Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE MANAGED CARE
1998 Marketing Materials

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EXECUTIVE SUMMARY

PURPOSE

To determine how well marketing materials met Federal guidelines in the first year after implementation of the *Medicare Managed Care National Marketing Guide*.

BACKGROUND

The Health Care Financing Administration (HCFA) has authority to establish how managed care health plans with Medicare contracts provide information to beneficiaries. The health plans are required to submit marketing materials to HCFA regional offices for review and approval before distribution. Marketing materials include pre-enrollment materials (e.g., advertisements and sales brochures) and member materials (e.g., membership rules and notices of change in benefits). The HCFA regional staff keep track of the marketing-material reviews.

The *Medicare Managed Care National Marketing Guide* (hereinafter called *National Marketing Guide*) was issued in November 1997. It serves as an operational tool for managed care plans and HCFA regional offices, and outlines what information is required or prohibited in marketing materials. While some instructions in the *National Marketing Guide* are voluntary, others are mandatory. The *National Marketing Guide's* most important goal is to "provide Medicare beneficiaries with current, accurate, consumer friendly, managed care marketing information that will assist them in making informed health-care choices."

We reviewed 319 marketing pieces approved by HCFA during calendar year 1998 in order to determine how well marketing materials met Federal guidelines. We also conducted a subjective review of whether the materials were consumer friendly.

FINDINGS

Few 1998 Approved Marketing Materials Were in Full Compliance with the *National Marketing Guide*

Only 13 percent of HCFA-approved materials which we reviewed (41 of 319) met all requirements of the *National Marketing Guide*. The 87 percent not in full compliance either (1) contained statements specifically prohibited, (2) had missing, incomplete, or inaccurate information, or (3) did not meet print-size requirements.

Nearly Half of Materials Reviewed Were Not Consumer Friendly

Forty-six percent (145 of 312) of materials were confusing or contained jargon. A comparison of pre-enrollment versus member materials revealed that, overall, member materials were less consumer friendly.

RECOMMENDATIONS

Our findings from this report and our companion report, *Medicare Managed Care: Goals of National Marketing Guide* (OEI-03-98-00270), wherein we surveyed users of the *Medicare Managed Care National Marketing Guide* and obtained HCFA tracking data on marketing-material reviews, provide evidence that the *National Marketing Guide*, while improving some aspects of the marketing-material review process, was not very successful at meeting its most important goal. That goal is to provide Medicare beneficiaries with accurate and consumer friendly marketing materials. Inaccurate and confusing materials may affect beneficiaries' ability to make informed health-care choices.

We recommend that HCFA:

- **update the *National Marketing Guide*.** The *National Marketing Guide* should further clarify which information is specifically prohibited or required in marketing materials. The *National Marketing Guide* should provide model materials that are accurate and easy to read. It should clarify policy and operational instructions regarding the lead and local regional office responsibilities, the Use and File System (which allows plans to distribute sales material without prior approval), and the health plans' use of checklists for member materials. It should also ensure that checklists for member materials contain all the required information.

- **standardize and mandate use of <u>member</u> materials**. The HCFA should work toward standardizing as many types of member materials as possible. Managed care plans should be required to use these materials when communicating with their enrolled Medicare beneficiaries.

- **develop standard review instruments.** These review instruments should be used by HCFA staff in determining if marketing materials (both pre-enrollment and member) contain all required information and do not contain prohibited information.

- **establish a quality control system.** The HCFA should periodically review a nationwide sample of previously approved marketing materials (both pre-enrollment and member) to determine if they meet Federal marketing guidelines.

- **track marketing-material reviews consistently and uniformly across all regions**.

- **conduct meetings to review Federal marketing requirements with managed care plans that continually submit materials not in compliance with the requirements.**

- **provide training on the use of the *National Marketing Guide* for HCFA reviewers and managed care plans.**

AGENCY COMMENTS

The Health Care Financing Administration (HCFA) reviewed our companion reports and concurred with our recommendations. The agency is updating the *National Marketing Guide* and plans to promote better understanding of the Use and File System. As of 2000, contracting health plans must use a standardized Summary of Benefits. In the future, beneficiary notifications such as the Evidence of Coverage will be standardized, and their mandatory use will be phased in. In 2001, the agency will have a new and comprehensive instrument for collecting benefit data and reviewing marketing materials. In addition, the Product Consistency Team will meet monthly and uncover and correct inconsistencies in operational or policy interpretations of standardized materials. As to quality control, the agency will verify that all final versions of beneficiary notices are the same as versions HCFA approved, and will review samples of printed marketing materials. The HCFA is also taking steps to address the tracking of marketing material reviews, monitoring of contractor performance, and training of staff. Appendix C contains the full comments.

We appreciate the comprehensiveness of HCFA's comments. We believe the agency's stated efforts can result in comparable and understandable materials which beneficiaries need to make informed health-care choices. We are hopeful that the updated *National Marketing Guide* will include clarification of lead and local regional office responsibilities, and clarification as to whether health plans must submit checklists along with the member materials they submit for HCFA's review. With regard to the Product Consistency Team, the past team was not fully able to realize the objectives stated in the agency comments (uncovering and correcting inconsistencies; updating the *National Marketing Guide* as needed). We are hopeful that the new team has the tools and authority needed to accomplish these important objectives.

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PURPOSE

To determine how well marketing materials met Federal guidelines in the first year after implementation of the *Medicare Managed Care National Marketing Guide*.

BACKGROUND

Marketing Regulations

Title XVIII of the Social Security Act (Part D, Section 1876[c][3][C]) provided the Health Care Financing Administration (HCFA) authority to establish how managed care health plans with Medicare contracts provide information to Medicare beneficiaries. Regulations which list prohibited marketing activities are in Title 42 of the Code of Federal Regulations (Section 422.80). Prohibited are activities that (1) discriminate against beneficiaries with poor health, (2) mislead or confuse beneficiaries, or (3) misrepresent the health plan or HCFA. These same regulations also require managed care plans to submit all marketing materials to HCFA for review and approval at least 45 days before their planned distribution.

Marketing Materials

Marketing materials include a wide range of materials used to communicate with beneficiaries before and after enrollment in a managed care plan. Pre-enrollment materials are essentially sales materials and include newspaper, radio, and television advertisements; summaries of benefits; application forms; telemarketing scripts; and slide presentations. Post-enrollment materials, more commonly called member materials, include letters confirming enrollment or disenrollment; notices about a change in providers, benefits, or premiums; letters with claim information; lists of covered and non-covered services; co-payment schedules; and subscriber agreements. Subscriber agreements contain member rights as well as member and plan responsibilities. Some subscriber agreements also list covered and non-covered services.

Medicare beneficiaries are exposed to marketing materials through different media, including literature, billboards, radio, television, informational meetings, and the Internet. Regardless of the medium used, plans must get approval from HCFA prior to distributing the information.

