

Moving Toward Integrated Marketing Rules and Practices for Medicare and Medicaid Managed Care Plans

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The Medicare and Medicaid programs have distinct requirements governing the way in which managed care plans communicate with and provide information to potential and current enrollees. Differences in marketing rules, materials, and practices reflect the programs' different populations and benefits, as well as the fact that Medicare is administered at the federal level by the Centers for Medicare & Medicaid Services (CMS) while Medicaid programs are separately administered by each state. States that were early innovators in Medicare-Medicaid integration (e.g. Arizona, Massachusetts, Minnesota, New Mexico, and Wisconsin)¹ struggled with often conflicting and confusing marketing requirements.

This technical assistance brief summarizes efforts to align managed care marketing across Medicare and Medicaid. Beginning with an overview of major differences between marketing rules for these two programs, it describes challenges that states face in developing integrated care programs for Medicare-Medicaid enrollees and the approaches used to address these challenges. The brief describes new opportunities to better align marketing requirements in the context of CMS' Financial Alignment Initiative, but this information may also be helpful for states that are pursuing integrated care through other models. This brief also provides examples of creative marketing approaches drawn from states pioneering integrated care and the Program of All-Inclusive Care for the Elderly (PACE).

IN BRIEF: Medicare and Medicaid have different requirements for marketing by managed care plans. This technical assistance brief provides an overview of Medicare and Medicaid managed care marketing requirements. It also highlights differences between marketing rules for these two programs and resulting challenges facing states that are developing integrated care programs for Medicare-Medicaid enrollees. Finally, the brief summarizes efforts to align managed care marketing rules and practices under Medicare and Medicaid, including new opportunities established by the Centers for Medicare & Medicaid Services (CMS) through the Financial Alignment Initiative, innovative state approaches, and the Program of All-Inclusive Care for the Elderly (PACE).

TOPIC	PAGE
I. Overview of Medicare and Medicaid Managed Care Marketing Requirements	1
II. Challenges with Marketing to Medicare-Medicaid Enrollees	2
III. Integrated Approaches to Marketing	3
IV. Conclusion	6

I. Overview of Medicare and Medicaid Managed Care Marketing Requirements

Medicare Advantage

Medicare managed care marketing requirements are outlined in the Medicare Marketing Guidelines (MMG),² a sub-regulatory guidance document updated annually, which implements CMS marketing regulations for Medicare Advantage organizations,³ including Dual Eligible Special Needs Plans (D-SNPs),⁴ and Prescription Drug Plans (PDPs).⁵ In the Medicare Advantage program, the definition of marketing includes communication with both potential enrollees and current enrollees that promotes the plan; informs beneficiaries that they may enroll, or remain

enrolled in, the plan; explains the benefits of enrollment in the plan; and explains how Medicare services are covered under the plan, including any conditions that apply to such coverage.⁶

Medicaid Managed Care

Federal Medicaid regulations establish broad managed care marketing parameters, allowing states the flexibility to develop many of the specific operational details. The regulations define marketing as communication with potential enrollees that can be reasonably interpreted as intended to influence their enrollment decisions. They also provide definitions for marketing terminology and requirements for state agency review of Medicaid plans' marketing materials.^{7,8} Other federal Medicaid regulations also cover information that is provided to current enrollees.⁹

All states have rules that expand upon federal Medicaid requirements; for example, states may impose more stringent literacy and translation requirements on materials, or enforce additional restrictions on allowable plan marketing practices. Additional marketing requirements may also be included in state contracts with Medicaid managed care plans. Because of these differences in state requirements, comparing Medicare requirements to federal Medicaid requirements may not capture variation at the state level.

II. Challenges with Marketing to Medicare-Medicaid Enrollees

Following are areas where differences between Medicare Advantage and federal Medicaid managed care marketing requirements exist (also detailed in Exhibit 1):

- Literacy/reading level standards;
- Translation requirements;
- Allowable marketing techniques, including unsolicited marketing of a plan's products;
- Use of independent agents and brokers; and
- CMS and/or state review and approval processes for marketing materials.

