United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

October 20, 2009

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Dear Secretary Sebelius:

As a senior member of the United States Senate and Ranking Member of the United States Committee on Finance (Committee), it is my duty to conduct oversight into the actions of the executive branch, including the activities of the Department of Health and Human Services (HHS). This duty includes monitoring HHS activities and conducting programmatic oversight to ensure that taxpayer dollars are used in accordance with applicable law.

I am writing regarding the "State Your Support" initiative for which there is a link on the homepage of the HHS.GOV website. On the homepage, visible to anyone who seeks access to official HHS services and information, there is a link labeled "State Your Support for health care reform *this year*." (Emphasis in original) Upon selecting this link, visitors are taken to the HEALTHREFORM.GOV website, which indicates that it is "an official U.S. government web site managed by the U.S. Department of Health and Human Services." Upon following the "State Your Support" link, rather than being provided a blank space for visitors to compose their own comments about health reform, visitors are instead presented with a pre-written letter to sign to the President in support of enactment of reform this year. By signing the statement, visitors affirm their commitment to work with the President and their Congressional leaders "**to enact legislation this year which provides affordable, high quality coverage for all Americans.**" (Emphasis added) Also, in order to "show their support," visitors are required to submit their names, zip codes and email addresses.

Any possible misuse of appropriated funds by the executive branch to engage in publicity or propaganda in support of an Administration priority is a matter that must be investigated and taken seriously. In 2005, Speaker Pelosi said the use of official funds for similar activities were "underhanded tactics" and that these tactics "are not worthy of our great democracy." Speaker Pelosi went on to say that, "[t]he President's commitment to freedom around the world should extend to the freedom of the American people to live without their tax dollars being used to run a government propaganda machine." Although Speaker Pelosi and I do not agree on many things, I do agree with her view that taxpayer money should not be used to run a "government propaganda machine."

The use of the official HHS.GOV website for activities that seem to be nothing more than government propaganda raises many serious questions. This is particularly true in light of memoranda issued by the Centers for Medicare & Medicaid Services last Friday, October 16 to Medicare Advantage Organizations, Part D Sponsors and others (sponsors). In one of the memoranda, sponsors were advised that before a plan provides any non-plan information to beneficiaries, including information concerning support for or opposition to legislation pending before Congress (memoranda enclosed), they must obtain prior authorization from the beneficiaries before providing any such information and that such prior authorization request to beneficiaries cannot also include any other non-plan related content.

In order to better understand the "State Your Support" initiative, I request written responses to the following questions and document requests by no later than Friday, October 30, 2009. When preparing responses, please restate the question and provide the responsive information.

1. Please detail the reason or purpose for the "State Your Support" initiative and identify when it was initiated and who initiated it.

2. Please provide all communications relating either directly or indirectly to the creation, implementation, execution and/or maintenance of the "State Your Support" initiative, including any with White House officials.

3. Please identify the name of each full-time or part-time employee of HHS or the White House involved directly or indirectly in the creation of the "State Your Support" initiative on the HEALTHREFORM.GOV website.

4. Anyone who clicks on the "State Your Support" button on HHS.gov is presented with a pre-written form letter. Furthermore, there is no function or opportunity whatsoever on this page to edit the pre-written letter. Among other things, the pre-written letter states, "we will support your budget" for health reform and "each of us must be willing to contribute to achieving this fundamental goal." Please respond to the following:

    a. Provide the names of each individual, including any White House officials, who were involved in the drafting of the pre-written letter.

    b. Provide a copy of each draft version of the letter from the first draft through the final version.

    c. Provide the names of each individual who reviewed drafts and indicate which individuals, including White House officials, approved edits to the letter and the final draft itself.

5. Please identify if any third party(ies) and/or grantee(s)/contractor(s) was involved directly or indirectly in the creation, implementation, execution, and/or maintenance of the "State Your Support" initiative. For each such third party, grantee or contractor identified, please provide the following:

    a. A copy of the grant or contract and any modifications; and

    b. Any and all documents, including emails, concerning the formation, execution and administration of the grant or contract, related directly and indirectly to the creation of the "State Your Support" initiative on the HEALTHREFORM.GOV website.

