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MEDICARE+CHOICE

New Standards Could Improve Accuracy and Usefulness of Plan Literature

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The Honorable Charles E. Grassley
Chairman
The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Jack Reed
United States Senate

Today, almost 7 million Medicare beneficiaries are enrolled in health plans offered by managed care organizations (MCO) that participate in the Medicare+Choice program, Medicare's alternative to its fee-for-service program.[1] Although Medicare managed care enrollment has nearly doubled in the last 3 years, approximately 32 million beneficiaries (83 percent) remain covered under fee-for-service. Many health care analysts believe that competition among MCOs can lead to enhanced benefit packages and lower out-of-pocket fees for Medicare beneficiaries. Analysts further believe that increased managed care enrollment may yield savings for the Medicare program. The potential of Medicare+Choice cannot be realized, however, unless beneficiaries are well-informed about their enrollment options.

Recently, the Health Care Financing Administration (HCFA), the agency responsible for administering the Medicare program, took steps to increase beneficiaries' awareness of their health care options. Beneficiaries can now obtain names of available plans and a summary of their benefit packages by calling a toll-free telephone number or logging onto HCFA's Internet Web site. The agency intends to include some of this information in the Medicare handbooks it will mail to all beneficiaries in October 1999. In spite of these new resources, however, MCOs' sales agents and member literature will remain beneficiaries' only source of detailed information about plans' benefits and out-of-pocket fees.[2] HCFA, therefore, continues to review and approve all member literature and other

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[1]A plan is a package of specific health benefits, out-of-pocket costs, and terms of coverage. An MCO is an entity that offers one or more plans. The Medicare+Choice program also allows non-MCO plans, such as private fee-for-service plans and medical savings account plans, to participate. However, as of Mar. 1999, no non-MCO plans had joined the program.

[2]"Member literature" includes benefit summary brochures, policy booklets, member handbooks, and plan letters regarding benefit changes.

marketing materials distributed by MCOs to help ensure that beneficiaries receive accurate information about their available health plan options.[3]

Because correct and useful information is vital to the success of the Medicare+Choice program, you asked us to assess (1) the extent to which MCOs' member literature provides beneficiaries with accurate and useful plan information and (2) whether HCFA's review process ensures that beneficiaries can rely on MCOs' member literature to make informed enrollment decisions. To address these issues, we assessed the accuracy, timeliness, completeness, and comparability of the member literature of 16 MCOs and studied HCFA's requirements and practices for reviewing and approving these materials. Our analysis focused on three benefits that vary in complexity: annual screening mammography, outpatient prescription drugs, and ambulance transportation. Our work was performed from August 1998 to April 1999 in accordance with generally accepted government auditing standards. Appendix I contains details on our methodology.

Results in Brief

Although HCFA had reviewed and approved the materials we examined, all 16 MCOs in our sample from four HCFA regions had distributed materials containing inaccurate or incomplete benefit information. Almost half of the organizations distributed materials that incorrectly described benefit coverage and the need for provider referrals. For example, materials from five MCOs stated that beneficiaries needed a physician's referral to obtain an annual screening mammogram. In fact, Medicare policy explicitly prohibits MCOs from requiring a referral for this service. In addition, one MCO marketed (and provided) a prescription drug benefit that was substantially less generous than the plan had agreed to provide in its Medicare contract. Moreover, some MCOs did not furnish complete information on plan benefits and restrictions until after a beneficiary had enrolled. Other MCOs never provided full descriptions of plan benefits and restrictions. Although not fully disclosing benefit coverage may hamper beneficiaries' decision-making, neither practice violates HCFA policy. Finally, as we have reported previously,[4] it was difficult to compare available options using member literature because each MCO independently chose the format and terms it used to describe its plan's benefit package. In contrast, the Federal Employees Health Benefits Program's (FEHBP)

[3]"Marketing materials" include any material managed care plans distribute to Medicare beneficiaries. In addition to member literature, these materials include radio, newspaper, and television advertisements.

[4]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

plans are required to provide prospective enrollees with a single comprehensive and comparable brochure to facilitate informed enrollment choices.

The errors we identified in MCOs' member literature went uncorrected because of weaknesses in three major elements of HCFA's review process. Limitations in the benefit information form (BIF), the contract form that HCFA reviewers use to determine whether plan materials are accurate, led some reviewers to rely on the MCOs themselves to help verify the accuracy of plan materials. Additionally, HCFA's lack of required format, terminology, and content standards for member literature created opportunities for inconsistent review practices. According to some regional office staff, the lack of standards also increased the amount of time needed to review materials, which contributed to the likelihood that errors could slip through undetected. Finally, the agency's failure to ensure that MCOs corrected errors identified during the review process caused some beneficiaries to receive inaccurate information. HCFA is working to revise the BIF and develop a standard summary of benefits for plans to use—steps that will likely improve the agency's ability to review member literature and other marketing materials—but other steps could be taken to improve the usefulness and accuracy of plan information.

Background

Medicare is the national health insurance program for those aged 65 and older and certain disabled individuals. In 1998, Medicare insured approximately 39 million people. All beneficiaries can receive health care through Medicare's traditional fee-for-service arrangement, and many beneficiaries live in areas where they also have the option of receiving their health care through a managed care plan. Of the almost 7 million Medicare beneficiaries enrolled in managed care as of March 1999, nearly all were enrolled in plans whose MCOs receive a fixed monthly fee from Medicare for each beneficiary they serve. Total Medicare spending is expected to reach about $216 billion in fiscal year 1999, with managed care's portion reaching approximately $37 billion.

Balanced Budget Act Required Major Program Changes

The Balanced Budget Act of 1997[5] (BBA) established the Medicare+Choice program as a replacement for Medicare's previous managed care program. Medicare+Choice was intended to expand beneficiaries' health plan options by permitting new types of plans, such as preferred provider organizations and provider-sponsored organizations, to participate in

[5]P.L. 105-33.

Medicare. BBA also established an annual, coordinated enrollment period to begin in 1999 during which beneficiaries may enroll or change enrollment in a Medicare+Choice plan.[6] Previously, MCOs were required to have at least one 30-day period each year when they accepted new members, but most MCOs accepted new members throughout the entire year. Also, before BBA, Medicare beneficiaries could join or leave a plan on a monthly basis. Beginning in January 2002, Medicare beneficiaries will no longer be able to enroll and disenroll on a monthly basis. If they experience problems with a plan, identify a better enrollment option, or simply have second thoughts, beneficiaries will have a limited time each year to change the election they made during the coordinated enrollment period.[7] Afterwards, they will be "locked into" their health plan decision for the remainder of the year.

Contracting Process Establishes Plan Benefit Packages

Each plan's benefit package is defined through a contracting process that establishes the minimum benefits a plan must offer and the maximum fees it may charge during a calendar year.[8] After a benefit package is approved by HCFA, a plan may not reduce benefits or increase fees until the next contract cycle. A BIF, which is included in an MCO's contract as an exhibit, describes in detail the services, copayments, and monthly premiums associated with each plan.

HCFA Reviews All Marketing Materials

HCFA's central and regional offices are involved in reviewing plans' marketing materials, which include member literature. The central office negotiates contracts and establishes national policy regarding marketing material review. HCFA's regional offices review marketing materials when submitted throughout the year and require MCOs to change the materials when they omit required information or are inaccurate, misleading, or unclear. While some regional offices may review materials that certain organizations distribute nationwide, generally each regional office is responsible for reviewing the materials to be distributed within its

[6]Individuals may enroll in a Medicare+Choice plan when they first become eligible for Medicare regardless of the time of year.

