

70.12 - Marketing Guidance for the Provider Setting

(Rev. 96, Issued: - 5-17-11, Effective: 5-17-11, Implementation: 5-17-11)

42 CFR 422.2268(j) and (k), 423.2268 (j) and (k)

As used in specific guidance about provider activities, the term “provider” refers to all providers contracted with the plan and its sub-contractors, including but not limited to, pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

These Medicare Marketing Guidelines are designed to guide plan sponsors and providers in assisting beneficiaries with plan selection, while at the same time striking a balance to ensure that provider assistance results in plan selection that is always in the best interest of the beneficiary. Providers that have entered into co-branding relationships with plan sponsors must also follow these guidelines.

70.12.1 - Plan Activities and Materials in the Health Care Setting

(Rev. 96, Issued: - 5-17-11, Effective: 5-17-11, Implementation: 5-17-11)

42 CFR 422.2268(k), 423.2268 (k)

Plan sponsors may not conduct sales activities in healthcare settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Plan sponsors are prohibited from conducting sales presentations, distributing and accepting enrollment applications, and soliciting Medicare beneficiaries in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

Only upon request by the beneficiary are plan sponsors permitted to schedule appointments with beneficiaries residing in long-term care facilities (including nursing homes, assisted living facilities, board and care homes, etc.).

Providers are permitted to make available and/or distribute plan marketing materials as long as the provider and/or the facilities distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and /or distribute plan marketing materials they should do so knowing they must accept future requests from other plan sponsors with which they participate.

Providers are also permitted to display posters or other materials in common areas within the long-term care facility and in admission packets announcing all plan contractual relationships.

Long term care facility staff are permitted to provide residents that meet the I-SNP criteria an explanatory brochure for each I-SNP with which the facility contracts. The brochure can explain about the qualification criteria and the benefits of being enrolled in an I-SNP. The brochure may have a reply card or telephone number for the resident or responsible party to call to agree to a meeting or request additional information.

70.12.2 - Provider-Based Activities

(Rev. 96, Issued: - 5-17-11, Effective: 5-17-11, Implementation: 5-17-11)

42 CFR 422.2268(j), 423.2268(j)

CMS holds plan sponsors responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. The plan sponsor must ensure that any providers contracted (and its subcontractors, including downstream providers or agents) with the plan sponsor comply with the requirements outlined in this chapter.

The plan sponsor must ensure that any providers contracted (including subcontractors or agents) with the plan sponsor to perform functions on their behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agree to the same restrictions and conditions that apply to the plan sponsor through its contract. In addition, the plan sponsor (and subcontractors, including providers or agents) are prohibited from steering, or attempting to steer an undecided potential enrollee toward a particular provider, or limited number of providers, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents). While conducting a health screening providers may not distribute plan information to patient.

CMS is concerned with provider activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan versus acting as the beneficiary's provider.

Providers may face conflicting incentives when acting as a plan sponsor representative. For example, some providers may gain financially from a beneficiary's selection of one plan over another plan. Additionally, providers generally know their patients' health status. The potential for financial gain by the provider influencing a beneficiary's selection of a plan could result in recommendations that do not address all of the concerns or needs of a potential plan enrollee. Beneficiaries often look to health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, and eligibility requirements for SNPs). To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan sponsor options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options.

All payments that plans make to providers for services must be fair market value, consistent for necessary services, and otherwise comply with all relevant laws and regulations, including the Federal and any State anti-kickback statute.

For enrollment and disenrollment guidance related to beneficiaries residing in long-term care facilities (e.g., enrollment period for beneficiaries residing in long-term care facilities and use of personal representatives in completing an enrollment application), please refer to Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual.

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their health care options. Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms.
- Accepting enrollment applications for MA/MA-PD plans or PDPs.
- Making phone calls or directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider.
- Mailing marketing materials on behalf of plan sponsors.
- Offering anything of value to induce plan enrollees to select them as their provider.
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health screening is a prohibited marketing activity.
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities.
- Distribute materials/applications within an exam room setting.