6. Regarding "State Your Support" letters signed:

    a. Since the implementation of the "State Your Support" initiative, how many individuals have signed letters?

    b. Identify which individuals and/or organizations, both inside and outside the executive branch, including White House officials, who will have or will receive copies of the letter or access to any information contained in the signed letters.

    c. Identify where the personal information contained in the letters are stored.

    d. Identify and explain the uses for personal information that is included in the letters.

    e. Please provide a complete list of who has access to the personal information, including any White House officials.

    f. Please provide a complete list of who has accessed the personal information, including any White House officials, and for what purpose.

7. Have individuals who submitted personal information been contacted either directly or indirectly by HHS? By another office within the executive branch including the White House? By a third party/grantee/contractor? If so:

    a. Who contacted these individuals?

    b. When was contact made?

    c. What was the purpose of the contact?

    d. State whether these individuals were given the opportunity to opt-in or out-of being contacted; and

    e. Provide copies of all communications made to these individuals.

    f. Indicate if and when other contacts are planned.

8. Regarding the costs and funding of the "State Your Support" initiative:

    a. Provide information, including all supporting documentation on the costs of initiating, executing, operating and maintaining the "State Your Support" initiative on the HEALTHREFORM.GOV website.

    b. Were Congressionally-appropriated HHS funds used for the "State Your Support" initiative, and if so, what was the total amount spent to date, and what is the total budget for the initiative? Provide supporting documents.

    c. If no HHS funds were used, indicate the exact source of the funds used for the "State Your Support" initiative and provide supporting documentation.

In cooperating with the Committee's review, no documents, records, data or information related to these matters shall be destroyed, modified, removed or otherwise made inaccessible to the Committee.

Thank you for your attention to this important matter. In addition to the written responses to the questions and document requests set forth in this letter, I request that my staff be briefed on this matter by appropriate HHS officials by October 30, 2009. Should you have any questions regarding this letter, please contact Christopher Armstrong or Michael Park of my Committee staff at (202) 224-4515. All formal correspondence should be sent electronically in PDF format to Brian_Downey@finance-rep.senate.gov or via facsimile to (202) 228-2131.

Sincerely,

Chuck Grassley

Charles E. Grassley
Ranking Member

Enclosures:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: October 16, 2009

TO: All Medicare Advantage Organizations, Part D Sponsors, 1876 and 1833 Cost Contractors, PACE and Medicare Advantage Demonstrations

FROM: Teresa DeCaro, RN, M.S., Acting Director
Medicare Drug and Health Plan Contract Administration Group

SUBJECT: Use of Federal funds for non plan-related activities

The purpose of this memorandum is to clarify the prohibition on using Federal Funds for non plan-related activities designed to influence state or federal legislation or appropriations, by Medicare Advantage (MA), Part D Sponsors, Cost Contractors, PACE and MA demonstration plans (including individual market and employer plans).

The Department of Health and Human Services' annual appropriations acts very specifically provide that no appropriated funds may be used to pay the "salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature." See Division F, Title V, § 503(b), Departments of Labor, HHS, and Education Appropriations Act, 2009, as enacted by § 5, Omnibus Appropriations Act, 2009, Pub. L. 111-8, 123 Stat. 524, 802 (March 11, 2009). While the existing requirements described above have been in effect for years, we want to make clear how this applies to bids and financial audits.

On July 10, 1997, CMS (then HCFA) released guidance that acknowledged identical requirements of the then-applicable appropriations act. The guidance advised that lobbying activities undertaken at the expense of risk contractor Health Maintenance Organizations/Competitive Medical Plans would be permitted subject to certain restrictions intended to ensure that beneficiaries would not confuse such activities with plan marketing materials reviewed and approved by CMS. In concluding that "risk contracts" did not implicate the "lobbying with federal funds prohibition," the guidance relied upon the assumption that a health plan could provide an assurance that, in arriving upon a negotiated fixed price, it had not included costs attributable to the plan's lobbying activities. The guidance distinguished "cost contracts" that involved individually identified cost elements accounted for on a cost report.