Marketing Guidelines

The *Medicare Managed Care National Marketing Guide,* hereinafter called the *National Marketing Guide,* became effective November 17, 1997. It supplemented the marketing chapter in the *Health Maintenance Organization/Competitive Medical Plan Manual,* issued March 1991. One of the goals of the *National Marketing Guide* is to "provide Medicare beneficiaries with current, accurate, consumer friendly, managed care marketing information that will assist them in making informed health-care choices."

The *National Marketing Guide* is an operational tool for managed care plan staff and HCFA reviewers. It incorporates Federal requirements, represents HCFA's official position on marketing policy, and contains operational instructions. It explains requirements for different types of materials and media. Some instructions in the *National Marketing Guide* are voluntary, and others are mandatory. For example, a chart in the *National Marketing Guide* describes marketing language that managed care plans "Must Use/Can't Use/Can Use" in sales materials. (Appendix A contains the entire chart as it appeared in 1998.) The *National Marketing Guide* also contains model member materials, which plans can choose to use or not use. However, when plans create their own version of a model piece, they must submit the piece for HCFA's review along with a HCFA checklist showing that required information is in the piece. The HCFA checklists are included in the *National Marketing Guide*. The HCFA policy is that certain information must be conveyed to Medicare beneficiaries. However, format and the addition of other information are left to the discretion of the health plans.

The *National Marketing Guide* was in the process of being updated when we wrote this report. The update will include changes to reflect the Medicare + Choice program, which went into effect January 1999. The Medicare + Choice program gives Medicare beneficiaries additional health plan options besides using a fee-for-service arrangement or joining a managed care plan. The updated *National Marketing Guide* will address these new insurance options.

The HCFA Reviewers

Staff in HCFA regional offices are responsible for various aspects of overseeing contracts between Medicare and managed care plans, including review of marketing materials and keeping track of the reviews. In 1998, a total of 96 staff members conducted reviews. According to reviewers, 31 percent of their time–on average–is spent conducting reviews. While reviewing marketing materials is only one of their duties, for some staff it is the most time-consuming. In 1998, the median number of hours per week spent on reviews was 10 hours, with some reviewers spending as many as 35 hours.

Reviewers must determine whether marketing materials meet regulatory requirements, accurately reflect the health plan's Medicare contract, and accurately describe benefits. Consequently, the review of materials can be extremely complex to perform, requiring

attention to numerous details. In the last quarter of calendar year 1998, most of the same HCFA staff responsible for conducting marketing reviews were also responsible for implementing the new Medicare + Choice program (effective January 1999). The program increases the types of health insurance plans HCFA staff must oversee.

Recent Developments in the Review Program

In August 1999, HCFA issued an operational policy letter which contains new and updated models of enrollment and disenrollment letters. The HCFA also created a standard form called the Summary of Benefits. All plans are required to use this form in fiscal year 2000 when describing their benefits to beneficiaries.

Currently, HCFA is conducting a pilot study to determine the effectiveness of having an outside contractor review marketing materials. The HCFA has also contracted an evaluation of the Medicare managed care marketing regulatory program to determine the program's strengths and weaknesses.

Studies by the Office of Inspector General

Medicare managed care has been the focus of many Office of Inspector General (OIG) studies. We have covered HCFA oversight of managed care plans, grievance and appeal issues, physician and beneficiary perspectives, beneficiary satisfaction, enrollment and service access problems, and use of disenrollment rates as performance indicators.

We have also addressed managed care marketing within the last three years. In *Medicare's Oversight of Managed Care* (OEI-01-96-00191), we found that while HCFA had increased the number of staff responsible for managed care oversight, some staff lacked managed care experience. The HCFA staff needed certain skills to evaluate various aspects of health plan operations, including marketing. We recommended that HCFA develop a more comprehensive training program for staff who oversee managed care plans. In *Medicare HMO Appeal and Grievance Processes* (OEI-07-94-00280), we found that many health maintenance organizations had marketing materials and operating procedures with incorrect or incomplete information on appeal and grievance processes. We recommended that HCFA (1) work with health plans to standardize appeal and grievance language in marketing materials and operating procedures, and (2) take a more active approach in monitoring the plans.

As a companion to this report, we are issuing, *Medicare Managed Care: Goals of National Marketing Guide* (OEI-03-98-00270). We found that the four established goals of the *National Marketing Guide* were not completely met but that some aspects of the review process had been improved; that certain elements were not well understood or applied uniformly; that marketing-material reviews were not tracked consistently across HCFA regions; and that HCFA reviewers and health plan representatives felt

improvements were needed. The findings from the companion reports were used to develop the recommendations contained in both reports.

SCOPE AND METHODOLOGY

Our purpose in this study was to determine how well marketing materials of managed care plans met Federal marketing guidelines in the first year after the *National Marketing Guide* was issued (November 1997 through November 1998). We did not determine whether benefits were accurately presented in materials.

We reviewed 319 pieces of HCFA-approved print materials, 249 of which came from 3 of the 10 HCFA regions. Since the materials were approved for use in 1998, our review did not include Medicare + Choice materials. We reviewed the materials with 24 OIG-created instruments designed specifically to evaluate different types of print materials, both pre-enrollment and member pieces. The instruments contained questions related to prohibitions and requirements in the *National Marketing Guide*. We formulated the questions from text in the "Must Use/Can't Use/Can Use" language chart, model member letters, checklists, and paragraphs highlighting important things for managed care plans to remember. Questions addressed issues ranging from the most critical information requirements (e.g., advertisements must state that beneficiaries must continue to pay their Medicare Part B premium) to print size.

One of the goals of the *National Marketing Guide* is that materials be consumer friendly, but there are no instructions as to what constitutes consumer-friendly text. In order to determine whether materials were consumer friendly, we added two questions on this subject to each review instrument. We asked, "Is this piece clear or confusing?" and "Is this piece jargon-free or written with jargon?" Our definition of a clear piece was that the meaning of all the text was obvious and not misleading. A jargon-free piece was one that did not contain jargon, or it contained jargon that was likely to be familiar to Medicare beneficiaries (e.g., primary care physician). We defined jargon as (1) technical language (i.e., words, terms, phrases, and acronyms specific to a certain field); and (2) sentences with strings of big words, overblown phrases, "-izing" words (e.g., finalizing, utilizing), invented words (e.g. signage), legalese, or bureaucratese. We recognize that determining whether pieces of writing are consumer friendly is a subjective process. Therefore, we developed the above criteria which we believe are fair, and applied them systematically.