In addition, the Medicare Advantage marketing guidelines are more comprehensive and include requirements not addressed by federal Medicaid marketing rules such as:

- Formatting guidelines;¹⁰
- Inclusion of disclaimers and specific wording of marketing materials;¹¹
- Rules about the content of Medicare Advantage organizations' websites;¹²
- Customer service call center requirements¹³ (e.g., hours of operation and standards for responsiveness); and
- Notification to enrollees following particular changes to benefits and/or provider participation.¹⁴

Some of these additional Medicare requirements may be covered by state-level Medicaid rules, but not necessarily in the same way. Distinct marketing rules for Medicare Advantage and Medicaid managed care plans create several challenges for states, plans, and beneficiaries. For example, states have difficulty monitoring inconsistent requirements for health plans that cover both Medicare and Medicaid services and developing marketing materials and practices to encourage Medicare-Medicaid enrollees to enroll into the same health plan for both sets of benefits. Health plans may struggle to comply with multiple and sometimes conflicting requirements between the two programs. Medicare-Medicaid enrollees may receive separate marketing and educational materials for each program, even if the benefits are offered through a single health plan. This complexity may impede beneficiaries' understanding of the full spectrum of services a health plan or provider offers. Given the predominance of cognitive limitations, low education levels, and language barriers among the Medicare-Medicaid eligible population, marketing information should be clear, accessible, and culturally and linguistically appropriate – a special challenge when the rules themselves differ between the two programs.

Exhibit 1: Comparison of Medicare and Medicaid Marketing Requirements

Topic	Medicare	Medicaid	Federal and State Differences
Literacy/ reading level	No specific standards for the literacy level of materials. Broadly, materials must be written in a “clear, concise, and well-organized manner.” (MMG Appendix 2; P.L. 111-274, 124 STAT. 2861 [October 13, 2010])	Medicaid rules contain standards about literacy and reading levels. Specifically, materials must be written “in a manner and format that may be easily understood” as well as available in formats that account for special needs, such as visual limitations or limited reading proficiency. Beneficiaries must also be informed of the availability of information in alternative formats. (42 CFR §438.10(b) and (d))	Although federal Medicare and Medicaid requirements are similar, most states impose more stringent literacy requirements than Medicare. For example, some states require that beneficiary correspondence and/or marketing materials be written below a particular grade level (e.g., sixth grade in California and seventh grade in Minnesota). From a state’s perspective, less specific Medicare requirements may be problematic because materials for an aligned Medicare benefit may not meet state literacy standards.
Written translation	Medicare Advantage organizations must make particular written materials available in any language that is the primary language of at least 5 percent of a plan’s service area. (MMG Sections 30.5; 42 CFR §422.2264(e), §423.2264(e))	States and plans must make written information available in each “prevalent” language in the state or applicable service area. Federal guidelines direct each state to establish a methodology to identify “prevalent” languages spoken by a significant number or percentage of enrollees and potential enrollees. (42 CFR §438.10(c))	States have discretion to determine what constitutes “prevalent languages,” which may result in different languages selected for written translation by Medicare and Medicaid. For example, in California, marketing materials must be translated into “prevalent languages” spoken by 3,000 beneficiaries in the plan’s service area, 1,500 in adjacent zip codes, or 1,000 in a single zip code. ¹⁵ Due to these differences, individuals who are enrolled in both Medicaid and Medicare could receive materials from one program in their primary language but not the other (e.g., only their Medicaid information in their primary language only if the state Medicaid requirement is more stringent than the Medicare 5 percent requirement). ¹⁶
Unsolicited marketing	Medicare Advantage organizations cannot conduct unsolicited marketing through direct contacts, including door-to-door or telephone solicitation. This prohibition does not apply to mailings and other print media. (MMG Section 70.5; 42 CFR §422.2268(d), §423.2268(d))	Managed care plans cannot conduct any “cold-call” marketing, meaning unsolicited personal contact for the purposes of marketing, including door-to-door and telephone solicitation. (42 CFR §438.104(a) and (b)(i)(v))	Medicare and federal Medicaid requirements related to unsolicited or cold-call marketing are similar. However, several states have more stringent beneficiary protection requirements than Medicare. Arizona prohibits Medicaid managed care plans from conducting any marketing solely intended to promote enrollment and requires that all marketing materials must include health information. ¹⁷ Texas prohibits managed care plans from conducting direct mail marketing. ¹⁸

