2012 Medicare Marketing Guidelines Training - Questions/Answers

General Questions

1. Why are there are no page numbers for the Medicare Marketing Guidelines?

A. Page numbers are not allowed on the official version of the online CMS manuals. However, we will continue to seek to address this issue for future versions of the Medicare Marketing Guidelines.

2. When can marketing for AEP 2012 season begin?

A. Marketing for AEP 2012 season can begin on October 1, 2011.

3. Does the Medicare Marketing Guidelines apply to plan-employed sales agents/brokers or external contracted agents/brokers?

A. The Medicare Marketing Guidelines (MMG) applies to the plan sponsors. The plan sponsors are responsible for ensuring that any plan employed and/or external contracted agents/brokers comply with Medicare requirements, including the MMG.

3. Can plan sponsors advertise and/or provide information to beneficiaries prior to 10/1 stating that 2012 benefits and rates will be available on 10/1?

A. No. Plan sponsors may not advertise 2012 benefits to beneficiaries prior to October 1, 2011. This also includes sending out information to remind beneficiaries of the AEP date change.

Section 20 Definitions

4. What is considered the sub-set of the population for ad-hoc materials? Would it be by geographic location or plan benefits?

A. CMS' intent for the definition of ad-hoc materials is that it be applied narrowly and not used for all situations that the plan sponsor may encounter. Generally, these are materials that refer to benefits or situations targeted to specific and small audiences. For example, a plan may need to send a communication only to a specific set of beneficiaries about a shortage of a specific formulary drug that they are taking due to a manufacturer recall letter.

5. Does an individual marketing appointment refer to a meeting between an agent and a "potential" enrollee?

A. An individual marketing appointment can be between an agent and a potential enrollee or an existing Medicare beneficiary that the agent may currently have as a client.

Section 30.1 Record Retention

6. Do plan sponsors have to retain all marketing materials for 10-years? If so, what kinds of materials does CMS require to be retained?

A. Plans are required to maintain marketing materials for a 10-year period as part of their contract with CMS. Examples of the types of marketing materials required for retention include, but are not limited to, marketing materials, policies and procedures, outbound enrollment and verification calls and documents related to agent/broker training and testing. Of course, CMS requires that plan sponsors retain records for all other Medicare operational areas as well.

Section 30.16 Plan Ratings

7. Can plan sponsors provide a link the plan sponsor's website to the CMS website, instead of posting the plan ratings on the plan sponsor's website?

A. No, CMS expects plan sponsors to post the actual plan ratings document on their website. A link to the CMS website is not sufficient.

Section 40.1 Marketing Material Identification Number

8. Does "CMS' need to appear before words "File&Use" in the marketing material identification number, thus displaying as "CMS_File_&_Use"?

A. No, the word "CMS" does not need to appear before the words "File&Use" in a marketing material identification number.

9. Does a marketing material identification number need to be on an agent's business card if a business card would be in a prospective member's sales kit?

A. Generally, agent business cards are not required to be submitted through HPMS for CMS review and would therefore, not have a marketing material identification number on the business card.

Section 40.1.1 Marketing Material Identification Number

10. Is the approval date of the non-English materials always that of the English version regardless of when the non-English version is submitted?

A. The approval date for non-English materials should be the date that appears on the English version. The File & Use date for non-English material should be the date the English version is eligible for use in the market place (generally five (5) days after the piece is filed in HPMS).

Section 40.4 Reference to Studies or Statistical Data

10. Do references in marketing materials that contain member surveys need to identify the related studies or statistical data?

A. Yes. The references in marketing materials that contain member surveys must identify the related studies or statistical data.

Section 40.11.1 Agent/broker Phone Number

11. Does an agent's business card have to list the plan sponsor's customer service number?

A. Yes. If an agent/broker's business card includes his/her phone number, then the plan sponsor's customer service phone and the TTY number must also be included and all requirements regarding the customer service number in the MMG must be met (e.g., hours of operation, etc).

Section 40.16 Standardization of Plan Name Type

12. Is the plan name considered to be the plan name printed from the HPMS Summary of Benefits or is it the organization's marketing name?

A. Yes, the plan name is listed in the HPMS Plan Bids module, which is included in the Summary of Benefits Report. The HPMS system auto-populates the plan type at the end of each plan name. The plan name, including plan type, and plan logo must be displayed on all marketing materials with some exceptions as referenced in Section 40.16 of the MMG.

Section 50 Marketing Material Disclaimers

13. Does the font size of the disclaimers need to be the same size as the largest font on the related advertisement?

A. Disclaimers do not need to be the same size as the largest font; however, CMS expects disclaimers will be prominently displayed on the material and be of similar font size and style similar to the rest of the material. Plan sponsors should also refer to Section 40.2 regarding the 12-point font size.