See Appendix B for more detail on how we reviewed the marketing materials. As mentioned earlier, the *National Marketing Guide's* language chart is in Appendix A.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Few 1998 approved marketing materials were in full compliance with the *National Marketing Guide*

Eighty-seven percent (278 of 319) of marketing materials which we reviewed (1) contained statements that are specifically prohibited, (2) had missing, incomplete, or inaccurate information, or (3) did not meet print-size requirements. All of these 1998 materials had been approved by HCFA regional offices.

Forty-eight percent of advertisements and sales brochures contained prohibited statements

Managed care plans are prohibited from advertising with statements that might mislead beneficiaries. Examples of such statements are in the "Must Use/Can't Use/Can Use" language chart (see Appendix A). Of the 176 advertisements and sales brochures we reviewed, 48 percent contained one or more prohibited statements.

We found prohibited statements on a variety of subjects. Regarding benefits, for example, an acceptable phrase in the language chart is "Minimal copays will apply." We found advertisements and sales brochures that contained the prohibited statement, "Minimal copays may apply." If plan premiums are mentioned, managed care plans must state that beneficiaries must continue to pay the Medicare Part B premium. But, we reviewed advertisements and sales brochures that contained the prohibited statement "no premium." This might mislead Medicare beneficiaries into thinking they no longer need to pay the Medicare Part B premium. On the subject of quality, plans can use superlatives or comparisons when they are substantiated (the source must be identified in the advertising piece). Yet advertisements and sales brochures contained unsubstantiated superlatives, such as "Access to the best physicians, specialists and hospitals in the area," and "The best doctors are part of our team."

Seventy-seven percent of materials had missing, incomplete, or inaccurate information

The *National Marketing Guide* contains information that managed care plans must convey in their marketing materials so that beneficiaries can make well-informed choices and know their rights. More than three-quarters of the approved marketing materials we reviewed (246 of 319) had one or more problems with this kind of information. It was either missing, incomplete, or inaccurate. Not all of the information is of equal significance. But all of it is meant to help beneficiaries become informed. Different types of materials are required to have different kinds of information. The table below contains

examples of information that must be conveyed to beneficiaries, and includes percentages for specific types of pieces where we found missing, incomplete, or inaccurate information.

Table 1. Information that must be conveyed but was missing, incomplete, or inaccurate

Type of Marketing Materials	Information That Must Be Conveyed	Percentage of Materials with Problems
Sales brochures	Explanation of difference between managed care and fee-for-service	100%
Subscriber agreements	Appeal procedures	90%
Subscriber agreements and member handbooks	General terms of contract between plan and Medicare program	67%
	Beneficiary options if contract between plan and Medicare is not renewed	61%
	Increase in plan premium is only permitted at beginning of contract year	42%
Advertisements and sales brochures	All beneficiaries (except those with end stage renal disease or in hospice programs) may apply for enrollment	42%
	Premium information must include statement that beneficiary must continue to pay Medicare Part B premium	20%
All pre-enrollment marketing materials	All routine care must be received from plan providers (a.k.a. lock-in)	42%

Source: OIG review of marketing materials, conducted February/March 1999

Thirty-four percent of materials did not meet print-size requirements

Of the 301 approved materials that we reviewed for print size, 34 percent (102 of 301) did not meet requirements. Managed care marketing materials for Medicare beneficiaries are required to be in 12-point or larger print size. Advertisements are the exception. The requirement for advertisements is that footnotes be the same print size as the sales message. Frequently, managed care plans put federally required information in an advertisement's footnotes. Beneficiaries might miss the information if footnotes are smaller than the sales message.

Of the marketing materials other than advertisements, 26 percent (36 of 139) were in print size smaller than 12 points. Forty-seven percent (65 of 139) were in 12 points or larger, and 27 percent (38 of 139) were unclear. Frequently, print size cannot be determined because the materials a managed care plan has submitted to HCFA are not in their final format, or the plan submitted a facsimile that has distorted print.

In advertisements alone, 41 percent (66 of 162) had footnotes smaller than the sales message, 24 percent (39 of 162) had footnotes of the same size, 12 percent (20 of 162) did not have footnotes, and 23 percent (37 of 162) were too unclear to tell size. In our review, we found footnotes as small as 6 points when the sales message was 13 points.

Nearly half of materials reviewed were not consumer friendly

Separate from our review of whether marketing materials met Federal guidelines, we conducted a subjective review to determine whether they were consumer friendly (see criteria on page 8). We recognize that responsible, well-informed individuals might legitimately disagree about whether language is consumer friendly. We based our conclusions on what we believe was a fair and systematic review of marketing materials.

We found 46 percent of materials (145 of 312) were confusing or contained jargon. Reviewing each criteria separately, 40 percent (125 of 312) were confusing, and 28 percent (87 of 312) contained jargon. Twenty-one percent of the materials (67 of 312) were both confusing and contained jargon.

In pre-enrollment materials, or materials that beneficiaries receive before enrolling in a managed care plan, we found 41 percent (85 of 205) were confusing or contained jargon. In member materials, or materials that beneficiaries receive after enrollment, we found 56 percent (60 of 107) were confusing or contained jargon.

Below are two figures that provide examples of confusing text and jargon that we found in marketing materials.

Figure 1. Examples of Confusing Text in Marketing Materials

"$0 copay for hearing test; one hearing aid for each ear every three (3) years, limited to $300 credit toward the purchase of each hearing aid for a total credit of $600." (Advertisement)

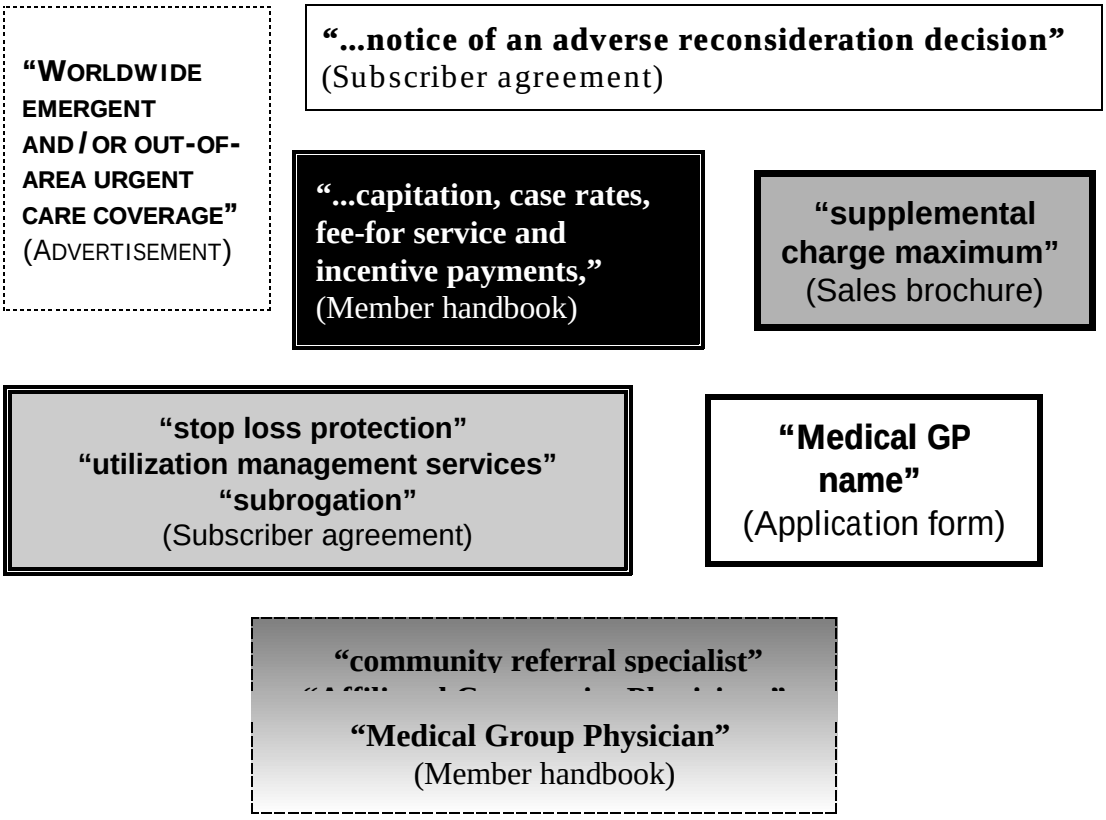
"All services and benefits for care and conditions within each of the following classifications shall be excluded from coverage under this plan except such services as may be specifically provided."