[7]Beneficiaries will have 6 months in 2002 and 3 months thereafter to change their enrollment choices. Exceptions to these limitations will be made if an organization materially misrepresents the plan or substantially violates a material provision of its contract.

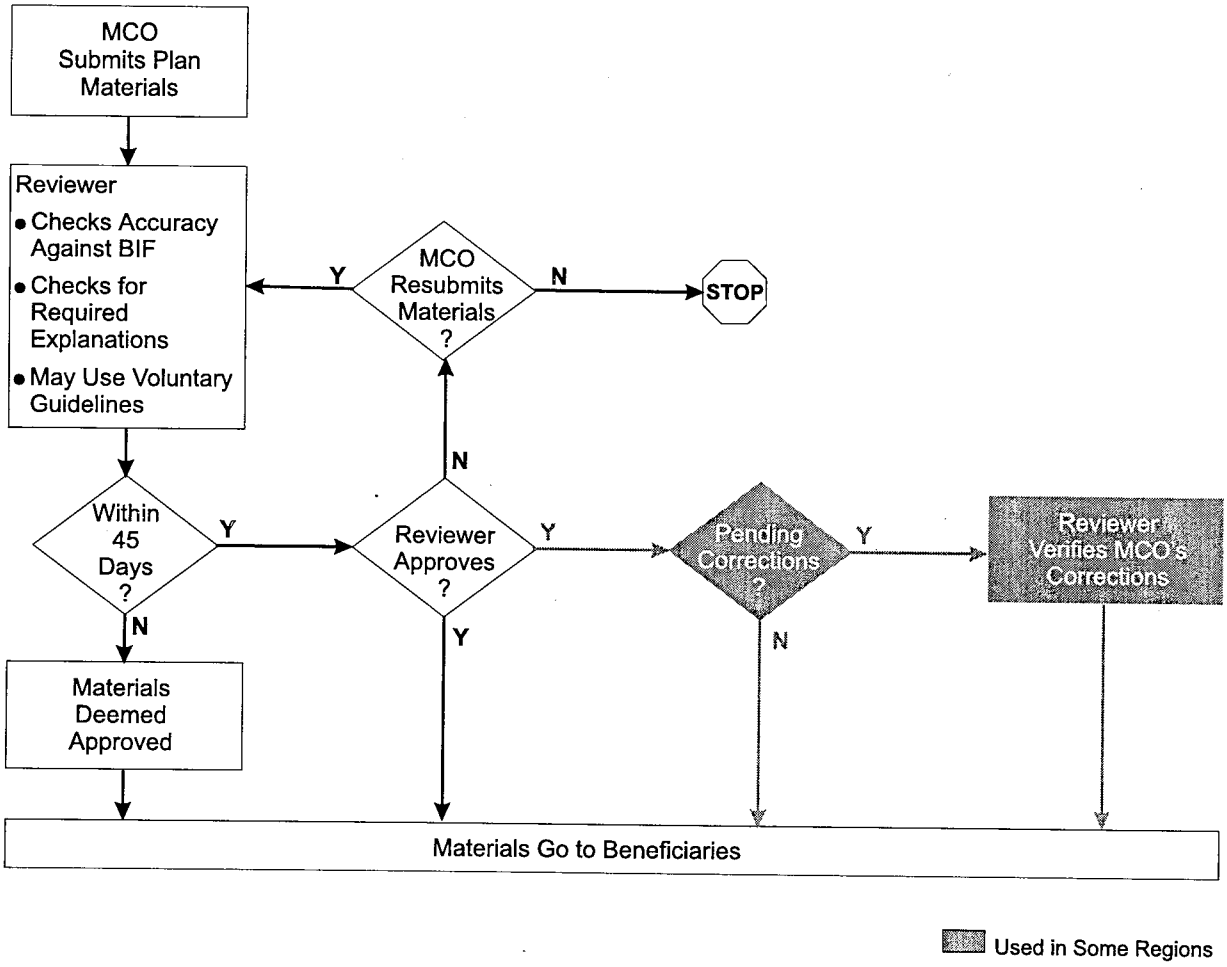
[8]HCFA approves plan benefit packages through a process formally known as the adjusted community rate proposal process, which is intended to ensure that Medicare does not pay MCOs more than a commercial purchaser would pay for the same benefits, after adjusting for differences in Medicare beneficiaries' health status and use of services. If Medicare's payment is higher, the MCO typically adds benefits to offset the difference. MCOs cannot charge fees—in the form of monthly premiums, copayments, or other cost-sharing—that are higher than what a beneficiary would likely pay under traditional Medicare.

geographic jurisdiction. To verify the accuracy of benefit information, regional staff are instructed to check plan materials against the BIF. HCFA staff also verify that MCOs have included certain information in their materials, such as explanations of provider restrictions and beneficiary appeal rights. HCFA provides guidance for both developing and reviewing marketing materials through its contract manual, marketing guidelines, and operational policy letters. Despite HCFA's authority to do so, the agency does not require MCOs to use standard formats or terminology in their marketing materials.

According to HCFA regulations, if HCFA staff do not disapprove submitted materials within 45 days, the materials are deemed approved, and MCOs may distribute the materials to beneficiaries.[9] Review procedures established by several regional offices allow "contingent approval"; that is, the materials are approved on the condition that the MCOs make specific corrections. When contingent approval is given, procedures in three regions call for HCFA staff to verify that the MCOs have made the required corrections before the materials are published and distributed to beneficiaries. (See fig. 1.)

[9]42 CFR, part 422.80.

Figure 1: HCFA's Process for Reviewing and Approving Marketing Materials



Source: GAO analysis of HCFA's review policies and practices.

Plan Information Is Necessary for Informed Choice

Historically, HCFA has done little to address beneficiaries' need for comparable and unbiased information about Medicare managed care plans. In 1996, we reported that beneficiaries received little or no comparable information on Medicare health maintenance organizations and that the lack of information standards made it difficult for beneficiaries to compare plans' member literature.[10] At that time, we

[10]GAO/HEHS-97-23, Oct. 22, 1996.