14. Why was the disclaimer language in section 50.1.1 changed form "customer service representative" to "sales person?"

A. This wording was changed to reflect CMS' expectation that a sales person would be attending the sales/marketing events to collect enrollment forms rather than a plan's customer service representative.

15. Our plan is a Medicare/Medicaid Dual SNP (D-SNP)? Which federal contracting statement should we use of those in section 50.1.2?

A. Section 50.1.2 of the MMG requires that at least one of the federal contracting statements be used and that these may not be modified. CMS added two new contracting statements for D-SNPs depending on whether they have a contract with the State Medicaid agency or not. CMS recommends that the organization use the federal contracting statement that best describes your organization.

16. How long does the toll free number, TTY number and the plan hours of operation need to be displayed on a television advertisement?

A. The plan sponsor's toll free number, TTY number and plan hours should be on the television advertisements long enough for a beneficiary to view and obtain the number in a reasonable amount of time.

17. Are plan sponsors required to use the new contracting statement for D-SNP materials? How will this affect a plan sponsor that has materials that would go out to the MA general population and the D-SNP population? Are plan sponsors required to provide two separate contracting statements?

A. Section 50.1.2 of the MMG requires that at least one of the federal contracting statements statements be used and that these statements may not be modified. For material that is sent to the general MA population and D-SNP population, CMS recommends that the plan sponsor uses the federal contracting statement that best describe the organization. Plan sponsors that have concerns about which federal contracting statements to use should consult with their CMS Regional Office Account Manager or Marketing Reviewer.

18. When will plans be expected to incorporate updated information and disclaimers into marketing materials?

A. The Medicare Marketing Guidelines are effective upon their release date of May 17, 2011. CMS expects plan sponsors to update disclaimers as appropriate.

Section 50.1.3 Disclaimers When Benefits Are Mentioned

19. Does the model disclaimer in this section apply to advertising materials that are distributed to both prospects and current members?

A. Yes. CMS expects plan sponsors to include this model disclaimer in their current contracting year marketing materials (advertising and explanatory) when advertising a current year benefit, formulary, pharmacy network, premium, or co-payment that such information may change in the upcoming contracting year.

Section 50.1.6 Availability of Non-English Translations

20. Does the non-English translation disclaimer apply to all explanatory marketing materials?

A. As stated in section 50.1.6, plan sponsors whose service areas meet the five (5) percent threshold for language translation must place the alternate language disclaimer on all materials as noted in § 30.11, 30.12, 30.13 and the Part D Transition Letter.

21. Is the alternate language disclaimer required on those materials identified in Section 30.11, 30.12 and 30.13 and the Part D Transition Letter?

A. Yes Plan sponsors must place the following alternate language disclaimer on all materials as noted in § 30.11, 30.12, 30.13 and the Part D Transition Letter. In addition, the disclaimer should be placed in both English and all non-English languages for which the plan sponsor's service area meets the five (5) percent threshold.

22. Are plan sponsors are required to use the alternate language disclaimer verbatim?

A. Yes. CMS expects that the disclaimer will be used verbatim.

Section 60.4.2 Provider Directories

24. Can a plan sponsor send a provider directory request card to all members on an annual basis in lieu of sending an actual directory?

A. No, CMS expects that plan sponsors send the provider directory to all members on an annual basis. Plan sponsors may consider sending change pages as outlined in Section 60.4 of the MMG to existing members only. A directory request card is not sufficient.

Section 60.5.3 Changes to Printed Formularies

25. Is there a CMS model for errata sheets for changes to printed formularies? What would be the CMS review period for errata sheets for printed formularies? What HPMS code should the plan sponsor use?

A. At the present time, CMS does not have a model errata sheet for changes to printed formularies. Any errata sheets (other than the ANOC/EOC) would require a forty-five day review period. We recommend that you contact your CMS Regional Office Account Manager for assistance regarding the appropriate codes under which to submit errata sheets for review.

Section 60.7 Annual Notice of Change and Evidence of Coverage

26. When is the LIS Rider due to be out to beneficiaries?

A. The LIS Rider must be sent to ensure member receipt by September 30th.

27. Why do plans have to send out an errata sheet to beneficiaries?

A. Errata sheets are required to correct errors and/or other corrections in a plan sponsor's approved documents. For example, plan sponsors that need to revise, correct and resend the ANOC/EOC must attach the standardized errata model document to the front of the corrected ANOC/EOC. CMS expects that current versions of the ANOC/EOC will be available on the sponsor's website. If a plan issues an errata sheet for an ANOC/EOC they must ensure the most up-to-date, corrected version is placed on the website.

Section 60.8

28. Can plan sponsors use the Annual Notice of Change/Evidence of Coverage (ANOC/EOC) to communicate National Coverage Decision (NCD) changes in addition, to posting the information to the plan website?

