Compliance with Medicare Marketing Requirements for Plans and Providers
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Overview of Topics

• Where to Begin?
• CMS Definition of “Marketing”
• CMS Technical Requirements
• CMS Beneficiary Protections / Content Requirements
• Nominal Gifts, Rewards and Incentives
• Provider Dos & Don’ts
• Other Things to Consider
• Strategies for Effective Compliance, Legal and Marketing Relationship
Where to begin?

- 42 C.F.R. § 422.2260-422.2268 (MA)
- 42 C.F.R. § 423.2260-423.2268 (PDP)
  - Chapter 3 of Medicare Managed Care Manual
  - Most current (2013) version released on June 6, 2013
  - NOTE: CMS usually updates MMG annually

Where to begin?

The C.F.R. sections specific to marketing and the MMG for marketing materials, in general, are intended to prevent plan sponsors from:
- making statements that are inaccurate
- misleading
- a misrepresentation of the plan or the benefits and services covered by the plan

The MMG is approximately 120 pages long and focuses on a wide variety of activities and requirements, not all of them specific to actual Marketing Materials.
CMS Definition of “Marketing”

“Steering, or attempting to steer, a potential enrollee towards a plan or limited number of plans, or promoting a plan or a number of plans.”

“Assisting in enrollment” and “education” do not constitute marketing.”

“The definition of marketing materials, as used in CMS regulations and these Medicare Marketing Guidelines, extends beyond the public’s general concept of advertising materials.”
Marketing Materials vs. Educational Materials

- **Marketing materials** are communication materials (any format) targeted to Medicare beneficiaries that promote or mention plan sponsor names, brand names, plan names, logos, plan benefits, coverage or features of any of plans.

- **Educational materials** are communication materials that inform a beneficiary about Original Medicare, Medicare Advantage or Medicare Part D in an unbiased way that does not steer, or attempt to steer, that enrollee toward a specific plan or group of plans.

- **Health education materials** are communication materials that promote general health, health education, or disease management, but do not include any specific plan-related information.

CMS Technical Requirements for Marketing Materials
CMS Technical Requirements

Submission to CMS

• 5-day file and use (subject to retrospective review)
• 10-day model review (prior approval)
• 45-day standard review (prior approval)
• Final, populated template version filings (subject to retrospective review)

Required use of “Standardized” document materials, including:

• Summary of Benefits (SB)
• Annual Notice of Changes (ANOC)
• Evidence of Coverage (EOC)
• Errata Notice (for ANOC/EOC)
• Notice of Denial of Coverage
• Notice of Denial of Payment

“Model” document materials:

• Use model without modification
• “Non-model” but must include all required elements and information in model
Hypothetical #1

WHAT IF . . . ?

CMS Beneficiary Protections / Content Requirements
CMS Beneficiary Protections / Content Requirements

CMS reviews against all MMG content requirements, which, in general, are intended to prevent plan sponsors from making statements that are inaccurate, misleading or misrepresent the plan, or the benefits and services covered by the plan. Beneficiary Protection / Content Requirements include:

- Anti-Discrimination
- Prohibited Terminology / Statements
- Required Disclaimers
- Allowable Use of Medicare Beneficiary Information
- Requirements for specific types of materials (e.g., scripts, websites, etc.)

General Rules to keep in mind:

- Transparency for Medicare beneficiaries
- Level playing field for all plans
- Superlatives (e.g., “best” or “highest rated”) are generally not allowed
- May not compare plans without everyone’s consent
- Do not claim CMS endorsement
- Do not lie or cheat
- Disclaimers aplenty . . .!
Unsolicited Contact Prohibitions

- CMS does not allow unsolicited emails or phone calls
  - including use of purchased lists or third-party referrals
- CMS does not allow door-to-door marketing or “stalking” in public areas
- Unsolicited direct mail is allowed

Important to Remember!

CMS holds plan sponsors responsible to have a system in place to ensure ALL Marketing Materials used in the marketplace are compliant with the MMG.

Plan Sponsors are accountable for any beneficiary communication materials, including those developed by downstream vendors, brokers, or providers, that mention the plan sponsor, the plan or any plan benefits or features.

It does not matter if the material is not sent by the plan; if the material promotes or explains the plan, it must meet MMG requirements.
Nominal Gifts, Rewards and Incentives
Nominal Gifts & Promotional Activities

- Any promotional activity or item offered to a potential enrollee or current member
  - Designed to attract attention and/or encourage retention
- Cannot be cash or cash equivalent
- Non-Discriminatory offering
- No waiving/lowering of copays
- Cannot be in the form of a health benefit
- Cannot inappropriately influence the choice of provider, practitioner or supplier
- Cannot be tied directly or indirectly to provision of a covered item or service
- Meals at sales/marketing events are NOT considered “nominal gifts” and are prohibited

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Nominal Gifts & Promotional Activities

Gifts and activities must be of “nominal value”
- Value of less than $15.00 per item
- Cannot exceed $50 per person, per year

Plan sponsors must track and document items given to current plan members
Rewards & Incentives

• From an MMG perspective “rewards and incentives” are different from “nominal gifts and promotional activities”

• Ability to offer rewards and incentives is limited to current members for receiving Medicare covered preventive services that have a $0 cost share
  – See MMG for links to more specific information about which preventive services have $0 cost share.