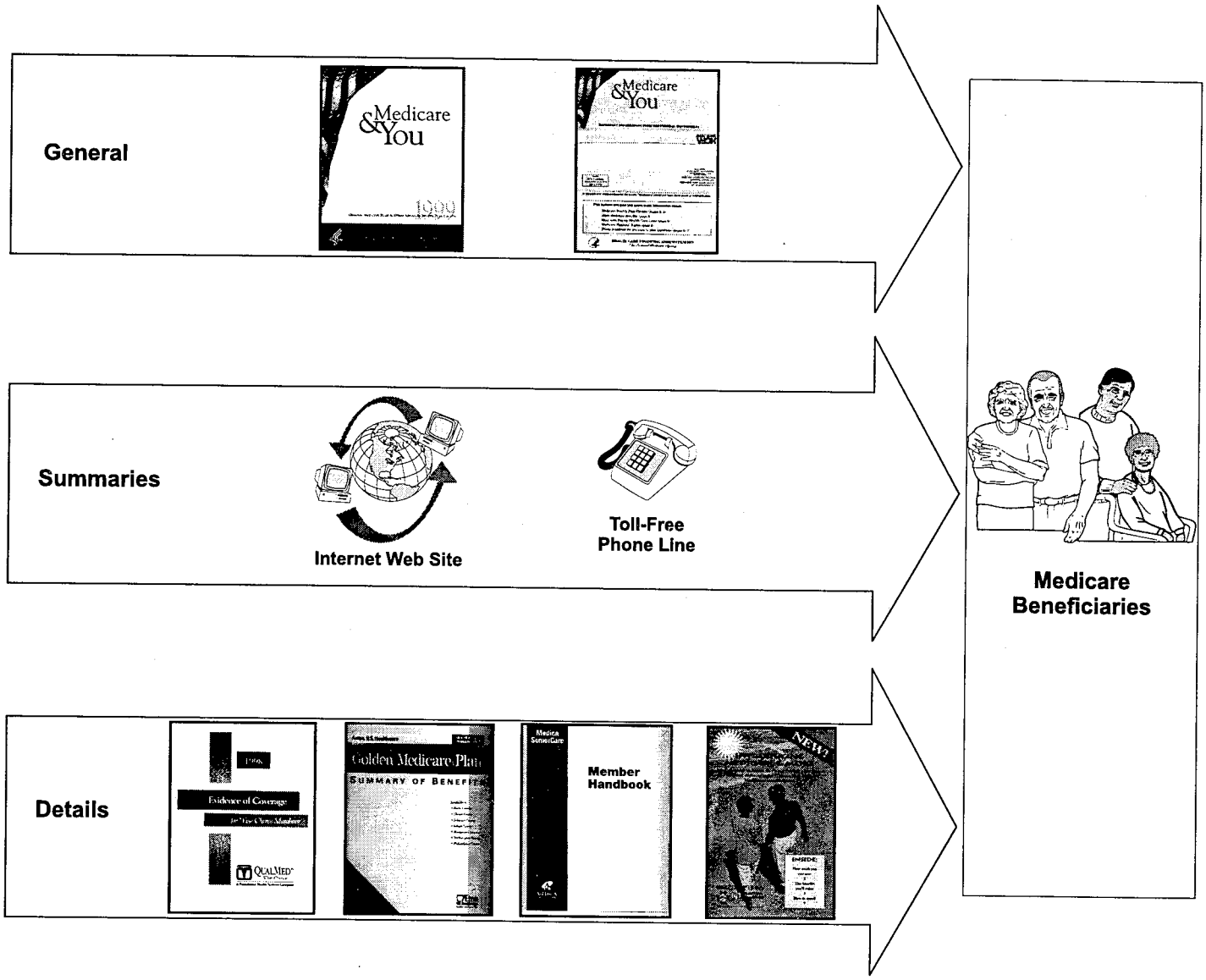
recommended that HCFA produce plan comparison charts and require plans to use standard formats and terminology in key aspects of their marketing materials.

BBA mandated that HCFA undertake a number of activities to provide Medicare beneficiaries with information about their health plan options. Beginning in November 1998, HCFA was required to provide an annual national educational and publicity campaign to inform beneficiaries about the availability of Medicare+Choice plans and the enrollment process. Also, each fall starting in 1999, HCFA must distribute to beneficiaries an array of general information about the traditional Medicare program, supplemental insurance, appeal and other rights, the process for enrolling in a Medicare+Choice plan, and the potential for Medicare+Choice contract termination. At the same time, HCFA must provide each Medicare beneficiary with a list of available Medicare+Choice plans and a comparison of plan options. All of these activities are designed to coincide with and support the coordinated open enrollment period slated to occur each November starting in 1999.

HCFA's goal is to make beneficiaries aware of their health plan options and to provide some summary information to help beneficiaries compare those options. According to HCFA officials, in 1999 each beneficiary will receive a Medicare handbook that contains some comparable information about available health plans.[11] Beneficiaries who want more information may call HCFA's toll-free telephone number (1-800-MEDICAR) or log onto the Internet Web site (www.medicare.gov). All of these resources—the Medicare handbook, toll-free telephone number, and Web site—are designed to help beneficiaries identify enrollment options and compare selected aspects of benefits. To obtain detailed information about specific plans, however, beneficiaries must continue to rely on MCOs' sales agents and member materials. (See fig. 2.)

[11]During the fall of 1998, HCFA included this information in the Medicare handbook distributed to beneficiaries in five states.

Figure 2: Plan Information Available to Medicare Beneficiaries



Sources: For general information, HCFA; for summary information, HCFA and MCOs; for detailed information, various MCOs' marketing materials.

Member Literature Frequently Was Not Accurate, Timely, Complete, or Comparable

Our investigation of 16 MCOs uncovered flaws in their plans' member literature, beneficiaries' only source of detailed benefit information. Much of the MCOs' plan literature contained errors or omissions about mammography and prescription drug benefits, ranging from minor oversights to major discrepancies. While we found no errors about ambulance services, some MCOs' member literature omitted information about the benefit. Moreover, beneficiaries frequently did not receive important information until after enrollment. Even then, beneficiaries in some plans received member literature that was incomplete and did not fully disclose plan benefits, exclusions, and fees. The lack of full disclosure in member literature leaves the beneficiary vulnerable to unexpected service denials and additional out-of-pocket fees. Making comparisons among health plans' benefits remains challenging because of the use of nonstandard formats and terminology. In contrast, FEHBP participants received plan brochures that contained relatively complete benefit descriptions presented in a standard format.

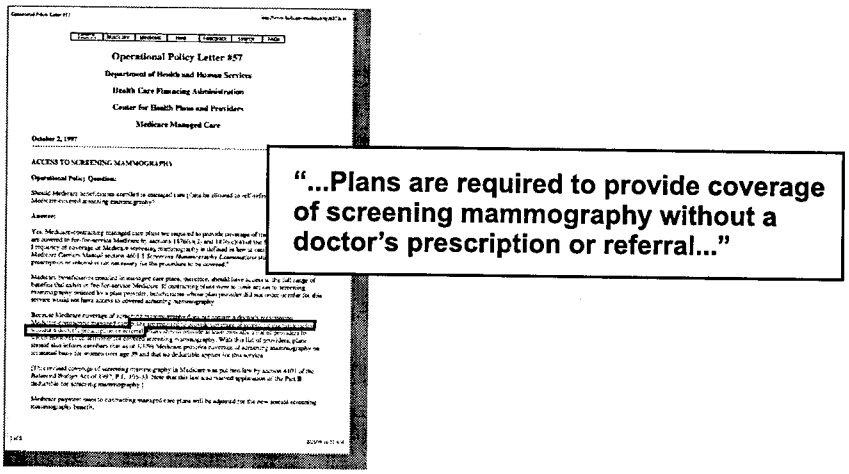
Beneficiaries Were Not Assured Accurate Plan Materials

We found significant errors and omissions in the plans' member literature that MCOs distributed to beneficiaries. For example, effective January 1998, HCFA required organizations to cover annual screening mammograms and to permit beneficiaries to obtain this service without a physician's referral. Also, MCOs were required to notify beneficiaries of this new Medicare benefit.[12] Materials from five MCOs, however, explicitly stated that beneficiaries must obtain physician referrals to obtain screening mammograms. (See fig. 3 for three examples.) Member literature from five other organizations failed to inform beneficiaries of their right to self-refer for this service.