Because the Medicare risk contracting program has undergone significant changes in the 12 years since the 1997 guidance was issued, superseding that guidance is warranted, and is being issued by way of this memo. One of the notable changes in the contracting program is the fact that the current bidding methodology employed under the MA and Part D program was not in effect in 1997. The current bidding method used for Parts C and D bids specifically account for administrative costs, and Federal dollars are associated with those amounts. Recent audits indicate that in some cases lobbying costs may have been included as administrative costs in Part C and Part D bids.

CMS therefore is clarifying that MA and PACE organizations, Part D sponsors, and 1876 and 1833 cost contractors that engage in lobbying activities must not include such costs in their bid or cost report. In addition, if an audit identifies that lobbying expenses have been paid with federal funds, entities will be required to return to the Federal government an amount equal to these expenditures.

We also direct organizations and sponsors to our current marketing guidelines that also provide guidance concerning enrollee communications, as well as the HPMS memo entitled "*Allowable Use of Medicare Beneficiary Information Obtained from CMS*," which includes information specific to lobbying activities that are permissible under our current regulations.

We intend to enforce this guidance on a prospective basis beginning with bids submitted for CY2011. If you have any questions about whether plan communications comply with the MA program requirements and guidance and federal law, we encourage you to contact Camille Brown at camille.brown@cms.hhs.gov.

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TO: All Medicare Advantage Organizations, Part D Sponsors, 1876 and 1833 Cost Contractors, PACE and Medicare Advantage Demonstrations

FROM: Teresa DeCaro, RN, M.S, Acting Director
Medicare Drug and Health Plan Contract Administration Group

SUBJECT: Allowable Use of Medicare Beneficiary Information Obtained from CMS

The purpose of this memo is to clarify the use of beneficiary information obtained from CMS by all Medicare Advantage (MA) Contractors, Part D Sponsors, cost contractors, PACE and MA demonstrations (including individual market and employer plans). The policy outlined in this memo supersedes prior guidance on this topic, and we intend to enforce this guidance on a prospective basis.

The CMS restrictions on use of beneficiary data are contained in the Data Use Attestation that is signed by all CMS MA, Part D, PACE, and cost plans in order to participate in the program. By signing the Data Use Attestation, organizations or sponsors agree that, as a condition of having been granted permission to use and receive beneficiary information from CMS databases, they will restrict the use of Medicare data to those purposes directly related to the administration of the Medicare managed care and/or outpatient prescription drug benefits for which they have contracted with CMS to administer. They also agree not to use that information to develop, market, or operate lines of business unrelated to their Medicare plan operations.

For purposes of these Data Use Attestations, CMS-provided data includes information provided by beneficiaries in the course of enrollment as well as data obtained solely as a result of access to CMS systems granted to the contracting organization or sponsor because it is a Part C, Part D, PACE or cost plan contractor. Except in cases in which the enrollee gave information as part of a commercial relationship prior to enrollment in the Medicare plan, the contracting organization or sponsor was only given the information on the application as a result of the contract with CMS.

While we feel it is important to protect Medicare beneficiaries from potentially unwelcome marketing and other communications, we also recognize plans' interest in contacting their enrollees on issues unrelated to the specific plan benefit that they contract with CMS to provide

to those enrollees. The current Medicare Marketing Guidelines (hereinafter referred to as "Guidelines") outline the requirements for acceptable marketing practices of other health-related lines of business, as well as non-health care related lines of business. Upon review of the Data Use Agreement, we determined that additional guidance related to the distribution of other types of non-plan related information would be of assistance. Attachment 1 to this memo includes a description of that guidance, as well as guidance on obtaining prior authorization from enrollees and on allowable mingling of plan and non-plan information.