(Summary of benefits)

"Additional Health Services recommended by Contracted providers after receiving the Health Services authorized by the original Referral are Covered if you obtain a new Referral from your Primary Care Physician before receiving such Health Services." (Subscriber agreement)

"Unlimited maximum on generic prescriptions after reaching $1,500 limit." (Advertisement)

Figure 2. Examples of Jargon in Marketing Materials



Source: OIG review of marketing materials, conducted February/March 1999

Marketing materials that are not clear and easy to understand may affect beneficiaries' ability to make informed health-care choices.

RECOMMENDATIONS

Our findings from this report and our companion report, *Medicare Managed Care: Goals of National Marketing Guide* (OEI-03-98-00270), wherein we surveyed users of the *Medicare Managed Care National Marketing Guide* and obtained data on marketing-material reviews, provide evidence that the *National Marketing Guide*, while improving some aspects of the marketing-material review process, was not very successful at meeting its most important goal. That goal is to provide Medicare beneficiaries with accurate and consumer friendly marketing materials. Inaccurate and confusing materials may affect beneficiaries' ability to make informed health-care choices.

We recommend that HCFA:

- **update the *National Marketing Guide*.** The *National Marketing Guide* should further clarify which information is specifically prohibited or required in marketing materials. The *National Marketing Guide* should provide model materials that are accurate and easy to read. It should clarify policy and operational instructions regarding the lead and local regional office responsibilities, the Use and File System (which allows plans to distribute sales material without prior approval), and the health plans' use of checklists for member materials. It should also ensure that checklists for member materials contain all the required information.

- **standardize and mandate use of <u>member</u> materials**. The HCFA should work toward standardizing as many types of member materials as possible. Managed care plans should be required to use these materials when communicating with their enrolled Medicare beneficiaries.

- **develop standard review instruments.** These review instruments should be used by HCFA staff in determining if marketing materials (both pre-enrollment and member) contain all required information and do not contain prohibited information.

- **establish a quality control system.** The HCFA should periodically review a nationwide sample of previously approved marketing materials (both pre-enrollment and member) to determine if they meet Federal marketing guidelines.

- **track marketing-material reviews consistently and uniformly across all regions**.

- **conduct meetings to review Federal marketing requirements with managed care plans that continually submit materials not in compliance with the requirements.**

- **provide training on the use of the *National Marketing Guide* for HCFA reviewers and managed care plans.**

AGENCY COMMENTS

The Health Care Financing Administration (HCFA) reviewed this report and the companion report on goals of the *National Marketing Guide* and concurred with our recommendations. We summarized the agency's comments below, however, the full comments are in Appendix C.

- **update the *National Marketing Guide*.** The agency is updating the *National Marketing Guide*, including checklists and model letters. They are also clarifying what is allowed and prohibited in marketing materials. As they believe the Use and File System is an important tool, they plan to develop materials to promote a better understanding of its operation.

- **standardize and mandate use of member materials**. Work toward standardizing certain materials has already begun. As of contract year 2000, health plans contracting with HCFA must use a standardized Summary of Benefits. In the future, beneficiary notifications such as the Evidence of Coverage will be standardized, and their mandatory use will be phased in.

- **develop standard review instruments.** The agency's goal is to have a new and comprehensive data collection instrument, called the Plan Benefit Package, fully implemented in contract year 2001. This instrument will have multiple uses, including a standardized way to collect descriptions of benefits from health plans. The instrument can then be used to review health plan marketing materials. In the meantime, a modified version of a prior data collection instrument will be used. In addition, the Product Consistency Team, comprised of representatives from all ten HCFA regional offices, will meet monthly. Through ongoing dialogue, the team is expected to uncover and correct any inconsistencies in operational or policy interpretations of standardized materials.

- **establish a quality control system.** The HCFA has established procedures for verifying that all final versions of beneficiary notices are the same as the versions HCFA approved. They also plan to review a sample of actual printed marketing materials from a random sample of health care organizations. The agency has also established a quality control system in their pilot study of the effectiveness of contracting the marketing material review to a single national contractor. Moreover, the Product Consistency Team will be critical to overall quality control efforts.

- **track marketing-material reviews consistently and uniformly across all regions.** The HCFA regional offices will be required to track receipt and approval of all marketing materials when the new Health Plan Management System becomes operational in 2000. The Managed Care Information System, which is currently used by a number of the regional offices, will become part of the new system.

- **conduct meetings to review Federal marketing requirements with managed care plans that continually submit materials not in compliance with the requirements.** The HCFA is in the process of updating a contractor performance monitoring protocol. The revised protocol will require HCFA reviewers who find a pattern of noncompliant marketing submissions to take action, including meeting with managed care plans. As the agency continues to review its marketing material review program, it will determine additional steps that need to be taken, including sanctioning.

- **provide training on the use of the *National Marketing Guide* for HCFA reviewers and managed care plans.** The HCFA currently includes a marketing session in their annual training program for reviewers. They plan to expand the program to address the needs of contracting health plans. In addition, they expect that Product Consistency Team meetings will promote better understanding of the *National Marketing Guide*.