[12]BBA revised Medicare coverage for annual screening mammography, ensuring that beneficiaries enrolled in managed care plans have access to the same benefit available in Medicare fee-for-service. HCFA Operational Policy Letter #57 implemented 42 CFR section 422.100 (h)(1).

Figure 3: Plan Referral Requirements for Screening Mammography Contradict Medicare Coverage

HCFA Operational Policy Letter #57



Excerpts From Medicare 1998 Plan Materials

- **MAMMOGRAMS.** One (1) baseline mammographic examination for women between the ages of 35 and 39. One (1) mammographic examination per calendar year for women age forty (40) or over. The Member must obtain a Referral from her Primary Care Physician before receiving this service. Other mammographic examinations will be covered only when recommended by the Primary Care Physician or a Referred Specialist.

	osteoporosis.	monthly/$3600 annual limit.
Mammograms	X-ray screening to detect breast cancer. One provided per year for women age 35 and older.	Must be ordered by your HEALTHCARE physician.

prior to surgery • Chemotherapy • Diagnostic tests • Medical supplies and equipment • X-rays • Mammograms • Laboratory services • Pap Smear screening	No charge. Services must be authorized by your Primary Care Physician.

(Figure notes on next page)

Note: Emphasis added.

Sources: For requirements, HCFA Operational Policy Letter #57; for examples, various MCOs' member literature.

Much of the MCOs' member literature provided incorrect or inconsistent information about prescription drug coverage. For example, the member literature for a large, experienced Medicare MCO specified an annual dollar limit for prescription drugs that was lower than the amount required by the organization's Medicare contract. The contract required the provision of unlimited generic drugs and coverage of at least $1,200 for brand-name drugs. This MCO's materials, which varied by county, understated the brand-name drug coverage, listing annual dollar limits as low as $600. When we contacted the MCO officials, they confirmed that they were providing the lower benefit coverage. On the basis of the MCO's enrollment for 1998, we estimated that about 130,000 members could have been denied part of the benefit that Medicare paid for and to which they were entitled under the MCO's contract. Another MCO provided conflicting information about its prescription drug benefit. In one document, the MCO alternately described its prescription drug benefit as having a $200 monthly limit and a $300 monthly limit. (The correct limit was $300.) In another case, an MCO used the same member literature for four separate plans, emphasizing that all members were entitled to prescription drug benefits. Actually, however, only two of the four plans offered a prescription drug benefit.

The member literature we reviewed did not contain errors regarding ambulance services, but the documents often omitted important information about the benefit. One MCO did not include any reference to the benefit in its preenrollment member literature. Three other MCOs stated that ambulance services were covered "per Medicare regulations" but did not define Medicare's coverage. Most of the remaining MCOs provided general descriptions of their ambulance coverage but did not give details of the extent of the coverage, such as whether the MCOs would pay for out-of-area ambulance service in an emergency.

Up-to-Date Plan Information Was Not Always Available When Beneficiaries Made Enrollment Decisions

Officials from several MCOs told us that their organizations typically issue a member policy booklet—a document that discloses the details of a plan's benefit coverage, benefit restrictions, and beneficiary rights—after a beneficiary enrolls. Moreover, MCOs often provided enrollees with outdated member policy documents. For example, one MCO failed to provide enrollees with a current member policy document until August 1998—8 months after the start of the new benefits year.

Distributing outdated information can be misleading. HCFA allows MCOs to use outdated plan member materials as long as the organizations attach an addendum indicating any changes to the benefit package. HCFA officials believe that this policy is reasonable because beneficiaries can determine a plan's coverage by comparing the changes cited in the addendum with the prior year's literature. However, some MCOs distributed outdated literature without the required addendum. When MCOs did include the addendum, the document did not always clearly indicate that its information superseded the information contained in other documents. In addition, some MCOs did not provide dates on their literature, which obscured the fact that the literature was outdated.

Adequate preenrollment benefit information will become even more crucial in 2001, as BBA's annual enrollment provisions begin to take effect in 2002 and Medicare beneficiaries are no longer able to disenroll on a monthly basis. To help beneficiaries make informed choices, BBA requires HCFA to provide beneficiaries with summary plan information before the annual November enrollment period. Furthermore, new regulations now require MCOs to issue letters by mid-October each year describing benefit changes that will be effective January 1 of the following year. MCOs must send these annual notification letters to all enrollees, and to any prospective enrollees upon request. However, HCFA has not required MCOs to provide more complete member literature prior to enrollment. As a result, beneficiaries still might not have the information they need to make sound enrollment choices.

Additionally, beneficiaries enrolling in plans before 2002 may be unaware that their plans may be terminating services shortly after the beneficiaries have enrolled. A plan must notify its members at least 60 to 90 days before it ends services.[13] However, there is no requirement that a terminating plan stop advertising and enrolling new members, with the result that in 1998, some beneficiaries unknowingly joined plans that soon exited the

[13]An MCO may terminate plan services through a modification, termination, or nonrenewal of its contract with HCFA.

Medicare program. For example, one MCO notified its members in May 1998 of its intent to end services in several Ohio counties. The MCO continued to advertise and enroll new beneficiaries without informing them that plan services would end on December 31, 1998. After inquiries from beneficiaries, the MCO ceased marketing activities in July. Although these marketing activities angered many beneficiaries, the MCO was operating within HCFA's notification requirements.[14]

Member Literature May Not Fully Describe Plan Benefits

Some beneficiaries do not receive important information about plan benefits and restrictions even after they have enrolled in a plan. Because HCFA's instructions regarding benefit disclosure are vague, MCOs vary in the amount of information they provide to beneficiaries.[15] Some organizations we reviewed provided relatively complete descriptions of plan coverage in a member policy booklet or similar document. However, other MCOs did not disclose important restrictions in any member literature.

In fact, MCOs that adopt HCFA's suggested disclosure language will send beneficiaries to an information dead end. In the guidelines it provides to MCOs, HCFA suggests that a plan's "evidence of coverage," a document frequently referred to as a member policy booklet, direct beneficiaries to the MCO's Medicare contract to obtain full details on the benefit package. According to HCFA, a member policy booklet should state that "[it] constitutes only a summary of the [plan] . . . . The contract between HCFA and the [MCO] must be consulted to determine the exact terms and conditions of coverage." HCFA officials responsible for Medicare contracts, however, said that if a beneficiary requested a contract, the agency would not provide it because of the proprietary information included in an MCO's adjusted community rate proposal. Furthermore, an MCO is not required, according to HCFA officials, to provide beneficiaries with copies of its Medicare contract. MCO officials we spoke with differed on whether their organization would distribute copies of its contract to beneficiaries. By establishing an MCO's Medicare contract—a document that is not usually available to beneficiaries—as the only document required to fully explain the plan's benefit coverage, HCFA cannot ensure that beneficiaries are aware of the benefits to which they are entitled.

[14]Until Jan. 2002, MCOs may market to and enroll beneficiaries throughout the year. Beginning in Nov. 2001, however, beneficiaries will have to select a plan during the open enrollment season. Consequently, primarily those individuals who become eligible on or after Jan. 1, 2002, may be affected by mid-year marketing.

[15]HCFA advises MCOs to provide information sufficient for beneficiaries to make informed enrollment choices.