A. No. NCDs can occur anytime throughout the contract year, therefore, it would not be acceptable to list the NCD changes in the ANOC. Plan sponsors may use a variety of mechanisms to inform enrollees of the change in coverage. At a minimum, the MAO must provide notice on the plan website within 30 days, with subsequent publication in the next plan newsletter or other mass mailing not specifically dedicated to the NCD notification.

29. Is it acceptable for a plan sponsor to post the National Coverage Decision (NCD) changes on the plan sponsor's website without providing the information in a mass mailing?

A. No. Plan sponsors are required to notify all enrollees of the new coverage or change in coverage of the item or service within 30 days of the release date of the NCD. In addition, the plan sponsor must provide subsequent information to beneficiaries regarding the NCD change either one time mailings or newsletter or other mechanisms that will inform beneficiaries of the change.

Section 70.2 Nominal Gifts

30. Does a plan sponsor have to track each beneficiary that receives more than one promotional item per promotional meeting for auditing/monitoring purposes?

A. At the present time, CMS does not require plan sponsors to track promotional items that a beneficiary may receive. However, any items provided that are in Section 70.1.2 must be tracked and documented during the contract year.

31. Does CMS consider a pen and a pad of paper as two (2) separate promotional gifts?

A. Yes, a pen and paper are considered separate promotional gifts but can be offered together as long as each item does not exceed the $15 threshold.

Section 70.4 Marketing through Unsolicited Contacts

32. What is the review timeframe for a business reply card (BRC)?

A. A BRC is considered a direct mail piece and may be submitted under the File & Use review process provided that the piece does not mention benefit and plan premium information as stated in Section 50.1.4 of the MMG. If the BRC includes specific plan benefits, then it is considered an explanatory material and must be submitted for review, which requires a 45-day review period.

Section 70.5 Specific Guidance on Third Party Contact

33. Can agents/brokers with existing Medicare Advantage clients conduct outbound telephonic contact?

A. The beneficiary must be an existing client of the agent/broker that is currently in a Medicare plan for the telephone contact to be an allowable outbound call.

34. What are the requirements for recording outbound Medicare Supplement calls?

A. CMS does not require that recording of outbound Medicare Supplement calls.

Section 70.6 Outbound Enrollment and Verification Calls to all new enrollees

35. Can CMS include the model Outbound Enrollment Verification scripts/letters with the Medicare Marketing Guidelines?

A. CMS released the model Outbound Enrollment Verification (OEV) script/letter with the ANOC/EOC and other model documents. These documents are posted on the CMS marketing website at http://www.cms.gov/ManagedCareMarketing/09_MarketngModelsStandardDocumentsandEducationalMaterial.asp#TopOfPage

36. Must plan sponsors follow the Outbound Enrollment Verification (OEV) process for incomplete applications?

A. Yes. As required in Section 70.6, if the enrollment application received is incomplete, plan sponsors are expected to concurrently conduct the outbound verification calls while obtaining information needed to complete the application. Plan sponsors that are unable to successfully complete the outbound verification on the first attempt, should send the applicant an enrollment verification letter.

Plan sponsors must not delay processing an enrollment request (including, but not limited to, activation of benefits and submission of enrollment request data to CMS) while completing the OEV process.

Section 70.7 & 70.8 Educational Events & Marketing/Sales Event

37. Is a plan sponsor required to comply with the guidance for educational events and sales/marketing events if they are invited to an event but are not sponsoring or co-sponsoring the event?

A. Yes. Plan sponsors that are invited to participate in an educational or sales/marketing event must follow CMS' requirements in Sections 70.7 and 70.8. CMS does not distinguish between attending versus sponsoring an event; therefore, plan sponsors are still held accountable for complying with the Medicare requirements.

Section 70.8 Marketing/Sales Events

38. We are an 1876 cost plan that is allowed to enroll year-round; however the guidance seems to indicate that agents may not accept 1876 Cost plan or SEP enrollment applications at sales events occurring outside of AEP?

A. Plan sponsors should be not accept 2012 enrollment application prior to the start of the 2012 AEP season (including 1876 cost plans). However, once the 2012 AEP season begins; your 1876 cost plan may begin to accept 2012 enrollment applications throughout the year.

Section 70.8.1 Notifying CMS of Scheduled Marketing Events

39. Does CMS intend for plan sponsors to cancel events forty-eight (48) hours in advance of the originally scheduled date?

A. Yes. CMS expects plan sponsors to notify cancelled events at least forty-eight hours in advance of the originally scheduled date and time. However, we do recognize that some events may be cancelled less than forty-eight (48) hours and thus have provided guidance on such situations under Section 70.8.1 of the MMG.