Rewards & Incentives

• Non-Discriminatory offering

• Monetary cap (cannot exceed $15 retail value per reward item)
  – Unlike nominal gifts and promotional activities, the $50 per member per year maximum does not apply.
  – However, rewards and incentives must be tracked and documented during the contract year

• Must comply with anti-kickback and other relevant fraud & abuse laws
Rewards & Incentives

- Despite the differences in purpose, subject to some of the *same* rules as nominal gifts & promotional activities:
  - Cannot be cash or cash equivalent
  - Non-Discriminatory offering
  - No waiving/lowering of copays
  - Cannot be in the form of a health benefit
  - Cannot inappropriately influence the choice of provider, practitioner or supplier
  - Cannot be tied directly or indirectly to provision of a covered item or service

Hypothetical #2

WHAT IF . . . ?
Limited Provider Activities

- CMS has expressed concern with providers participating in marketing activities because:
  - Providers may not be aware of all plan benefits and costs
  - Providers may confuse beneficiaries if perceived as acting as an agent or plan representative instead of in the beneficiary’s medical interest
  - Providers may face conflicting incentives when acting on a plan sponsor’s behalf

- Providers must remain neutral and objective when assisting patients with information about plan options
- Communications from providers to patients should be clearly in the voice of the provider (do not blur the line between provider and plan in a misleading way)
Providers MAY:

- Provide names of plan sponsors they contract with and objective, publicly available information about plan benefits and formularies
  - Examples: Information from Medicare & You or Medicare Plan Finder on Medicare.gov

- Refer patients to other sources for more information
  - Examples: HICAP / SHIPs, CMS / Medicare.gov website, plan websites or marketing materials, etc.

- Provide information and assistance to patients applying for Low Income Subsidy (LIS) or “Extra Help”

Providers MAY:

- Make plan marketing materials available in common areas (e.g., hospital / nursing home cafeterias, community / recreational rooms, conference rooms)
- Providers are also permitted to display plan marketing materials in waiting rooms, but . . .
  - plan sponsors are NOT permitted to conduct sales or enrollment activities in waiting rooms
- If providers make plan marketing materials available in common areas and waiting rooms . . .
  - provider must make available for all contracting plans (not expected to proactively ask all plans for marketing materials)
  - enrollment forms / applications may not be made available
Providers MAY NOT:

- Distribute or display plan marketing materials within an exam room setting
- Make available or distribute plan enrollment applications or accept completed enrollment applications
- Mail marketing materials on behalf of plan sponsors or their agents
- Make phone calls or distribute materials to direct, urge or attempt to persuade beneficiaries to enroll in a specific plan or set of plans
- Offer anything of value to induce plan members to select them as their provider
- Offer anything of value to induce beneficiaries to enroll in a particular plan or set of plans
- Conduct health screening as a marketing activity

Provider Affiliation Materials

- Providers may mail (or email) a **one-time** notification announcing a new plan affiliation within 30 days of the effective date of the contract
  - Subsequent affiliation notices (or any sent after 30 days) must include the names of all plans that contract with the provider
- Communications that include only plan names and/or contact information are not subject to CMS review
- Communications that include any additional plan information (e.g., describe plan benefits or features) must be submitted to CMS for review / approval
- CMS holds plans accountable for ensuring provider affiliation materials are compliant with MMG
Privacy

• CMS expects plans to comply with HIPAA privacy rules
• Additionally, all plans contracted with CMS are subject to a Data Use Attestation (DUA) restricting use of “Medicare data” to only those purposes directly related to Medicare plan administration
  – “Medicare data” includes information a plan receives from a member when they enroll.
  – MMGs specifically discuss the DUA, and provide more detail about permissible / impermissible activities
• Under MMGs, without authorization from member, plan cannot communicate about things like pending state or federal regulation or volunteer opportunities
• MMGs explain how plan can obtain authorizations, but some allowances are seemingly at odds with HIPAA requirements

What Else to Worry About?

• Fraud and Abuse concerns
• Anti-Kickback statute
• Civil Penalty statute
• OIG Guidance on Beneficiary Inducements (e.g., Special Advisory Bulletin, August 2002)
• CAN-SPAM, FTC and FCC Requirements (e.g., Do Not Call)
• State Laws (e.g., Raffles)
• Potential for Beneficiary Confusion (Clarity and Accuracy of Message)
Strategies for Effective Compliance, Legal and Marketing Relationship

- Focus on Relationship
  - **Listen** to understand their objective
  - Build **Trust** by citing regulations or guidance to support your positions
  - Don’t just say **NO**, explain why and offer other **solutions** when possible

- Focus on **Reputation**
  Ask the 3-M questions when faced with difficult compliance / ethical issues
  - How will this impact our **members**?
  - How would this look in the **media**?
  - Would your **mother** be proud of you?

- Clear **Communication**
  - “Required” vs. “Recommended”
  - “Risks” and “Consequences”
  - Accountability for actions / decisions
Review / Final Q&A

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