Vague or incomplete benefit descriptions leave beneficiaries vulnerable to unexpected service denials. For example, disputes sometimes arise when beneficiaries are told they do not have the coverage they believed they would have when they enrolled. An official from the Center for Health Dispute Resolution (CHDR), HCFA's contractor that adjudicates managed care appeal cases, told us that CHDR uses the information in MCOs' member literature to determine whether plan members are entitled to specific benefits that are not covered by Medicare fee-for-service. When an MCO's literature is vague, CHDR allows the MCO to submit internal plan memorandums that clarify its benefit coverage. But beneficiaries generally do not receive these internal memorandums. Consequently, beneficiaries who must rely on incomplete member literature and sales agents' verbal interpretations of this literature are likely to be unaware of important benefit limitations or restrictions.

Meaningful Plan Comparisons Were Difficult to Achieve

Inconsistent formats and terminology made comparisons among plans' benefit packages difficult. We generally had to read multiple documents to determine each plan's benefit coverage for mammography, prescription drugs, and ambulance services. Answering a set of basic questions about three plans' prescription drug benefits, for example, required a detailed review of twelve documents: two from plan A, five from plan B, and five from plan C (see fig. 4). It was not easy to know where to look for the information. For example, we found the answer to the question of whether a plan used a formulary in plan A's summary of benefits, plan B's Medicare prescription drug rider, and plan C's contract amendment.[16] Plan C's materials required more careful review to answer the question because the membership contract indicated the plan did not provide drug coverage. However, an amendment—included in the member contract as a loose insert—indicated coverage for prescription drugs and the use of a formulary.

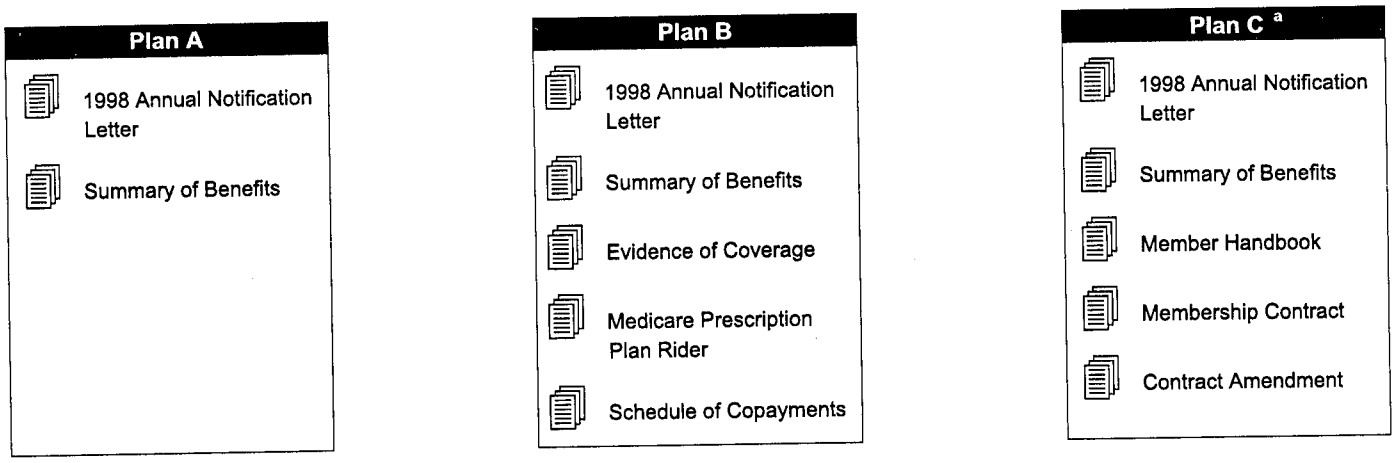
[16]In general, a formulary is a list of drugs that MCOs prefer their physicians to use in prescribing drugs for enrollees. The formulary includes drugs that MCOs have determined to be effective and that suppliers may have favorably priced for the MCO. Any drug not included on a formulary is considered a nonformulary drug, which may cost the beneficiary more or may not be covered at all.

Figure 4: Multiple Plan Documents Needed to Answer Basic Drug Benefit Questions

Basic Questions We Asked About Prescription Drug Benefits

1. Does this plan have an annual maximum benefit limit?
2. Are the copayments for generic and brand drugs different?
3. Is it less expensive to get prescriptions through a mail-order option?
4. Does this plan use a formulary?

Multiple Plan Documents Needed to Answer These Questions



[a]Plan documents contradict each other regarding covering nonformulary drugs.

Source: GAO analysis of MCO member literature.

As in previous studies, we found plans' materials did not use comparable terms or formats.[17] For example, it was difficult to determine whether the three plans offered by one MCO covered nonemergency ambulance transportation, because each plan's materials used different terms to describe the benefit. The lack of clear and uniform benefit information almost certainly impedes informed decision-making. HCFA officials in almost every region noted that a standard format for key member literature, along with clear and standard terminology, would help beneficiaries compare their health plan options.

[17]GAO/HEHS-97-23, Oct. 22, 1996, and Medicare Managed Care: Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices (GAO/T-HEHS-98-162, May 6, 1998).

Each FEHBP Plan Distributes a Single, Complete Member Policy Brochure

FEHBP, administered by the Office of Personnel Management (OPM), is similar to the new Medicare+Choice program in that it serves a large and diverse population, allows participation of different types of health care organizations, and allows plans' benefit packages to vary. Unlike HCFA, however, OPM requires FEHBP plan materials to follow standard formats and terms. OPM officials believe this requirement helps FEHBP members make informed decisions. FEHBP health care organizations produce a single, standard brochure for each plan that is the "contractual document" between the member and the organization. This brochure is a complete description of the plan's benefits, limitations, and exclusions. The 1999 FEHBP brochure explicitly states the following objective: "This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure."

OPM officials said that the brochures must describe what each plan's coverage includes, as well as what it excludes, so that there is less chance for misunderstanding. The benefit information must be listed in a prescribed format and language to facilitate members' comparisons among plan options, but OPM's standards allow variation in some language to accommodate differences in plans' benefits and procedures. Each plan's brochure must include a benefit summary presented in OPM's prescribed format. OPM officials update the mandatory brochure language every year to reflect changes in the FEHBP's requirements and organizations' requests for improvements to the language. Finally, OPM requires organizations to distribute plan brochures prior to the FEHBP annual open enrollment period so that prospective enrollees have complete information on which to base their decisions. OPM officials told us that all participating organizations publish brochures that adhere to OPM's standards.

Although OPM's process for reviewing and approving member literature is generally similar to HCFA's, it differs in important ways. The process begins when FEHBP organizations submit benefit coverage information to OPM in standard brochure format. OPM contract specialists then review the brochures to verify compliance with mandatory terminology and format requirements and to ensure that nonstandard information is presented appropriately, given the plans' benefit packages and organizational structures. For example, organizations offering fee-for-service (indemnity) plans would use different language in describing plan procedures and restrictions than MCOs would. Organizations are then responsible for printing and distributing the brochures. To verify the accuracy of the final documents, OPM obtains 20 brochures from each plan's first print run.[18]

[18]We did not review OPM's processes or validate the accuracy of plan brochures.

According to an OPM official, if OPM contract reviewers identify errors, they can require organizations to attach an addendum, reprint the brochures, or pay a fine. The official said that any errors identified are generally minor and are corrected through an addendum attached to the brochures.