Section 70.9 Personal/Individual Appointments

40. Does the term "plan sponsor's representative" apply both to a plan sponsor's internal employees and the plan's contracted external agents/brokers?

A. Yes. The term "plan sponsor's representative" applies to both internal employees and contracted external agents/brokers.

Section 70.12.2 Provider-Based Activities

41. If a patient asks his/her provider or their staff about Medicare Advantage plans, is it acceptable for the provider to give the beneficiary a "consent to contact" form whereby the beneficiary selects that they would like one or more of the plans to contact them with more information?

A. No. Providers may not give beneficiaries a "consent to contact" form. Providers should be an objective third party and should not proactively request any type of "consent to contact" forms for the beneficiary to complete while in the provider's office. The provider or their staff may refer the beneficiary to 1-800-Medicare, www.Medicare.gov, the local SHIP or directly to the MA plan if the beneficiary has any questions.

Section 80.1 Customer Service Call Center Requirements

42. Does the plan's customer service center need to be open on Thanksgiving Day and Christmas Day?

A. Annually, CMS sends out reminder notices to all plan sponsors regarding CMS' expectations on the customer service operating hours during the holidays. Plan sponsors may also contact their CMS Regional Office Account Manager for additional questions.

Section 90.2.1 Ad-Hoc Enrollee Communications Submission

43. Should the hours of operations and TTY phone number be included in ad-hoc communications?

A. Yes, CMS expects that ad-hoc enrollee communications will include the customer service number including a TTY number, and hours of operation should the beneficiary have questions regarding the communication being sent to them.

Section 90.6.1 Materials Qualified for File & Use Submission

44. Will some template materials now be eligible for File & Use based on the content?

A. Yes, some template materials may now be eligible for File & Use provided that the template material has a marketing code associated with F&U eligibility. Plan sponsors that have concerns as to whether a template material qualifies for F&U should consult with their CMS Regional Office Account Manager.

Section 90.7.3 Model Materials

45. If a plan sponsor chooses to modify a model document, can they eliminate any text from the model? Additionally what does the reference to "all elements" mean?

A. Model documents modified by the plan sponsor will result in a forty-five (45) day review period. If there is any elimination of the model language text then the plan sponsors is responsible for ensuring that the revised modified language text is comparable in context to the language text that was deleted. Additionally, all elements include, but are not limited to model language text, plan name, type, and logo, required disclaimers, and marketing material identification.

46. Can a plan sponsor submit model materials as File & Use when the material is considered a static template?

A. CMS makes the distinction between standardized model materials and model materials as provided in sections 90.7.2 and 90.7.3 respectively. Materials qualified as File & Use are to be used without modification. If it is a static template model material and used without modification and there is a corresponding eligible File & Use material code available, then the static template model material may be submitted as File & Use. Plan sponsors that have concerns as to whether such material qualifies for File & Use should consult with their CMS Regional Office Manager.

Section 90.11 Submission of Non-English (Alternate Formats) Materials

47. Will there be new process for providing attestations for translated materials and/or non-English materials?

A. Yes. CMS will issue separate guidance regarding the new attestation of translated materials or non-English formats.

48. How are plan sponsors suppose to submit Braille materials as they are not in a format we can upload in HPMS?

A. Plans are still required to attest that the Braille material is accurate and reflects the approved English version. As provided in section 90.11, CMS expects that plan sponsors will keep the Braille version available for auditing and record retentions purposes as well.

Section 120 Compensation

41. How does CMS define “fair market value” in regards to agent/broker compensation?

A. As stated in the June 5, 2009 HPMS memorandum to all plan sponsors, CMS analysis of the compensation data led to the establishment of the national cut-off for fair market values (FMV) at $400 for health plans and $50 for prescription drug plans for initial compensation – with some exceptions for specific states. CMS also established a low-end cut-off, in addition to the high-end FMV cut-off, in order to create a FMV range that represents permissible compensation amounts.

Section 120.4 Agent/Broker Use of Marketing Materials

42. Do agents and brokers materials that mention Medicare or plan-specific benefits have to be submitted by the plan sponsor for CMS review and approval?

A. Yes. As provided in section 120.4, any agent/broker materials that reference Medicare specific benefits must be submitted by a plan sponsor to CMS for review and approval.

Section 120.5.8 Third Party Marketing Entities

33. Does a plan sponsor have to compensate agents/brokers based upon the compensation schedule that was submitted to CMS? Are plan sponsors able to separately compensate the TMO for administrative services at fair market value?

A. Plan sponsors should only be compensating agents/brokers according to their current compensation schedule that was submitted to CMS. Plan sponsors are allowed to compensate the TMO separately for administrative services at fair market value. It should be noted that CMS does not establish the amount considered to be "fair market value" for administrative services.