Topic	Medicare	Medicaid	Federal and State Differences
Use of independent agents and brokers	Medicare rules allow independent and plan agents and brokers to conduct marketing activities for health plans, under particular conditions. They must be licensed and undergo annual training and testing that meets CMS requirements. Medicare also establishes specific rules about independent agent and broker compensation. (MMG Sections 120.1-120.4.7; 42 CFR §422.2274 and §423.2274)	Medicaid rules do not address the use of independent agents or brokers. Most state Medicaid managed care programs contract with a single enrollment broker to process enrollments and provide enrollees with information regarding managed care enrollment options. The enrollment broker must be independent from managed care entities and free from conflict of interest. (42 CFR §438.810 - Expenditures for enrollment broker services)	Several states, such as Ohio, specifically prohibit independent agents or brokers in Medicaid managed care programs. ¹⁹ If a health plan covers both Medicare and Medicaid benefits, allowing independent agents and brokers to provide information on the plan's Medicare benefits, but allowing only the state's enrollment broker to provide information on the Medicaid benefits, could be confusing for health plans, agents/brokers, and potential enrollees.
Review and approval of marketing materials	Managed care plans must submit marketing materials to CMS for prospective review or for acceptance under the File & Use process (described below) via the Health Plan Management System (HPMS) Marketing Module. CMS must review materials within a specified timeframe (e.g., 10 days for materials based on model templates, and 45 days for materials not based on model templates) or materials are automatically “deemed” approved by CMS and plans may begin to use them. Under the File & Use process, plans may distribute certain materials five days after filing with CMS in the HPMS Marketing Module. (MMG Section 90.2; 42 CFR §422.2262, §423.2262)	Managed care plans must receive state approval of all marketing materials before distribution. States typically establish and consult with an advisory committee to review managed care plans' marketing materials. Federal Medicaid regulations do not specify requirements for review or approval of materials for current enrollees. (42 CFR §438.104(b)(i) and (c))	Each state establishes requirements and processes for Medicaid marketing, enrollment, and marketing material review, while Medicare has a specific system (HPMS) and timeframe for its review process. In general, states do not have access to HPMS, and their timeframes and criteria for review are likely to differ from Medicare's. However, states that participate in the Financial Alignment Initiative have access to HPMS to review Medicare-Medicaid Plan materials for their demonstration.

III. Integrated Approaches to Marketing

Despite differences in requirements, CMS and states share the goal of educating Medicare-Medicaid enrollees about their health coverage options while preventing marketing improprieties by aggressive health plans or brokers. CMS is working with states to resolve some of the differences in Medicare and Medicaid marketing rules and practices.

Marketing requirements for Medicare-Medicaid Plans

CMS and states using the capitated financial alignment model are developing a single set of marketing rules for Medicare-Medicaid Plans (MMPs). After signing a Memorandum of Understanding (MOU)²⁰ with CMS, each state works with CMS to design a state-specific MMP marketing guidance document. This document uses the MMG as a foundation to govern MMP marketing practices. Each state-specific MMP marketing guidance document must include beneficiary protections that are at least as beneficiary-friendly as Medicare requirements.

Several states participating in capitated model financial alignment demonstrations have finalized 2014 contract year MMP marketing guidance documents: California, Illinois, Massachusetts, New York, Ohio, and Virginia.²¹ Examples of the state-specific MMP marketing guidance requirements in these states are shown in Exhibit 2.

In addition to developing a single set of marketing rules for MMPs, both CMS and the states will undergo a joint review process to approve integrated MMP marketing materials. Traditionally, states have not had access to the Medicare Health Plan Management System (HPMS), but CMS has established new functionality in the system to allow for joint review. Most materials will be jointly reviewed, although CMS and states may mutually decide that some should be reviewed by CMS only (such as Part D materials) or the state only (such as advertising materials, or materials that would normally be required to be submitted via the File & Use process but that states wish to prospectively review). MMPs will submit all marketing and informational materials into an HPMS module, which then routes different materials to the state and/or CMS depending upon which type of review is required. Also, states can decide whether to designate some materials as subject to the File & Use process, which would exempt those materials from CMS and state prospective review and approval.

Under Medicare Advantage rules, CMS must complete review of marketing materials within a specified time, otherwise, materials are “deemed” as approved for marketing. However, deeming requirements are waived for MMP materials that require joint CMS-state or state-only review under the financial alignment initiative. Submitted materials not yet reviewed will remain in a “pending status” until they receive formal approval.