The current Medicare Marketing Guidelines can be found at http://www.cms.hhs.gov/ManagedCareMarketing on the web. If you have any questions about whether plan communications comply with the MA or Part D program requirements and guidance and Federal law, we encourage you to contact Camille Brown at camille.brown@cms.hhs.gov .

Allowable Use of Medicare Beneficiary Information Obtained from CMS
Attachment 1
October 16, 2009

Below are the detailed instructions for when prior authorization is required for use of Medicare Beneficiary Information obtained from CMS, followed by how prior authorization may be obtained. Lastly, we outline sending non-plan and non-health related information, once the authorization is approved. A brief review of our current guidance as well as the additional guidance is below. (The Medicare Marketing Guidelines ("Guidelines") will be updated to reflect these edits on next revision.)

While plans with a previous commercial relationship with Medicare beneficiaries (and employers offering Medicare plans) may have obtained their personal data through that relationship, and therefore are not obligated to follow the guidelines set forth in the Data Use Agreement, we encourage plans to follow these Data Use guidelines as a good business practice for protecting beneficiaries from potentially unwelcome marketing and other communications. Examples of what is considered a previous commercial relationship include membership in such products as:

- Long-term care insurance
- Life-insurance policies
- Non-Medicare employer or retiree plans
- Medigap policies

When authorization is required

A. As outlined in Section 40.14.1 of the Guidelines, plan sponsors are permitted to send current members information about health-related issues, as long as the material includes instructions describing how the individuals may *opt-out* of receiving such communications. Examples of health-related issues plans may communicate without receiving the prior authorization of current enrollees include:
    a. Long-term care insurance
    b. Separate dental or vision policies
    c. Value-added items and services (VAIS)
B. As outlined in Section 40.14.5 of the Guidelines, plan sponsors are permitted to send current enrollees information about non-health related services/issues, provided they obtain authorization from an enrollee *prior to* using an enrollee's protected health information to provide marketing/information about an item or service that is not health-related. Examples of non-health related issues plans may communicate after receiving prior authorization ("*opt-in*") of current enrollees include:
    a. Accident-only policies
    b. Life insurance policies
    c. Annuities

C. With the release of this guidance, we clarify that other materials distributed to members that are unrelated to the administration of plan benefits, or are not related to health-related issues or other lines of business offered by the same organization, are also subject

to the prior authorization ("*opt-in*") requirements set forth in Section 40.14.5 of the Guidelines. Examples of these types of issues include information on:

a. Volunteer or community activities
b. Pending State or Federal legislation
c. Joining grassroots advocacy organizations and information about such advocacy

D. CMS will continue to permit organizations and sponsors to provide information to their existing enrollees about current plan coverage and other Medicare Advantage, Prescription Drug, or Medigap products offered by that organization or sponsor without any prior authorization from enrollees. Provided that the information is not confusing or misleading, or includes references to information that requires prior authorization, plans may provide relevant plan and health information to members, including monthly newsletters, information on disease management programs, mailings describing rationale on why benefits have changed, and information on Medicaid and other community or social services programs.

Obtaining prior authorization

The following provides guidance on how the prior authorizations may be obtained. With any of these examples, the plan must receive the member's "opt-in" authorization prior to receiving any non-plan or non-health related information, and plans should keep evidence of authorization for audit purposes.

- Organizations and sponsors may send, at their own expense, written requests to enrollees to obtain the beneficiary's authorization for the organization or sponsor to contact him/her for purposes unrelated to plan benefits administration or CMS contract execution. The beneficiary must sign and return the request before the plan can send non-plan related materials or information. This authorization may also be obtained by directing a beneficiary to a website to provide the requisite consent. Note that if the plan uses a website for the "opt-in" process, the link from the plan's Medicare product website must inform the beneficiary that he or she is leaving the Medicare product website and going to the non-Medicare product website. (Guidelines section 100.1)
- Beneficiaries can complete authorization in person at marketing events, health fairs, or other public venues.
- Beneficiaries can complete the authorization over the telephone, provided that the authorization is recorded. The call must be a *beneficiary-initiated* inbound telephone call.
- Beneficiaries can complete the authorization via an email to the plan, provided that the authorization includes an electronic signature.