OIG RESPONSE

We appreciate the comprehensiveness of HCFA's comments. We believe the agency's stated efforts can result in comparable and understandable materials which beneficiaries need to make informed health-care choices. We are hopeful that the update of the *National Marketing Guide* will include clarification of lead and local regional office responsibilities, and clarification as to whether health plans must submit checklists along with the member materials they submit for HCFA's review. These two elements of the guidelines were not specifically mentioned in the agency comments regarding various elements of the guidelines that would be updated.

We have one other concern regarding the Product Consistency Team. The agency states they will be relying on the team to play a critical role in quality control, to uncover and correct inconsistencies in operational or policy interpretations of standardized materials, and to update the *National Marketing Guide* as needed. The past team was not fully effective in these areas, and we are hopeful that the new team has the tools and authority needed to accomplish these important objectives.

APPENDIX A

National Marketing Guide's Language Chart in 1998

Marketing Language: "Must Use/Can't Use/Can Use" Chart

The following items: Lock-in, Eligibility, and Contract with Government, are required items in advertising and marketing materials.

Subject	Must Use	Can't Use	Can Use	Reason
Lock-in	• Enrolled members "must use (name of plan) (contracting, affiliated, or name of plan participating) providers" • "Plan available to all Medicare beneficiaries" MEDIA: All except outdoor advertising. *Outdoor advertising has the option of excluding this topic. ***** See definition of outdoor advertising on page 124.	• "Participating providers" unless you use plan name	• Enrolled members "must use (name of plan) (contracting, affiliated, or name of plan participating) providers"	HCFA requires lock-in for all media to inform beneficiaries of managed care requirement. Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising.
Quality*****		• Superlatives (e.g. highest, best) • Unsubstantiated comparisons	• Qualified superlatives (e.g. among the best, some of the highest) or superlatives (e.g. ranked number 1), if they can be substantiated (Source must be identified in the advertising piece.) • "Plan delivers (adjective) quality of care." • Descriptions of plan's initiatives related to quality. • Can use satisfaction survey results. (Must disclose year and source.) MEDIA: All	Quality is not a required topic in marketing materials.

***** HCFA has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in plan operation.

Subject	Must Use	Can't Use	Can Use	Reason
Premiums/ Costs	• If a plan premium is mentioned, it must be accompanied by a statement that beneficiaries must continue to pay Part B premium or Medicare premium. MEDIA: Print • TV-Part B caveat must be flashed in TV safe range or mentioned in narration.	• "No premium" • "No premiums or deductibles" • "Free"	The following may be used. • "No plan premium." • "Plan premium equals _____" • $0 plan premium • "At no extra cost to you" but only if referring to a specific benefit • "No plan premiums or deductibles" • "No premiums or deductibles (you must continue to pay the Medicare Part B premium)" • "No premium beyond your monthly Medicare payment" • "No premiums other than what you currently pay for Medicare MEDIA: All except outdoor advertising (See "Must Use") • "Plan premium" MEDIA: Outdoor. Outdoor advertising has the option of excluding this topic.	• Materials must disclose that beneficiaries must continue to pay the Part B premium and continue their Medicare Part B coverage while enrolled in the HMO. Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising.
Testimonials	• Content must comply with HCFA marketing guidelines, including statements by members.	• Cannot have non-members say he/she belongs. (Can use actors, but they cannot say they belong to the plan.) • Speaker must identify specific health plan membership MEDIA: All		

APPENDIX A

Subject	Must Use	Can't Use	Can Use	Reason
Contract with the Government	• Must include one of the phrases from the can use column MEDIA: All except outdoor. Outdoor advertising has the option of excluding this topic.	• "Recommended or endorsed by Medicare" • Cannot imply that plan has a unique or custom arrangement with the government, e.g.: -- "Special contract with Medicare" -- "Special plan for Medicare beneficiaries"	• "HMO with a Medicare contract" • "A federally qualified HMO with a Medicare contract" • "A federally qualified Medicare contracting HMO" • "Medicare approved HMO" MEDIA: All	Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising.
Physicians and Other Health Care Providers	• If the number of physicians and other health care providers is used, it must include only those available to Medicare beneficiaries MEDIA: TV, radio, outdoor • If the number of physicians and other health care providers is used, it must include only providers available to Medicare beneficiaries. If a total number is used it must separately delineate the number of primary care providers and specialists included. MEDIA: Print and direct mail	• Implication that providers are available exclusively through the particular HMO unless such a statement is true • "Participating providers" unless you use plan name	• "(Plan's name) participating providers" • "Network" providers • "Contracting" providers • "Affiliated" providers • Number of providers should be same total number of Medicare providers MEDIA: All	• Do not use the word "participating" when referring to plan providers (unless you use plan name), since it could be confused with a participation agreement with Medicare. Plans should either use "contracting" or "plan name" when referring to plan providers.
Limited Open Enrollment Period			• Describe open enrollment period if open enrollment is not continuous MEDIA: All	

APPENDIX A

Subject	Must Use	Can't Use	Can Use	Reason
Eligibility	• Must indicate that <u>all</u> Medicare beneficiaries may apply.	• "No health screening" unless specific mention is made of ESRD and hospice • "Seniors" unless term appears with "and all other Medicare eligibles" • "Plan designed especially for seniors" • "Senior plan" unless part of plan name • "Individuals age 65 and over" • "You must have Parts A and B of Medicare"	• "Anyone with Medicare may apply" • "Medicare entitled" • "Individuals eligible for Medicare" • "Individuals on or entitled to Medicare" • "Medicare beneficiaries" • "Medicare enrollees" • "People with or on Medicare" • "Seniors and all other Medicare-eligibles" • "No physicals required" • "No health screening" if a caveat is included for ESRD and hospice • "If you do not have Medicare Part A, you may purchase Part A coverage from Social Security or purchase equivalent coverage from the HMO" MEDIA: ALL	• Since all Medicare beneficiaries may enroll in Medicare-contracting HMOs, you may not refer to your plan as a "senior plan" (unless you refer to it as part of the plan name). The term "senior plan" implies that disabled beneficiaries may not enroll. • Medicare Part A is not a requirement for enrollment in Medicare-contracting HMOs. Plans may require beneficiaries who are not covered under Part A to purchase equivalent coverage directly from the plan
Claims Forms/ Paperwork		• "No paperwork" • "No claims or paperwork/complicated paperwork" • "No claims forms"	• "Virtually no paperwork" • "No paperwork when using plan providers" • "Hardly any paperwork" MEDIA: All	• Members may be required to submit bills or claims documentation when using out-of-plan providers.