Previous approaches to integrating Medicare-Medicaid marketing

State Initiatives. Other states are advancing initiatives to better align Medicare and Medicaid requirements outside of the financial alignment initiative through provisions in contracts with D-SNPs, required by the Medicare Improvements for Patients and Providers Act (MIPPA).²² Following are examples of MIPPA contract requirements that seek to streamline marketing practices in Medicare and Medicaid:

- **Direct Marketing.** Arizona includes a provision in its contracts with D-SNPs that encourages plans to conduct direct marketing only to individuals enrolled in the Medicaid managed care plan operated by the same parent organization. Although beneficiaries in Arizona may choose to enroll into any Medicare Advantage plan or to remain in fee-for-service Medicare, informing beneficiaries about the option to enroll into plans operated by the same company may increase integration. New Jersey uses its MIPPA contract to require that D-SNPs’ written materials not exceed a fourth to sixth grade reading level and so takes into account the educational diversity of beneficiaries in the state.
- **Review Process Coordination.** Under the Minnesota Senior Health Options (MSHO) program, a long-standing integrated managed care program for Medicare-Medicaid enrollees age 65 and over, Minnesota established a process for joint review of education and marketing materials with its CMS Regional Office. Both CMS and the state must approve materials regarding benefits and provider networks, among others. New Jersey requires D-SNPs to submit Medicare marketing materials that include any state-specific Medicaid information for state review prior to submission to CMS, including File & Use materials.²³ Tennessee requires D-SNPs to submit all marketing materials upon CMS’ prior

review and approval that are distributed to any current or potential beneficiaries.²⁴ In both New Jersey and Tennessee D-SNP marketing materials cannot be used until state and federal reviews are complete.

Materials Simplification. As part of Minnesota’s alternative demonstration to “Align Administrative Functions for Improvements in Beneficiary Experience” for beneficiaries enrolled in the MSHO program, the state plans to simplify and improve integration of MSHO marketing and enrollee communication materials. The state will convene a collaborative MSHO Plan Member Materials Workgroup to develop streamlined model materials for use by MSHO D-SNPs, based on materials developed for MMPs participating in the CMS Financial Alignment Initiative.

Exhibit 2: Comparison of MMG and State-Specific Marketing Guidance for Medicare-Medicaid Plans

Topic	Medicare Marketing Guidelines (MMG) ²⁵	Differences in State Medicare-Medicaid Plan (MMP) Guidance ²⁶
Timeline to begin marketing activities (MMG: Introduction)	Marketing for the upcoming contract year (starting January 1) may not occur prior to October 1.	For the first year of the demonstration, MMPs may not conduct marketing until they pass a readiness review and sign a three-way contract with the state and CMS. The initial marketing activities may not commence earlier than 90 days prior to the start of the state’s passive enrollment period or prior to the effective date of enrollment for the following contract year thereafter. This is functionally equivalent to the Medicare Advantage prohibition on marketing prior to October 1 each year, except that the start of MMP marketing may occur at different times, depending on the state. After the first year of the demonstration, MMPs follow the same timeline as Medicare Advantage and may not market before October 1.
Requirements pertaining to non-English speaking populations (MMG: Section 30.5)	Plans must make particular written materials available in any language that is the primary language of at least five percent of a plan’s service area, and must include a standardized multi-language insert in several materials with written information about interpreter service availability in a variety of languages.	States’ requirements for translation of materials into “prevalent languages” supersede MMG requirements when they are deemed to be more beneficiary-friendly in each state. Some states require additional languages for the multi-language insert; for example, MMPs operating in one Ohio region must add the required paragraph in an additional language, Somali, which is not required by Medicare.
Required materials and timelines for receipt for new and continuing enrollees (MMG: Section 30.7)	New enrollees must receive several materials—such as pharmacy/ provider directories, and an annual notice of change (ANOC) or evidence of coverage (EOC) and a membership identification card at the time of enrollment or as needed, no later than 10 calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later.	There are different requirements for beneficiary receipt of materials depending on whether beneficiaries opt into the MMP or are passively enrolled. New enrollees in most states who are passively enrolled must receive a welcome letter, integrated formulary information, pharmacy/provider directory (or information about how to receive the directory), and a summary of benefits within 30 calendar days prior to the effective date of enrollment. They must receive an identification card and member handbook prior to the date of enrollment. ²⁷
Marketing multiple lines of business (MMG: Section 40.8)	Plans may provide marketing materials that describe other lines of business if they comply with HIPAA rules and state law governing those lines of business, include instructions for individuals to indicate they do not wish to receive such information, and ensure that the organization’s Medicare products are clearly and understandably distinct from the other products.	Organizations offering both MMPs and Medicare Advantage plans in a service area may only market MMP offerings in MMP materials. Illinois and New York specify that MMPs may not send marketing materials to current enrollees about other Medicare products offered by the same parent organization unless enrollees proactively request it.