Providers contracted with plan sponsors (and their contractors) are permitted to do the following:

- Provide the names of plan sponsors with which they contract and/or participate (See § 70.12.3) for additional information on affiliation.)
- Provide information and assistance in applying for the LIS.
- Make available and/or distribute plan marketing materials including provider affiliation materials for a subset of contracted plans only as long as providers offer the option of

making available and/or distributing marketing materials from all plans with which they participate.

CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates. To that end, providers are permitted to:

- Provide objective information on plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs.
- Provide objective information regarding plan sponsors' plans, including information such as covered benefits, cost sharing, and utilization management tools.
- Make available and/or distribute PDP enrollment applications, but not MA or MA-PD enrollment applications, for all plans with which the provider participates.
- Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at <http://www.medicare.gov>/or 1-800-MEDICARE.
- Print out and share information with patients from CMS' website.

The "Medicare and You" Handbook or "Medicare Options Compare" (from <http://www.medicare.gov>), may be distributed by providers without additional approvals.

There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plan sponsors should advise contracted providers of the provisions of these rules.

70.12.3 - Provider Affiliation Information

(Rev. 96, Issued: - 5-17-11, Effective: 5-17-11, Implementation: 5-17-11)

42 CFR 422.2268, 423.2268

Providers may announce new affiliations and repeat affiliation announcements for specific plan sponsors through general advertising (e.g. radio, television). New affiliation announcements are those providers that have entered into a new contractual relationship with the plan sponsor. Providers may make new affiliation announcements within the first 30 days of the new contract agreement. An announcement to patients of a new affiliation which names only one plan sponsor may occur only once when such announcement is conveyed through direct mail, e-mail, or phone. Additional direct mail and/or e-mail communications from providers to their patients regarding affiliations must include all plans with which the provider contracts.

Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Multiple plan sponsors can either have one plan sponsor submit the material on behalf of all the other plan sponsors, or have the piece submitted and approved by CMS for each plan sponsor mentioned prior to use. Materials that indicate the provider has an affiliation with certain plan sponsors and that only list plan names and/or contact information does not require CMS approval.

70.12.4 - SNP Provider Affiliation Information

(Rev. 96, Issued: - 5-17-11, Effective: 5-17-11, Implementation: 5-17-11)

42 CFR 422.2268, 423.2268

Providers may feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider's affiliation or arrangement by placing the SNP affiliations at the beginning of the announcement and may include specific information about the SNP. This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated.

70.12.5 - Comparative and Descriptive Plan Information

(Rev. 96, Issued: - 5-17-11, Effective: 5-17-11, Implementation: 5-17-11)

42 CFR 422.2268, 423.2268

Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of all of the different plans with which they contract. Materials may not "rank order" or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plan sponsors involved in the comparison and must be approved by CMS prior to distribution (e.g., these items are not be subject to File & Use). The plan sponsor must determine a lead plan to coordinate submission of these materials (refer to § 90.2 for more information on submission of marketing materials).

70.12.6 - Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service Providing Third-Party

(Rev. 96, Issued: - 5-17-11, Effective: 5-17-11, Implementation: 5-17-11)

42 CFR 422.2268, 423.2268

Providers may distribute printed information comparing the benefits of different plan sponsors (all or a subset) in a service area when the comparison is done by an objective third party (e.g. SHIPs, State agency or independent research organizations that conduct studies). For more information on non-benefit/service providing third party providers, refer to § 40.14.6.

70.12.7 - Providers/Provider Group Websites

(Rev. 96, Issued: - 5-17-11, Effective: 5-17-11, Implementation: 5-17-11)

42 CFR 422.2268, 423.2268

Provider websites may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plan sponsors with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.

NOTE: The preceding requirement is not applicable to certain plan types such as section 1876 cost plans, Medicare MSAs, 800-series employer group waiver plans, and Religious Fraternal Benefit plans. SNPs may use the links, and the SNP should notify the provider that they may use the OEC link if they choose to but that it is not required.