Regardless of the method by which the prior authorization is obtained (written, telephonic, on a website, etc), the following rules apply:

1. The request may include one or more types of information for which authorization is being sought. If more than one type of information is on the form, a check box (or verbal agreement, if a telephonic authorization) needs to be assigned to each type of information. Furthermore, the type of information can only be described in general terms.

For example, "Check the boxes of the types of information you would like to receive: life insurance, long-term care insurance, pending State and Federal legislation, grass-roots advocacy."

2. The request for authorization should not include any non-plan or non-health related content, nor should it be included in the same mailing as information on non-health related issues (Reference B and C, above), unless the plan has previously received prior authorization to send that particular non-health related information to that member. (For example, a request for authorization to send information about life insurance should not include a statement like "Make sure your spouse's future is secure, with a life insurance policy from us," and/or should not be sent with documents that include details about the life insurance policy.)
3. The request for authorization can be included in the same mailing as plan-related or health-related mailings to members (Reference A and D, above), so long as allowable by current Guidelines (including section 40.13). The request for authorization may not be included on the enrollment form (whether in hard copy or in electronic forms available via the plan's website) or made during the processing of a telephonic enrollment.
4. The request for authorization should not be confusing or misleading to members by purporting to have current plan benefit information or by suggesting that the content includes official information from the Medicare program.
5. These requests for authorization are not subject to review by CMS, and should not be uploaded into HPMS. However, per Section 90.20 of the Guidelines, plan sponsors are still responsible for ensuring that all materials intended for Medicare beneficiaries meet the applicable CMS marketing standards as outlined in the guidelines.
6. CMS is adopting the same requirements for these authorizations as required by the HIPAA privacy rule. Additional details on what is required for an acceptable attestation can be found at 45 CFR 164.508[1].

Sending non-plan and non-health information once prior authorization is received

Any non-plan and non-health related content cannot be given to the members until after the authorization is received. In addition, once the authorization is received,:

1. Non-health related content (Reference B and C, above) cannot be included with plan-related materials. This includes mailings and websites, as well as outbound telephone calls related to current plan information. Note that if the plan uses a website to provide non-health related content, the link from the plan's Medicare product website must inform the beneficiary that he or she is leaving the Medicare product website and going to the non-Medicare product website. (Guidelines section 100.1)
2. Health-related content (Reference A, above) can be included with plan-related materials. (Guidelines sections 40.14.1 – 40.14.6)

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[1] As they review the applicable regulatory provisions and draft the necessary documents, plans may wish to look at the guidance CMS provided to its contractors in the CMS Internet-Only Manual System in Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6, Section 190 (I). You can locate this Manual at: http://www.cms.hhs.gov/Manuals/IOM/list.asp.

3. As with all other materials that plans send to Medicare beneficiaries, plans are responsible for ensuring that any non-plan related content provided as a result of beneficiary authorization is accurate and not confusing or misleading, and does not inappropriately imply Medicare's approval, or suggest that the content includes official information from the Medicare program. In addition, these materials should include the disclaimer, "Medicare has neither reviewed, nor endorses, this information." (Guidelines section 40.5 and 40.14.6) This also includes any mailing envelopes in which the non-plan related information is sent. (The requirements to label envelopes or mailings in Guidelines 50.6 do not apply to non-plan or non-health related materials.)

If the contracting organization or sponsor wishes to include the request for authorization in plan mailings, as opposed to a separate mailing at its own expense, the claimed administrative costs must reflect an appropriate reduction to reflect the share of the document preparation and mailings cost that is attributable to the organization's or sponsor's efforts to seek authorization to send non-plan related materials. (Guidelines section 40.14.1-2)