Topic	Medicare Marketing Guidelines (MMG) ²⁵	Differences in State Medicare-Medicaid Plan (MMP) Guidance ²⁶
Marketing material disclaimers (MMG: Sections 50.1-50.14)	Plans must include several disclaimers on marketing materials related to federal/state contracting, benefits and premiums, availability of non-English translators, SNP materials, online enrollment requests, third party materials, and Star Ratings. Disclaimers must be prominently displayed on the materials and must be of similar font size and style.	All states revised requirements related to disclaimers on materials. Certain disclaimers have been replaced with new disclaimers relevant to MMPs and federal-state contracting. Other disclaimers have been determined to be inapplicable to MMPs, and some disclaimer language has been added.
Required documents (MMG: Sections 60.1, 2, 4, 5, 7)	Plans must produce marketing materials that adhere to specific Medicare templates, including: <ul style="list-style-type: none"> • A Medicare identification card; • Member handbook; • Summary of Medicare benefits; • Formulary including all Part D drugs; • Medicare provider and pharmacy directories; and • Annual notice of change (ANOC) to current enrollees. 	CMS designed templates for a set of integrated marketing materials for Medicare-Medicaid enrollees based on existing MA materials. States may use these templates as a foundation and then tailor to the state’s Medicare-Medicaid enrollee population. Examples of these integrated material templates are: <ul style="list-style-type: none"> • Single identification card for both programs; • Member handbook; • Summary of benefits that describes all Medicare and Medicaid services; • Comprehensive formulary including all Part D and Medicaid-covered drugs; • Combined provider and pharmacy directories for all Medicare and Medicaid providers; and • ANOC to current enrollees.
Promotional activities (MMG: Section 70.1)	Plans may conduct promotional activities that have nominal value, are offered to all individuals, and are not a health benefit nor tied to the provision of any covered item or service.	States may have more restrictive requirements related to promotional activities and nominal gifts than Medicare allows. For example, MMPs in Massachusetts may not offer nominal gifts or financial incentives. In Illinois and New York, MMPs may not offer financial or other incentives or nominal gifts to potential enrollees, although they can offer promotional items to current enrollees that are consistent with the MMG.
Customer service call center requirements and use of alternative technology on weekends and holidays (MMG: Section 80.1)	Plans must operate customer service call centers that meet specific standards, such as operating 7 days a week, at least from 8:00 am to 8:00 pm. Plans may use alternative technologies on weekends and federal holidays, February 15 through September 30 only.	MMPs may use alternative technologies, such as an interactive voice response system, on Saturdays, Sundays, and federal holidays in lieu of live customer service representatives.
Oversight and use of independent brokers (MMG: Section 120)	Plans that that use independent or plan-employed brokers or agents must comply with state licensure and appointment laws, meet federal training and testing standards and report when any agents are terminated.	No states included in this analysis permit the use of independent or plan-employed brokers to promote enrollment. MMG provisions related to independent agents/brokers do not apply to MMPs. Enrollment transactions must be processed by the state enrollment broker, a vendor that contracts with the state to enroll eligible individuals and provide objective information about enrollment options.