Weaknesses in HCFA's Review Process Allowed Problems in Plan Materials to Go Uncorrected

Although HCFA approved all the member literature we reviewed, weaknesses in three critical elements of the agency's review process allowed errors to go uncorrected and important information to be omitted. Our review showed that the structure of HCFA's contracting documents has created problems in determining the accuracy of plan materials and has resulted in the omission of important benefit details by several organizations. Additionally, HCFA's lack of consistent standards has contributed to inconsistent reviews and extra work and may have increased the chance of errors slipping through the review process undetected. Moreover, MCOs have failed to correct plan materials as required by HCFA staff. HCFA has begun to address some, but not all, of the issues we have identified.

HCFA's Standard for Gauging Accuracy in Plan Materials Is Faulty

MCOs' Medicare contracts, which include the BIF, establish the foundation for HCFA's review of marketing materials. HCFA reviewers are instructed to use the BIF to check that plan member literature accurately reflects the contracted benefits and member fees. Reviewers told us, however, that the BIFs often do not provide the required detail, and our work revealed that the BIFs did not provide consistent or complete benefit descriptions. For instance, the BIFs did not always specify whether a plan's prescription drug benefit covered only specific drugs. Restricting coverage to a list of specific drugs, or a formulary, is a common element of plans' benefit packages. Yet of our sample of 16 MCOs, 14 used formularies in one or more of the plans they offered, but only 8 disclosed this restriction in their BIFs.

Because BIFs are often incomplete, reviewers sometimes rely on benefit summary sheets provided by MCOs to verify the accuracy of plan materials. This practice is contrary to HCFA policy, which requires an independent review of the MCOs' plan literature. The reviewers who approved the erroneous materials cited earlier explained that some of the errors might have occurred because the MCOs' summary sheets incorrectly described plans' benefits. This was the explanation given by the reviewer who approved the plan member literature advertising a $600 annual benefit

limit for brand-name prescription drugs instead of the contracted $1,200 annual limit.

Lack of Standards Hampers Review of Important Member Literature

The lack of detailed standards for plans' member literature can result in misleading comparisons and put some MCOs at a competitive disadvantage. Without detailed standards, HCFA reviewers have wide discretion in approving or rejecting plan materials. The MCO representatives and HCFA officials we spoke with said that this latitude leads to inconsistent HCFA decisions. An MCO official told us that, while several plans in a market area required a copayment for ambulance services if a beneficiary was not admitted to a hospital, not all plans were required to disclose that fact. The HCFA reviewer responsible for one plan's materials required the plan to disclose the fee, yet different HCFA staff in the same regional office who reviewed other plans' materials did not require similar disclosure. These inconsistent review practices caused one plan's benefits to appear less generous, even though several other plans had similar benefit restrictions.

The lack of mandatory format and terminology standards for key member literature, such as benefit summary brochures and member policy booklets, increases the amount of time and effort needed to review and approve plans' member literature. Moreover, unlike many government programs, Medicare does not require MCOs to use standard forms for such typical administrative functions as enrollment, disenrollment, and appeals. Instead, each organization creates its own forms. Consequently, HCFA staff spend a great deal of time reviewing disparate documents that could be routine forms. Several reviewers commented that the volume and complexity of MCOs' member literature contributed to the likelihood that errors would pass through the review process undetected. Agency staff said that they could spend more time reviewing important member documents, such as member policy booklets, if HCFA required the use of standard forms for administrative functions.

HCFA officials recognize that standardizing key documents and terms would facilitate their review of plans' marketing materials and reduce the administrative burden on both HCFA and MCOs. Some agency officials expressed concern, however, that MCOs might resist efforts to standardize the way information is presented. In fact, many of the MCO officials we spoke with said they would welcome some standardization because it could save them time and money. One MCO official commented that MCOs may not be using HCFA's current guidelines and suggested standards because they are voluntary and use language that is legalistic and

confusing to beneficiaries. Several MCO officials stressed that any mandatory standards should be developed with industry input and with the advice of professional marketing specialists.

Reviewers Did Not Ensure That Final Materials Incorporated Required Corrections

MCOs are responsible for correcting errors in their marketing materials and distributing accurate information. Some HCFA reviewers told us that they do not approve marketing materials until the MCO has corrected all identified errors. Other HCFA reviewers told us that they give contingent approval—that is, they approve the material if the MCO agrees to make specific corrections. The MCO is required to send a copy of the print-ready document to HCFA so the reviewer can verify that the corrections were made. Reviewers often did not have copies of the print-ready or final documents in their files, however. Several reviewers admitted that it was difficult to get the final documents from MCOs and that they generally trust the organizations to publish materials as approved or to make the corrections outlined in approval letters. Moreover, reviewers noted that the contingent approval practice was adopted to expedite reviews when materials required only minor corrections.

However, MCOs did not always correct the errors HCFA identified during the review process. We reviewed one plan's summary of benefits that incorrectly commingled 1997 and 1998 benefit information. The document we received from the MCO official contained several handwritten notations correcting inaccurate benefit information. For example, the copayment for prescription drugs was listed as $5, but a handwritten note indicated that there was no copayment for generic drugs. The HCFA staff member responsible for approving the material showed us a working copy of the document on which she had indicated the need for numerous changes. The published document we observed, however, did not incorporate many of these corrections. The reviewer had been unaware that the published document contained errors because she had never received a print-ready copy from the MCO.

New HCFA Efforts Hold Promise and Challenge

HCFA has undertaken several efforts to address some of the problems we identified during our review. The agency is developing a new plan benefit package (PBP) that it hopes will replace the BIF. The PBP's new format improves upon the BIF by standardizing the information collected from each plan. The PBP includes detailed checklists that make it easier to obtain consistent benefit information from plans. However, the PBP is flexible enough to capture benefit features that do not fit neatly into a

predetermined checklist. Using the PBP should also facilitate efforts to standardize member literature. HCFA intends to pilot test the PBP with a few MCOs this year for contract submissions effective in 2000. HCFA officials estimate that the PBP proposal will need to begin the Office of Management and Budget's clearance process no later than August 1999 to achieve full implementation by 2000. Otherwise, full implementation could be delayed.

Agency officials also recognize the importance of more uniform member literature and have articulated their intent to standardize key documents in future years. As a first step, HCFA established a work group to develop a standard format and common language for all plans' benefit summaries. HCFA hopes to establish the benefit summary by May and plans to use it in the fall 1999 benefit summary brochures. Achieving this goal will require HCFA's work group to reach consensus on standards for clear and accurate information and to avoid imposing burdensome requirements on MCOs. HCFA's long-term goals include establishing standards for other key documents, but the agency has not yet developed a coordinated strategy for its long-term efforts or decided whether such standards will be voluntary or mandatory.

Conclusions

Beneficiaries who enrolled or considered enrolling in the plans we reviewed were not well-served by plans' efforts to produce member materials or HCFA's review of them. The information that plans distributed was often confusing and hard to compare. Some plans distributed inaccurate or incomplete information or provided the information after beneficiaries had made their enrollment decisions, when it was less useful. These problems significantly limited beneficiaries' ability to make informed decisions about their health plan options. Moreover, some beneficiaries may have been denied health care coverage to which they were entitled or required to pay unexpected out-of-pocket fees. In contrast, each FEHBP plan must provide prospective enrollees with a single, comprehensive brochure to facilitate comparisons and informed enrollment choices.