APPENDIX A

Subject	Must Use	Can't Use	Can Use	Reason
Benefits				
a. Comparison	• If premiums and benefits vary by geographic area, must clearly state this or must clearly state geographic area in which differing premiums and benefits are applicable. • If only benefits vary, clearly state geographic area in which benefits are applicable. MEDIA: All		• "Premiums and benefits may vary by county" or "These benefits apply to the following counties" • "Except for _____ county" MEDIA: All	• Premiums, benefits and /or copayment amounts may vary by county within a given service area. This must be clearly conveyed in all marketing materials. • If benefits are specified within the piece, any applicable copayment should be stated or you may include the general statement as shown.
b. Limitations		• Minimal copays **may** apply • At no extra cost to you or free, if copays apply	• State exact dollar amount limit on any benefit • "Limitations and restrictions may apply" • "Minimal copayments will apply" • "Minimal copayments may vary by county"	
c. Prescription Drugs	• If prescription drugs are mentioned and have limitations, must say: • limited drug coverage; • drug coverage benefits subject to limitations; or • up to xxx annual limit or xxx limit per year and other limits and restrictions may apply.	• "We cover prescription drugs" unless accompanied by reference to limitation • "Prescription drug coverage" unless accompanied by reference to limitation	• State which benefits are subject to limitations • Fully disclose dollar amount of copayments and annual limit • If limited, you must say so • Limited drug coverage with xx copayments and xxx annual limit • "Prescriptions must be filled at contracting or plan affiliated pharmacies." MEDIA: All	Prescription drugs are an important benefit that must be adequately described. Any dollar limits must be clearly conveyed.

APPENDIX A

Subject	Must Use	Can't Use	Can Use	Reason
Definitions		• "Life threatening" • "True emergency"	• Emergency -- definition as stated in current HCFA policy. • Urgent -- definition as stated in current HCFA policy. MEDIA: Direct mail	• Emergency criteria should be explained per Medicare guidelines rather than in the commercial context.
Drawings/ prizes		• "Eligible for free drawing and prizes" MEDIA: Direct mail, flyers, print advertising	• "Eligible for a free drawing and prizes with no obligation" • "Free drawing without obligation" MEDIA: Direct mail, flyers, print advertising.	• It is a prohibited marketing practice to use free gifts and prizes as an inducement to enroll. Any gratuity must be made available to all participants regardless of enrollment. The value of any gift must be less than the nominal amount of $10.
Sales presentation s	• "A sales representative will be present with information and applications." MEDIA: Flyers, invitations and print advertising • "A sales representative may call." MEDIA: Response card • A telecommunications device for the deaf (TDD) is available to get additional information or set up a meeting with a sales representative. • For accommodation of persons with special needs at sales meetings, call (Health Plan Phone Number).	• "A plan representative will be available to answer questions."		• This phrase must be used whenever beneficiaries are invited to attend a group session with the intent of enrolling those individuals attending. • This phrase must be included on any response card in which the beneficiary is asked to provide a telephone number.

APPENDIX B

OIG's Methods For Reviewing Marketing Materials

Marketing material medium. Our review was of hand-held printed marketing materials. We did not review materials designed for radio, television, Internet, or billboards. Nor did we review telemarketing scripts or slide presentations.

Universe of materials. All 319 pieces we reviewed had been reviewed and approved by the Health Care Financing Administration's (HCFA's) regional staff in 1998 and were on file in those offices.

Source of materials. A majority of the materials we reviewed came from 3 of the 10 HCFA regions. Of the 319 pieces that we reviewed, 249 came from these three regions. We selected these regions because they represented a variety of managed care experience and differing population sizes of Medicare beneficiaries. We went on-site to the three regional offices and reviewed all print materials approved within one calendar quarter of 1998. We also reviewed 10 mailed pieces of approved print materials from the remaining 7 HCFA regional offices.

Types of materials. Prior to determining the types of materials to review, we reviewed Federal marketing guidelines in the *Health Maintenance Organization/Competitive Medical Plan Manual* and the *Medicare Managed Care National Marketing Guide*, referred to as the *National Marketing Guide* in this report. We compiled a list of types of marketing materials that were addressed in these two sources. Most marketing materials fit into one of two broad categories: pre-enrollment materials and member materials. The former includes advertising and any kind of promotional materials used to interest Medicare beneficiaries in the managed care plan. The latter consists of communications to members of the plan. These might be letters notifying members of a change in providers or a change in benefits; information about a claim or payment; subscriber agreements conveying rights of the member as well as member and plan responsibilities; and letters confirming enrollment and disenrollment. A few pieces, e.g., Directory of Providers, can fit into both categories. Such pieces are often in promotional packets, and they are also given to members. In our analysis, we counted them as pre-enrollment materials. The types of print materials we did not review (see tables on page 22) were ones not specifically referred to in the two sources of Federal guidelines mentioned above. We learned about these other types of print materials during our on-site reviews and from respondents in our surveys.

Review instruments. We created 24 types of review instruments to match the variety of pre-enrollment and member materials described in Federal guidelines. Our instruments contained questions related to prohibitions and requirements in the *National Marketing Guide*. We formulated the questions from text in the "Must use/Can't use/Can use" language chart,

model member materials, checklists, and paragraphs highlighting important things for plans to remember when creating materials. The instruments contained from 5 to 86 questions depending on the type of piece reviewed. Questions addressed issues ranging from the most critical information requirements (e.g., advertisements with premium information must state that beneficiaries must continue to pay their Medicare Part B premium) to formatting (i.e., print size). The longest review instrument (86 questions) was for the subscriber agreement. This was actually a two-part instrument with the second part focusing on appeal rights and procedures. We used this second part for the determination and appeal sections of the subscriber agreements, and for two other types of materials: (1) the standard determination letter (used when a member's request for a service is denied) and (2) the notice of non-coverage (necessary for members who believe they were discharged too soon from a hospital). Both of these materials include members' rights to appeal and the appeal procedures. The instrument's questions addressed the many steps in the appeal process, including standard and expedited determinations, standard and expedited reconsiderations, and hospital discharges.

Format of review questions. Possible answers to questions in the review instruments were "Yes, No, Not mentioned, Can't tell." An example of a question is, "Are footnotes in this ad the same size as the sales message?" We would select "Yes" as the answer if the footnotes were the same size, "No" if the footnotes were not the same size, "Not Mentioned" if the ad did not contain footnotes, and "Can't Tell" if the print size was too blurred for us to tell. Frequently, plans submit to HCFA photocopies or facsimiles that have distorted print. They also submit e-mails that contain the text of their marketing materials but no indication of the final format.