Program of All-Inclusive Care for the Elderly (PACE).²⁸ PACE is a managed, provider-based program in 29 states that serves more than 20,000 frail, elderly Medicare-Medicaid enrollees. Often considered the first truly integrated program for Medicare-Medicaid enrollees, PACE blends separate capitation payments from and provides full benefits for Medicare and Medicaid.²⁹ A Program Agreement signed by CMS, the state, and the PACE organization authorizes marketing and enrollment activities. In a format similar to the Medicare Marketing Guidelines,³⁰ CMS established marketing guidelines for PACE providers. PACE providers must also comply with state marketing requirements, such as the following:

- **Federal-State Collaboration.** The CMS Regional Office (RO) Account Manager and the State Administering Agency (SAA) collaborate to review and approve PACE marketing materials and to answer the PACE provider's questions.
- **Marketing and Enrollment Materials Distinction.** Providers use marketing materials to educate the public and prospective enrollees about their programs. Materials for current enrollees are not considered marketing materials.
- **Accessibility for a Vulnerable Population.** Marketing information must be available in alternative formats (e.g., materials in Braille). Providers must make reasonable accommodations to communicate marketing information in accordance with the Americans with Disabilities Act (ADA) and the Rehabilitation Act. All providers should make available interpreter services and printed copies of all marketing materials to prospective and current beneficiaries in English and any other languages as determined by the state.
- **No Unsolicited Contact.** Providers may not engage in direct, unsolicited contact with non-referred potential enrollees, including outbound calls.

IV. Conclusion

Both CMS and states are committed to ensuring that Medicare-Medicaid enrollees receive information about health care options that is accessible, understandable, and accurate. To minimize the differences between Medicare and Medicaid marketing requirements and mitigate the challenges associated with those differences, state and federal partners are working together to implement creative solutions for aligning marketing requirements. New marketing practices for MMPs maintain consistency with the MMG, while allowing states to preserve certain requirements related to content and literacy/translation standards, allowable marketing techniques, and approval processes, among others.

Efforts to align Medicare and Medicaid marketing requirements through the Financial Alignment Initiative can impact other programs and entities. Demonstration activities can provide examples of potential contract language for states that contract with D-SNPs to encourage Medicare-Medicaid administrative alignment. Improved alignment across state and federal programs may alleviate administrative burdens for health plans that must comply with two programs' requirements. The approaches discussed in this brief afford both CMS and states additional flexibility and support mutual interests in ensuring beneficiaries have appropriate information to choose coverage that best meets their needs.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees and other high-need, high-cost Medicaid beneficiaries. The state technical assistance activities provided within the **Integrated Care Resource Center** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