Revisions to HCFA's current review process and procedures could greatly improve the quality of plans' member literature. For example, full implementation of HCFA's new contract form for describing plans' benefit coverage, the PBP, could help ensure that approved member literature is accurate and fully discloses important plan information. Similarly, standard terminology and formats for key member literature would facilitate full disclosure and provide beneficiaries with comparable plan

information. Moreover, new standards for the distribution of key member literature would enable beneficiaries to have the information they need when they need it. The required use of standard forms for routine administrative functions, such as member enrollment, could reduce HCFA's workload and allow staff to spend more time reviewing important member literature. Finally, efforts to standardize review procedures would help ensure consistent application of the agency's marketing material review policy.

Recommendations to the Administrator of the Health Care Financing Administration

In October 1996, we recommended that the Secretary of Health and Human Services direct the HCFA Administrator to (1) require standard formats and terminology for important aspects of MCOs' marketing materials, including benefits descriptions, and (2) require that all literature distributed by organizations follow these standards. Although HCFA has taken initial steps toward this end, significant work remains. Therefore, we are both renewing our previous recommendations and recommending that the HCFA Administrator take the following additional actions to help Medicare beneficiaries make informed health care decisions and reduce the administrative burden on agency staff and MCOs.

- Require MCOs to produce one standard, FEHBP-like document for each plan that completely describes plan benefit coverage and limitations, and require MCOs to distribute this document during sales presentations and upon request.
- Fully implement HCFA's new contract form for describing plans' benefit coverage, the PBP, for the 2001 contract submissions to facilitate the collection of comparable benefit information and help ensure full disclosure of plans' benefits.
- Develop standard forms for appeals and enrollment.
- Take steps to ensure consistent application of the agency's marketing material review policy.

Agency Comments

HCFA agreed with our findings that the agency's review process and procedures need to be strengthened in order to ensure that beneficiaries receive accurate and useful information. The agency also concurred with our recommendations to improve the oversight of Medicare+Choice organizations' marketing materials and to require the use of standardized formats and language in plans' member materials. HCFA has steps under way that may help correct some of the problems we found. For example, the agency is developing a standardized summary of benefits document

and intends to require Medicare+Choice organizations to use the document beginning in November 1999.

While HCFA's efforts may standardize important aspects of plans' materials, such as information about appeal rights, these efforts stop short of requiring Medicare+Choice organizations to provide a single standard and comprehensive document that describes plan benefits and beneficiaries' rights and responsibilities as plan members. HCFA believes that Medicare+Choice organizations should retain the flexibility to develop materials that differentiate their services from those provided by other Medicare+Choice organizations. We agree that MCOs should be able to differentiate their plans. However, requiring MCOs to provide an FEHBP-like brochure, in addition to other plan materials, would preserve the MCOs' flexibility and provide Medicare beneficiaries with more complete and comparable information than they may currently receive. In fact, these standard brochures may encourage plans to compete on real differences in plan features. The full text of HCFA's comments appears in appendix II.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 1 day after the date of this letter. At that time, we will send copies of this report to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Jacob Lew, Director, Office of Management and Budget; the Honorable Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration; and other interested parties. We will also make copies available to others upon request.

This report was prepared under the direction of James Cosgrove, Assistant Director, by Marie James, Keith Steck, and George Duncan. If you or your staff have any questions about this report, please contact Mr. Cosgrove at (202) 512-7029 or me at (202) 512-7114.

William J. Scanlon
Director, Health Financing
and Public Health Issues

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Abbreviations

BBA	Balanced Budget Act of 1997
BIF	benefit information form
CHDR	Center for Health Dispute Resolution
FEHBP	Federal Employees Health Benefits Program
HCFA	Health Care Financing Administration
MCO	managed care organization
OPM	Office of Personnel Management
PBP	plan benefit package

Scope and Methodology

To do this work, we reviewed relevant policies and procedures at Health Care Financing Administration (HCFA) headquarters and regional offices. We also interviewed HCFA officials at headquarters and at all regional offices and spoke with representatives of industry and beneficiary groups. We visited four regional offices (Atlanta, Chicago, Philadelphia, and San Francisco) that cover high managed care penetration areas. In addition, we analyzed 1998 member literature and Medicare contracts for 16 of the 346 MCO contracts effective in 1998 (4 from each region we visited). Our sample included MCOs that varied in enrollment levels, structure, location, and years of Medicare experience. Because each MCO can offer more than one plan—for example, a standard option and a high option—we reviewed key materials for a total of 26 plans. We considered key member literature to include benefit summary brochures, member policy booklets,[19] member handbooks, and plan letters related to benefit changes. The plans we reviewed used various combinations of these key documents to disclose the details of their benefit packages, including benefit restrictions and members' rights. Finally, we compared the Federal Employees Health Benefits Program and Medicare's standards for plans' member literature.

Our analysis focused on three benefits that vary in complexity: ambulance transportation, annual screening mammography, and outpatient prescription drugs. We selected ambulance transportation and screening mammography because these benefits must be provided by all Medicare plans and are relatively simple to describe and understand. We selected the outpatient prescription drug benefit because it is complex, not covered by traditional Medicare, and an important consideration in many beneficiaries' enrollment decisions.

[19]MCOs typically use a member policy booklet as the agreement between the plan and the beneficiary. This document may also be referred to as a member contract, evidence of coverage, or subscriber agreement.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

APR 6 1999

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare+Choice: Revised Standards and Procedures Could Improve Accuracy and Usefulness of Plan Information"

TO: William J. Scanlon, Director
Health Financing and Systems Issues, GAO

We appreciate the opportunity to review your draft report to Congress concerning Medicare+Choice plan marketing materials. We agree that HCFA should continue efforts to ensure that beneficiaries receive useful information from managed care organizations, and to improve the effectiveness and efficiency of the Medicare+Choice program.

We are enclosing our comments to the specific recommendations. We look forward to working with GAO and the Congress as we further our commitment to provide beneficiaries with the information they need in order to make informed health care decisions.

Enclosure

Comments of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report: "Medicare+Choice: Revised Standards and Procedures Could Improve Accuracy and Usefulness of Plan Information"

Overview

In order for beneficiaries to make the choice that is right for them with regard to their options for receiving their Medicare benefits, they need credible and unbiased information. With the Balanced Budget Act of 1997 (BBA), the Congress for the first time provided a stable funding source for a national information campaign that we have referred to as the National Medicare Education Program (NMEP). This effort includes the *Medicare & You* handbook, 1-800-MEDICARE, and a new beneficiary web site. While we hope that the NMEP will serve as a major source of accurate and unbiased information, we agree with the GAO that Medicare beneficiaries will continue to rely on information provided by Medicare+Choice (M+C) organizations.

We concur with the GAO's recommendations and agree that improved oversight of M+C organizations' marketing materials, as well as the use of standardized formats and language, will benefit the program. These changes are needed to help ensure that beneficiaries receive accurate and useful information. In fact, HCFA had previously identified many of these same issues and has already begun working to correct these problems and improve program oversight. For example, HCFA is already beginning efforts to require the use of standardized benefit information and to increase the consistency of marketing review for contract year 2000. We also have steps underway to assure the implementation of a more detailed and standardized reporting of benefit information -- the plan benefit package (PBP) by contract year 2001.