APPENDIX B

Table 1. Types of print pre-enrollment materials we reviewed and types we did not review

PRE-ENROLLMENT MATERIALS	
Types Reviewed	**Types Not Reviewed**
▸ Enrollment application forms ▸ Advertisements - newspapers, magazines ▸ Advertisements - direct mail, letters to non-Medicare members turning 65 ▸ Sales brochures, booklets, leaflets ▸ Summaries of Benefits ▸ Directories of Providers ▸ Member Handbooks	▸ Instructions for enrollment application forms; translator and/or witness forms ▸ Event invitations; event registration forms ▸ Letters asking former member to re-join plan ▸ Letters asking beneficiary for opportunity to explain plan in their home ▸ Letters from a provider promoting the plan ▸ Letters saying plan tried to contact beneficiary ▸ Surveys for beneficiary to evaluate a sales meeting ▸ Surveys for beneficiary to evaluate readability of sales material ▸ Envelopes; postcards; thank you cards

Table 2. Types of print member materials we reviewed and types we did not review

Types reviewed	
▸ Letters confirming enrollment ▸ Letters denying enrollment ▸ Letters confirming voluntary disenrollment ▸ Letters confirming involuntary disenrollment ▸ Letters describing annual changes in benefits, premiums, providers, etc. ▸ Letters describing a mid-year change in benefits, premiums, providers, etc. ▸ Letters re: member's failure to pay plan premium ▸ Letters with plan's determination of member's request for service ▸ Letters providing status of an appeal ▸ Letters providing status of a filed grievance ▸ Notices of Non-Coverage (used if beneficiary believes discharge from hospital is too early) ▸ Letters describing Physician Incentive Plan ▸ Letters notifying members that provider is no longer with plan ▸ Letters addressing operational changes (e.g., change in business hours) ▸ Letters responding to a member's request for information ▸ Subscriber agreements (contains members' rights, members' and plan's responsibilities; covered and non-covered services)	▸ Member card materials ▸ Letters with retroactive date of enrollment ▸ Disenrollment application forms ▸ Letters denying disenrollment ▸ Letters confirming disenrollment after date of death ▸ Letters regarding premium refund when member paid unnecessarily ▸ Schedules of co-payments ▸ Letters notifying member that benefits are exhausted ▸ Invoices; payment for claims ▸ Letters describing Advance Directive (living will) ▸ Letters requesting update of member's name, address, and phone number ▸ Letters informing members of senior advocacy board ▸ Letters thanking member for sharing concerns ▸ Birthday cards; invitations to events for members ▸ Letters requesting referrals from current member of any potential new members ▸ Surveys to determine demographics of plan's elderly members who are still working ▸ Surveys of member satisfaction ▸ Surveys of member reasons for disenrollment ▸ Surveys of member's health ▸ Wellness materials (disease prevention information)

APPENDIX C

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

DATE: JAN 24 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Medicare Managed Care: Goals of National Marketing Guide" (OEI-03-98-00270), and "Medicare Managed Care: 1998 Marketing Material" (OEI-03-98-00271)

We appreciate the opportunity to comment on these two reports regarding marketing materials. We agree that the Health Care Financing Administration (HCFA) should continue and strengthen efforts to ensure that beneficiaries have access to understandable and comparable information regarding Medicare managed care options.

We also wish to acknowledge and thank you for the support provided by your staff regarding HCFA utilization of marketing material review checklists developed for use during these two studies. The OIG marketing review checklists have been extremely helpful as we develop improved review procedures to be used by both Medicare managed care organizations and HCFA Regional Office reviewers.

We are enclosing our comments to the specific recommendations. We look forward to continuing our work with the Congress, your office, beneficiary groups, and other interested parties to assure that beneficiaries have the information they need to make informed health care decisions.

Attachment

In addition, HCFA plans to fully implement the Plan Benefit Package (PBP) –a data collection instrument-- as part of the 2001 Medicare managed care contract. The PBP will standardize the method whereby HCFA collects information from plans. Furthermore, the PBP will be used to generate the standardized Summary of Benefits which HCFA requires all health plans to use. This approach will facilitate and expedite the review of managed care materials by HCFA staff. Combined with ongoing internal training, work to standardize other documents, and heightened review efforts, the PBP will help improve the reliability and accuracy of plan information the beneficiaries need to make informed decisions on their health care.

We agree with the OIG's finding that some aspects of the review process have improved due to the NMG, and we further agree that more work needs to be done to make sure that the NMG is well understood and applied uniformly. We also agree that additional effort is needed to ensure the accuracy of health plan marketing materials. As noted, the PBP and ongoing staff training efforts already underway are critical steps toward attaining this goal.

We too were disturbed by the OIG's findings that such a high percentage of marketing materials were not in compliance with all the relevant HCFA regulations. Although the OIG study focused primarily on marketing materials from health plans in only three regions, we believe HCFA can, and should, make further improvements in our work with all the plans. The OIG makes several recommendations, including: 1) updating the NMG; 2) standardizing materials and review instruments; and 3) establishing a quality control system. HCFA concurs with the OIG's recommendations and, as discussed in our comments, we have already begun to implement many of these recommendations.

Specific Comments

OIG Recommendation

The Health Care Financing Administration should update the National Marketing Guide (NMG).

HCFA Response

We concur. We will continue to update and improve the NMG. However, we believe our efforts toward more consistent review and enforcement of the guidelines are just as important. Thus, our work includes a series of steps, such as:

- Making the guidance in the NMG clearer for HCFA staff and health plan staff with regard to determining what is allowed and prohibited in the marketing material.
- Providing health plans with model beneficiary letters. We recently released Operational Policy Letter (OPL) 99.100 containing 24 model letters, particularly related to enrollment and appeals materials. These model letters provide plans with sample language that is easy for beneficiaries to read and understand. These letters will soon be formally incorporated into the NMG.

- Developing improved reviewer checklists that help to facilitate and add consistency to HCFA review of member materials submitted by health plans. As part of this improvement process, we will use the OIG's review checklists in implementing the recommendations.

Also, as the OIG recommends, HCFA will take steps to better educate HCFA and plan staff on the operations of the "Use and File" system. This system, which allows plans to release material prior to HCFA approval, does not seem to be well understood by many interviewed in your report. We believe that the Use and File system is an important tool, and we will develop materials to promote a better understanding of its operation.

OIG Recommendation
HCFA should standardize and mandate use of member materials.

HCFA Response
We concur. The types of documents M+C organizations have used to describe their benefits vary widely. M+C organizations have used their own structure, format, and language in providing benefit information. However, this flexibility has made it difficult for beneficiaries to make informed comparisons when choosing among M+C organizations. To meet the need for comparable information and to address concerns raised by the Senate Aging Committee, we launched a comprehensive effort to standardize materials published by plans.

A critical part of this effort is the standardization of the Summary of Benefits --a key document used by health plans to inform potential members of a plan's benefit package. Medicare beneficiaries have indicated the Summary of Benefits is the most important document provided by the M+C organization used in selecting a health plan. As of the beginning of contract year 2000, HCFA required M+C organizations to provide a standardized Summary of Benefits to all prospective and current members. The feedback from both the industry and beneficiaries on this material has been very positive. The M+C organizations will be required to use the standardized Summary of Benefits automatically generated from the PBP. HCFA will provide the information in the standardized Summary of Benefits on the Medicare.gov web site and beneficiaries will be able to request plan specific information through 1-800-MEDICARE.