Endnotes

- ¹ J. Verdier, M. Au and J. Gillooly. Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans. Mathematica Policy Research, prepared for the Medicare Payment Advisory Commission. October 2010. Available at: http://www.medpac.gov/documents/Jun11_ManagingDualEligibles_CONTRACTOR.pdf.
- ² Final Contract Year (CY) 2014. Medicare Marketing Guidelines. Available at: <http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>.
- ³ A Medicare Advantage (MA) plan is a Medicare managed care plan offered by a private company that contracts with Medicare to provide all Medicare Part A and Part B benefits. MA plans may offer Medicare Part D benefits as well.
- ⁴ Dual Eligible Special Needs Plans (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid). D-SNPs may combine benefits available through Medicare and Medicaid.
- ⁵ Prescription drug plans (PDPs) are operated by private companies and offer Medicare Part D drug benefits but not Part A and Part B benefits. Medicare Advantage Regulations, 42 C.F.R. Part 422 and Voluntary Medicare Prescription Drug Benefit, 42 C.F.R. Part 423.
- ⁶ MMG—Section 10 and Appendix 1; 42 CFR §417.428, §422.2260, and §423.2260.
- ⁷ Medicaid Managed Care Regulations, Marketing Activities, 42 CFR §438.104.
- ⁸ 42 CFR §438.104, Marketing Activities.
- ⁹ 42 CFR §438.10, Information Requirements.
- ¹⁰ For Medicare Advantage, “when specified by CMS, organizations must use standardized formats and language in model materials.” (42 CFR 422.2262(c), 423.2262(c)). MMG – Section 40.2: Font Size Rule.
- ¹¹ MMG—Section 50: Marketing Material Types and Applicable Disclaimers, and Section 60: Required Documents.
- ¹² MMG – Section 100: Plan/Part D Sponsor Websites and Social/Electronic Media.
- ¹³ MMG - Section 80: Telephonic Activities and Scripts.
- ¹⁴ MMG – Section 60.5.5: Provision of Notice to Beneficiaries Regarding Formulary Changes, 42 CFR 423.120(b)(5); Medicaid: 42 CFR 438.10 (f)(4). Regarding notifications about Primary Care Provider termination: Medicare: MMG 60.4: Directories; Medicaid: 42 CFR 438.10 (f)(5).
- ¹⁵ State of California, Health and Human Services Agency, Department of Health Care Services. Medi-Cal Managed Care Division (MMCD) All Plan Letter 02003. June 17, 2002. Available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2002/MMCDAPL02003.pdf>.
- ¹⁶ G. Burke and K. Prindiville. Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles. National Senior Citizens Law Center. August 2011. Available at: <http://www.nslc.org/wp-content/uploads/2011/08/Duals-Alignment-Issue-Brief.pdf>.
- ¹⁷ United States Government Accountability Office. Report to the Congressional Requesters. Consumer Protection Requirements Affecting Dual-Eligible Beneficiaries Vary across Programs, Payment Systems, and States. December 2012, GAO-13-100. Available at: <http://www.gao.gov/assets/660/650558.pdf>.
- ¹⁸ Texas Health and Human Services. Uniform Managed Care Manual, Chapter 4.3, Prohibited Marketing Practices, Policy MP-02.00. Available at: <http://www.hhsc.state.tx.us/medicaid/UMCM/Chp4/4.3.pdf>.
- ¹⁹ Ohio Administrative Code 5101:3-26-08 Managed health care programs: marketing. Available at: <http://codes.ohio.gov/oac/5101:3-26-08>.
- ²⁰ When a state meets the standards and conditions for the Financial Alignment Initiative, CMS and a state develop and sign an MOU to establish the parameters of the demonstration in that state.
- ²¹ For 2014 contract year MMP marketing guidance documents see: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html>.
- ²² The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (as amended by the Affordable Care Act) requires D-SNPs to obtain contracts with State Medicaid Agencies to help improve the integration of Medicare and Medicaid benefits for dually eligible beneficiaries.
- ²³ Dual Eligible Special Needs Plan Contract Between State of New Jersey Department of Health and Human Services, Division of Medical Assistance and Health Services and D-SNP Contractors: http://nj.gov/humanservices/dmahs/info/d-snp_contract.pdf.
- ²⁴ TENNCARE contractor risk agreement between the SMA and D-SNP effective January 1, 2014.
- ²⁵ Final Contract Year (CY) 2014. Medicare Marketing Guidelines.
- ²⁶ Final CY 2014 Marketing Guidance for Massachusetts Medicare-Medicaid Plans; Released: July 16, 2013. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination->

Office/Downloads/FinalCY2014MarketingGuidanceMA.pdf; Final CY 2014 Marketing Guidance for California Medicare-Medicaid Plans; Released: July 10, 2013. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FinalCY2014MarketingGuidanceCA.pdf>; Final CY 2014 Marketing Guidance for Illinois Medicare-Medicaid Plans; Released: September 13, 2013; Revised November 21, 2013. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014MarketingGuidanceIL.pdf>; Final CY 2014 Marketing Guidance for New York Medicare-Medicaid Plans; Released: May 2, 2014. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014MarketingGuidanceNYFIDA.pdf>; Final CY 2014 Marketing Guidance for Virginia Medicare-Medicaid Plans; Released: October 30, 2013. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014MarketingGuidanceVA.pdf>; Final CY 2014 Marketing Guidance for Ohio Medicare-Medicaid Plans; Released: November 20, 2013. Available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014MarketingGuidanceOH.pdf>.

²⁷ The timeline in Ohio is slightly different. New enrollees who are passively enrolled must receive a welcome letter, integrated formulary information, pharmacy/provider directory (or information about how to receive the directory) and a summary of benefits the 15th of the month prior to the effective date of enrollment. They must receive an ID card and member handbook before enrollment begins and the ID card may not be received early than 15 calendar days prior to the effective date.

²⁸ Authorized under sections 1894, 1905(a), and 1934 of the Social Security Act and 42 CFR, Part 460.

²⁹ Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. Chapter 3. June 2012. Available at: http://www.medpac.gov/document_TOC.cfm?id=672.

³⁰ Program of All-Inclusive Care for the Elderly (PACE) Chapter 3 - Marketing Guidelines. Center for Medicare and Medicaid Services. Revised May 28, 2012. Available at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Downloads/PACE-Marketing-Guidelines.pdf>.