only to enrolled members (but marketing materials on such website are subject to review)

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Section 30—Plan/Part D Sponsor Responsibilities

- **New**: Agent/broker websites that mention specific MA/Part D products must be submitted to CMS for review (even if no benefits or plan rules are included on the website).
- **New**: In lieu of providing a hard copy provider directory and pharmacy directory, Sponsors may provide a separate notice indicating how to access the directories online and how to request a hard copy

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Section 40.3—Reference to Studies or Statistical Data

- If a Sponsor uses a non-CMS study or survey in marketing materials, it must include the following in the piece (in the text or a footnote) and in the submission to HPMS:
  - Statement that the study/survey or statistical data is not endorsed by Medicare;
  - The name of the organization sponsoring the study;
  - Information about the Plan's/Part D Sponsor's relationship with the
  - entity that conducted the study; and,
  - The publication title, date, and page number.
- If the piece cites a non-CMS award, it must
  - State that the award was not given by Medicare;
  - State the plan's official CMS Star Rating can be found at www.medicare.gov; and
  - Give equal prominence (font size and/or screen time) to the Medicare Star Rating information relative to other awards or surveys mentioned.

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Section 40.9—Providing Materials in Different Media Types

- Sponsors may provide Provider and/or Pharmacy Directories electronically without prior member consent.
  - However, Sponsors must provide a written notice to members (email or standard mail) informing them how to access the directories electronically and when they will be available.

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Section 50.15—Pharmacy/Provider Directory and Formulary Disclaimers

- **New disclaimer** when formularies and/or provider or pharmacy networks are mentioned, indicating they may change at any time and member will be notified when necessary.
- **New disclaimer** for Sponsors with limited access to preferred cost-sharing pharmacies, indicating that advertised lower costs may not be available in all pharmacies.

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Section 60.3—Add'l. Materials Enclosed with Required Post-Enrollment Materials

- **Clarification**: Post-enrollment materials can continue to be bound together, as long as the separate pieces are distinct from each other (e.g., tabbed)

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Section 60.4--Directories

- **New**: At the time of enrollment and annually by Sept. 30, plans can either send hard copy provider and pharmacy directories, or a separate notice explaining where to find the directory(ies) online or how to request hard copies of the directories.
  - This notice can be included in the ANOC/EOC mailing, but cannot be bound to any other documents.
  - Required language is provided for the notice.
  - The notice is subject to translation requirements.
  - The website must state the option to request a hard copy of directories.
  - Hard copies must be mailed within 3 business days of the request.

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Section 60.5.5—Provision of Notice to Enrollees Regarding Formulary Changes

- **Clarification**: If the Sponsor does not provide 60 days advance written notice to members affected by formulary changes, the Sponsor must provide a 60-day fill of the prescription, and written notice of the formulary change.

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Section 60.6—Part D Explanation of Benefits

- MMPs that use the model Part D EOB must include all Medicaid excluded drugs and OTCs in the EOB.

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Section 60.8—Other Mid-Year Changes Requiring Enrollee Notification

- **Clarification**: Sponsors must notify enrollees of mid-year benefit changes at least 30 days prior to the effective date.

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Section 70.9.3—Scope of Appointment

- Expands the requirement of submitting Business Reply Cards (BRCs) to CMS that document a beneficiary's:
  - Confirmation of attendance at a sales event;
  - Request for additional information.

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Section 70.11.2—Provider Affiliation Announcements

- Contracted providers are no longer allowed to make new affiliation announcements in advertisements. Can only announce new affiliations by direct mail, email, or telephone.

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Section 80.1—Customer Service Call Center Requirements

- **New**: Interpreters and CSRs for the TTY services should be available within 7 minutes of the time of answer by the Sponsor's CSR.

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Section 90.2.1—Submission of Non-English and Alternate Format Materials

- Both non-English and alternate format materials are submitted as Alternate Format materials in HPMS. (Materials that can't be submitted to HPMS (e.g., Braille) should be discussed with AM).
- Large print materials do not need to be submitted as alternate format materials as long as the text size and layout are the only changes from the original.
- Plans should submit materials as multi-lingual if they have English and one or more other languages. These should not be submitted as alternate format materials in HPMS.

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Section 90.2.2—Submission of Websites for Review

- **Clarification**: Sponsors must submit webpages to CMS for review when there are changes to benefits, premiums, or cost-sharing.

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Section 90.2.4—Submission of Mobile Applications (New Section)

- Mobile applications (“apps”) must be submitted to CMS for approval.
- CMS will review the actual app; screen shots or text on a separate document are not acceptable.

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Section 100.1—General Website Requirements

- Plans must post the following documents for the upcoming contract year on their website on Sep. 30:
  - ANOC/EOC
  - Provider/Pharmacy Directories
  - Formulary and Drug Utilization Management Documents
  - Multi-language Insert

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Section 100.1—General Website Requirements

- Plans can't require the entry of information (other than zip code, county, and/or state) for non-beneficiary specific website content.
- Plans can't state that Plan/Part D Sponsor is not responsible for the content of their social media pages or the websites of any downstream entity that provides information on the Plan/Part D Sponsor's behalf.
- Plans must review and update website content monthly.

100.4 – Online Provider/Pharmacy Directory Requirements

- The online provider directory must indicate which providers are not accepting new patients.
- Plans should contact network providers monthly to obtain updated info on:
  - Ability to accept new patients;
  - Street address and phone number(s);
  - Office hours;
  - Other changes that affect availability to members.
- Plans must also update provider directories whenever they are aware of changes.

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Section 100.6—Social Media (New Section)

- Marketing materials to be posted on social media (e.g., Facebook, Twitter, YouTube, Linked In, etc.) must be submitted to HPMS.
- Plans cannot post materials with plan-specific benefits, premiums, cost-sharing or Star ratings for products offered in the next contract year prior to Oct. 1.
- If required information is posted on social media, it must also appear on the plan's website.

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Section 100.7—Mobile Applications (New Section)

- Apps targeted to potential enrollees must be submitted to HPMS.
- Apps that provide info to current members about their plan or provide non-plan-specific health information do not have to be submitted to HPMS.
- Plans must provide CMS access to their mobile apps on request.
- If an app does not contain complete benefit, premium and copayment info, the information included in the app cannot be misleading, and the app must inform the beneficiary where to find complete information.
- If the app contains provider/pharmacy network info, it must include and give equal weight to all contracted providers/pharmacies (though it can limit info by geographic area).

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Section 120.2—Plan Reporting of Terminated Agents

- Plans must report the following to CMS Account Manager
  - For-cause terminations;
  - Sales of Medicare products made by agents w/o a valid license.

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