We were disturbed by the GAO's findings that all of the M+C organizations sampled in the report had distributed inaccurate or misleading information. This has occurred in part because not all final marketing material is reviewed by HCFA before use by M+C organizations. We will immediately implement the necessary policies to ensure that M+C organizations make required changes in marketing materials before they are used. Furthermore, HCFA will formally request that the GAO provide the names of the plans that are cited in the report as having violated HCFA policies. We will investigate and take appropriate action.

HCFA will continue to work closely with the Congress, GAO, beneficiary groups and other interested parties to assure that beneficiaries have complete, accurate and understandable information both to understand and compare their health plan options. We will continue to examine instances where current marketing policies could be better

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implemented and areas where policies should be clarified or expanded.

GAO Recommendation

In October 1996, we recommended that the Secretary of HHS direct the HCFA Administrator to:

-- Require standard formats and terminology for important aspects of MCO's marketing materials, including benefit descriptions.

-- Direct the HCFA Administrator to require that all literature distributed by organizations follow these standards.

We recommend that the Administrator of HCFA:

-- Require each plan to produce one standard, FEHBP-like document that completely describes its benefit coverage and limitations and require organizations to distribute this document during sales presentations and upon request.

HCFA Comment

In principle, we concur with the GAO recommendations. HCFA has a two-phase standardization effort underway with the following goals and time lines.

Phase I: Standardize the Summary of Benefits document in time for use in the Fall 1999 HCFA beneficiary education campaign

Based on concerns raised at the Senate Aging Committee's hearing in May 1998, we have begun work to standardize the Summary of Benefits. This document is the key document used by health plans to inform potential members of a plan's benefit package. Similarly, Medicare beneficiaries have indicated the Summary of Benefits is the most important document provided by the M+C organization that they use in selecting a health plan.

The type of documents M+C organizations have used to describe their benefits varies widely. M+C organizations have used their own structure, format, and language in providing benefit information. But this flexibility has made it difficult for beneficiaries to make comparisons when choosing among Medicare+Choice organizations. Thus, beginning in contract year 2000, HCFA will require M+C organizations to use a standardized Summary of Benefits and provide them to all prospective and current members, beginning with the November 1999 open enrollment period.

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HCFA is currently producing the model template guide and instructions for the standardized Summary of Benefits. After consultation with beneficiary groups and plan representatives, the document will be distributed to M+C organizations by the end of May 1999. We anticipate a HCFA training session for all interested parties after the document is released.

Phase II: Standardize Remaining Documents

Again, after appropriate consultation with beneficiary groups and plan representatives, HCFA will require that remaining beneficiary notification (as opposed to advertising) materials (e.g., the Evidence of Coverage, enrollment application forms, appeals-related materials) be standardized. These materials will be in place for use in the Fall of 2000 HCFA beneficiary education campaign. It is critical to note that our standardization efforts will focus on the above materials and the important aspects of the marketing materials, such as benefits and appeal rights. 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. These advertising materials, however, should always accurately reflect the benefits offered, and HCFA will be diligent in its efforts to assure that advertising materials are not misleading.

GAO Recommendation

-- Fully implement the agency's new contract form for describing plan benefit coverage, the PBP, for the 2001 contract submissions to facilitate the collection of comparable benefit information and help ensure full disclosure of plan benefits.

HCFA Comment

We concur with GAO. In fact, about 16 months ago, HCFA began revising the Benefit Information Form (the 1998 BIF) by developing the Plan Benefit Package (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

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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.

Now on p. 9.

- **Screening Mammography**. GAO found that selected 1998 M+C organization marketing material on Medicare's screening mammography benefit was inconsistent with Agency stated policy (Page 8). 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.

Now on p. 11.

- **Prescription Drug Benefit**. The GAO report identified inconsistent M+C organization information about prescription drug coverage from one marketing document to another. The report goes on to find instances of incorrect information on this benefit in marketing material (Page 9). 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, preferred brand, 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 to our reliance on the PBP, HCFA will continue to improve staff training and marketing review efforts at the Regional level. As described in the last section of our response, HCFA will refer the mammography and drug benefit issues to our Marketing Product Consistency Team for further review and analysis.

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Now on p. 14.

The PBP will not only improve the HCFA review process and assist beneficiaries, but it will benefit the Center for Health Dispute Resolution (CHDR) as well. As mentioned in the GAO report, CHDR should have access to standardized benefit information as part of its adjudication of beneficiary appeal cases (Page 12). Implementation of the PBP will support the full disclosure of plan benefits, scope, exclusions, and fees thus expediting the adjudication of beneficiary appeals by CHDR.

GAO Recommendation

-- Develop standard forms for appeals and enrollment.

HCFA Comment

We concur with the GAO recommendation. HCFA recognizes the importance of establishing standard formats and common language for beneficiary appeal notices. We have undertaken several efforts to address some of these concerns. First,we recently issued an Operational Policy Letter (OPL) to M+C organizations transmitting model language for a Notice of Discharge and Appeal Rights. This notice advises Medicare beneficiaries in inpatient hospital settings of their appeal rights at the time of discharge. In addition, we are developing another OPL to transmit model denial notice language for service and payment denials for managed care enrollees. Both of these notices are scheduled to be consumer tested. Our goal is to require mandatory use of the final, standardized appeal notices by M+C organizations in 2000.

Second, we have developed model language for letters and forms that all M+C organizations could use for enrollment notification. In the near future, after consultation with outside groups, we intend to mandate the use of the enrollment notification language. Finally, HCFA is currently piloting a disenrollment process with 1-800-MEDICARE. The purpose of this pilot is to (1) establish an alternative neutral mechanism other than the Social Security Administration in which a beneficiary can disenroll from the M+C plan to original Medicare; and (2) develop a standard tool in which useful disenrollment reason information can be collected from beneficiaries.

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GAO Recommendations

-- Take steps to ensure consistent application of the agency's marketing review policy.

HCFA Comment

We concur with the GAO recommendation. HCFA is aware of the issues regarding uniform application of marketing review regulations and guidelines across the 10 HCFA Regional Offices. HCFA will continue and expand its existing effort to address the complex issue of uniformity of review. This effort includes the following activities:

(a) Final Verification of all Marketing Materials. HCFA central office will issue a directive that all final marketing documents must be reviewed before they are used to ensure that HCFA's required changes are incorporated.

(b) HCFA is pursuing options regarding the feasibility of centralized marketing review. We will initiate a nationally representative, 6-month pilot study on the efficacy of a private sector contractor performing the review of marketing materials. We will compare the effectiveness of a centralized review system with the current system.

(c) The "Medicare Managed Care Marketing Product Consistency Team (PCT)." This group is comprised of representatives from all 10 HCFA Regional Offices and HCFA Central Office policy and operational staff. The group meets monthly to update the National Marketing Guide and to address any marketing issues that have arisen regarding operational or policy interpretations. The PCT will further review the GAO's findings and determine additional changes that need to be made to our marketing review practices and training of HCFA staff.

(d) Development of a single source of information on marketing. HCFA is currently working on issuance of the M+C Manual as the definitive operational document for participation in the Medicare managed care program. Chapter 5 of this manual will incorporate the National Marketing Guide and all marketing related Operational Policy Letters. It is an effort to bring into a single source document all available operational information related to participation in marketing activities in the Medicare managed care program.

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