HCFA is also working on other materials to provide beneficiaries with the information needed to make informed decisions about their health care options. After appropriate consultation with beneficiary groups and plan representatives, HCFA is requiring that remaining beneficiary notification (as opposed to advertising) materials (such as, the Evidence of Coverage, enrollment application forms, appeals-related materials) be

standardized. We released the Model Evidence of Coverage (EOC) for contract year 2000 on December 1, 1999. The Model is accessible through the HCFA web site. Though it serves as a model, and is voluntary for this contract year, the release of the Model EOC will help prepare plans and HCFA staff for the beginning of the phase-in process for mandatory use of the EOC in contract year 2001.

We believe that M+C organizations should retain some flexibility in creating their advertising materials in order to differentiate their services from those provided by other M+C organizations. But, these advertising materials should always accurately reflect the benefits offered, and HCFA will be diligent in its efforts to assure that advertising materials are not misleading.

OIG Recommendation
HCFA should develop standard review instruments.

HCFA Response
We concur. HCFA is already refining two review protocols to help standardize the review process. As one part of this effort, HCFA revised the Benefit Information Form (the 1998 BIF) by developing the PBP. HCFA plans to fully implement the PBP as part of the 2001 Medicare managed care contract.

The description of plan benefits is the foundation of the marketing review process. For the 1998 and 1999 contract years, the BIF was used to approve benefits in the Adjusted Community Rate (ACR) and to review M+C organization marketing material. Following a comprehensive review of the 1998 BIF, it became clear that a standard, more detailed reporting format system was needed. For 2000, the BIF has been modified as part of the transition to the PBP. The BIF 2000 reduces the need to have a separate data collection effort for Medicare Compare data for plan year 2000, thereby saving HCFA staff valuable time and effort and reducing the need for duplicative data validation. For 2001, the PBP will be used to perform these functions and will improve the reliability and accuracy of managed care organization contract documents.

The PBP focuses on creating a standard structure for the description of benefits in order to facilitate the review of marketing material. By establishing a standard benefit content structure, HCFA will ensure more reliable and accurate benefit information, in addition to creating standard reporting formats and terminology. The PBP more completely captures the different benefits M+C organizations offer, thus assisting HCFA in the approval of managed care organization marketing material. Below are two specific examples of how the Plan Benefit Package (PBP) will facilitate standardized review of marketing materials.

- **Screening Mammography.** In a study published in April 1999, the GAO found that selected 1998 M+C organization marketing material on Medicare's screening mammography benefit was inconsistent with HCFA's stated policy. The 1998 BIF would not have automatically identified such discrepancies because it did not address the issue of prior authorization, thereby allowing for error. The PBP will address this important issue by requiring all managed care organizations to identify the authorization rules for each service category. For the mammography service category, the PBP is predetermined by HCFA policy and is not an optional description by the M+C organization. As a result of this refinement, the PBP does not allow managed care organizations to enter any authorization rules for the Medicare screening mammography benefit.

- **Prescription Drug Benefit.** Also in the April 1999 GAO study, it was reported that M+C organization information about prescription drug coverage from one marketing document to another and that drug information was sometimes incorrect. While the 1998 BIF may have provided some drug benefit information, this information was not in sufficient detail to capture some of the key differences in the drug benefits offered. The PBP addresses this problem by requiring information on the rules for generic, brand, and mail order drugs, as well as the maximum plan benefit coverage amount (dollars), co-payments, and plan use of a drug formulary. This will allow for easier review and comparison of information.

In addition, HCFA has created a Product Consistency Team (PCT) comprised of representatives from all ten HCFA Regional Offices (ROs). The group meets monthly to review marketing issues, to develop solutions, and to update the NMG as needed. Through this ongoing dialogue, the team is able to uncover and correct any inconsistencies in operational or policy interpretations of standardized materials. This is a relatively new team, and we believe that it will significantly improve HCFA's ability to monitor marketing materials.

OIG Recommendation

HCFA should establish a quality control system.

APPENDIX C

HCFA Response

We concur. In fact, we have already taken four clear actions to ensure that we are monitoring quality to the greatest extent possible.

1) **Established the PCT** -- We believe the PCT is critical to our quality control effort.
2) **Established procedures for final verification review of all beneficiary notification materials** -- We will review all beneficiary notification materials at the final proof stage to confirm that the final text version has not changed after HCFA's initial approval of the document.
3) **Created process for review of published materials** -- We will review a random sample of actual printed marketing materials from a random sample of health care organizations to monitor health plans' compliance with the final verification review process.
4) **Initiated pilot study of a process for review of materials on the national level** -- We have also established a quality control system as part of a pilot study of the effectiveness of outsourcing the marketing material review process to a single national contractor.

OIG Recommendation

HCFA should track marketing materials consistently and uniformly across all regions.

HCFA Response

We concur. Again, the PCT is a key tool in assuring consistent review of marketing materials. As the PCT meets and becomes aware of possible misinterpretations of the guidelines, it will assist in updating the NMG so that the NMG becomes a more consistent and reliable tool for plans.

Also, the new Health Plan Management System (HPMS) will establish a better tracking system that can be used consistently by the ROs. The HPMS will incorporate the Managed Care Information System, the tracking system currently used by many of the ROs to track marketing materials. The ROs will be required to use this tracking system to track receipt and approval of all marketing materials when it becomes fully operational in 2000.

OIG Recommendation

HCFA should conduct meetings to review Federal marketing requirements with managed care plans that continually submit materials not in compliance with the requirements.

HCFA Response

We concur. Several of our ROs currently conduct face-to-face meetings with managed care plans that continually submit materials not in compliance with the requirements. We

are in the process of updating HCFA's M+C Contractor Performance Monitoring System protocol and will include a requirement that HCFA reviewers who find a pattern of noncompliant marketing submissions take action (including meetings with managed care plans) to improve the quality of submitted materials. Further review of our Medicare managed care marketing program will help us determine additional steps that need to be taken to address this issue, up to and including sanctioning plans who are frequently not in compliance with the straight-forward requirements.

OIG Recommendation

HCFA should provide training on the use of the NMG for HCFA reviewers and managed care plans.

HCFA Response

We concur. HCFA currently includes a marketing review session in our annual training support program for reviewers. We already have plans to expand this training program to address the needs of the contracting health plans. The HCFA central office and the ROs will provide training for reviewers and managed care plans.

Also, the PCT meetings will also provide a vehicle for promoting a better understanding of the NMG. We welcome the OIG's recommendations in this matter. We intend to provide the checklist used by the OIG in its review of managed care plans along with additional information so that they better understand the requirements and guidelines. We will continue to expand our dialogue with health plan staff to provide as much technical assistance and guidance as is needed to make sure that all relevant parties have a strong understanding of the NMG.