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

CENTER FOR DRUG AND HEALTH PLAN CHOICE

TO: All Medicare Advantage and Prescription Drug Plan Sponsors Operating in 2009 Except Cost Contracts, PACE organizations, SNP and Employer Plans, and Contracts with Zero Enrollment in 2009

FROM: Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group

Danielle R. Moon, J.D., M.P.A., Director, Medicare Drug & Health Plan Contract Administration Group

SUBJECT: 2010 ANOC/EOC Timeliness and Accuracy Assessment

DATE: February 3, 2010

Annually in the fall, CMS conducts readiness assessments of all Part C and D sponsors. These tools provide CMS valuable information regarding sponsors' progress toward meeting established requirements critical to ensuring a plan's enrollees receive effective medical and drug coverage in the upcoming benefit year. One of the areas we focus on every year in the readiness assessment is marketing. In recent years, we have identified a number of problems with organizations' and sponsors' compliance with our ANOC/EOC requirements. Not only have there been problems with the timeliness of ANOC/EOC mailings to current enrollees, but there have been inaccuracies in some of the mailings, as well.

As a reminder, ANOC/EOCs for the 2010 benefit year were to be received by beneficiaries no later than October 31, 2009. In order for CMS to accurately gauge the extent of ANOC/EOC compliance problems, Part C and D sponsors must complete the attached inquiry via CMS' online web tool. All sponsors were notified in the December 1, 2009 HPMS memo entitled "CY 2010 Medicare Advantage and Prescription Drug Readiness Assessment Request," to expect this additional request. The inquiry asks sponsors to identify every instance in which ANOC/EOCs were not mailed to beneficiaries on time and/or contained any inaccurate information.

Among other details, you must report the date that the last wave of ANOC/EOCs was issued to your members, and for members who received documents late, the number of affected members according to the date by which they were received. With regard to inaccuracies, you must provide details on the types of errors in the ANOC/EOCs, if any. We are asking for specific information on the nature of the errors to gauge the impact of inaccurate ANOC/EOCs based on differences in advertised medical and/or pharmacy costs, and differences in advertised medical and/or pharmacy benefits.

Sponsors and organizations must complete the on-line web tool by close of business on **Thursday, February 18, 2010**. Instructions for completing the on-line web tool are provided below. We will only accept electronic submissions via the URL listed below.

Sponsors must report late mailings or inaccuracies even if they were already reported to CMS via the CY 2010 Medicare Advantage and Prescription Drug Readiness Assessment or other communication vehicles. Sponsors whose internal verification activities do not identify late mailings or inaccuracies must still complete the online web tool. We will analyze all submissions to ensure that we have received a response for each contract number.

Failure to meet the requirement for accurate and timely issuance of ANOC/EOCs is considered a serious violation of Part C and D program requirements. In the October 20, 2009 HPMS memo, entitled "Timely and Accurate Submission of the Standardized Combined Annual Notice of Change/Evidence of Coverage (ANOC/EOC)," CMS indicated that failure to provide accurate documents in a timely manner is a contractual and regulatory violation. CMS has determined that any organization failing to provide accurate and timely documents may be carrying out its contract with CMS in a manner that is inconsistent with the effective and efficient implementation of CMS' regulations, and this failure may constitute grounds for imposition of civil money penalties.

Organizations should be prepared to provide supporting documentation to verify the responses to this inquiry upon request.

Specific Instructions

In conducting this exercise and reporting your results, please keep in mind the following:

- Cost Contracts and PACE organizations need not respond to this request.
- Contracts that exclusively offer employer (800-series) plans or Special Needs Plans (SNPs) need not respond to this request. However, if your contract offers both non-SNP individual market plans as well as SNPs and/or employer plans, you must respond and provide data only for your non-SNP and non-employer PBPs.
- Contracts that are new for 2010 and contracts that were active in 2009 but had no enrollment need not respond to this request.
- This assessment focuses only on ANOC/EOCs due to members by October 31, 2009. Therefore, do not include information pertaining to your members with November 1, 2009 or December 1, 2009 enrollment effective dates.
- When reporting accuracy errors, include inaccuracies pertaining to supplemental benefits.
- If one ANOC/EOC document contained multiple inaccuracies, be sure to correctly identify all types of inaccuracies in the various categories we ask about (medical costs, prescription drug costs, medical benefits, prescription drug benefits).
- Similarly, if a single ANOC/EOC was both late and inaccurate, be sure to report both types of problems for the same document.

Accessing the Online Web Tool

Simultaneously with the release of this memo, CMS is sending an email from DrugBenefitImpl@cms.hhs.gov to each compliance officer with the link to the 2010 ANOC/EOC Timeliness and Accuracy Assessment. Please click on the link in that email to complete and submit the tool electronically to CMS.

We are aware that some organizations will not receive the email due to firewall constraints. If your organization's compliance officer did not receive the email notification, or if it is more convenient for you, click on or paste the following link into your web browser to access the assessment:

https://vovici.com/wsb.dll/s/11dc4g42cde

Please note that the Unique ID for accessing the assessment is your Contract ID. CMS expects a separate submission for each individual contract ID. For security reasons, the respondent must enter the compliance officer's email address (case sensitive as it appears in HPMS) in the password field. If you have trouble logging in, please contact one of the individuals listed below.

Deadline

Using the online tool as described above, please submit the 2010 ANOC/EOC Timeliness and Accuracy Assessment by **Thursday, February 18, 2010**.

CMS Contact

If you have any questions about the 2010 ANOC/EOC Timeliness and Accuracy Assessment, please contact Jennifer Shapiro at jennifer.shapiro@cms.hhs.gov, Marla Rothouse at marla.rothouse@cms.hhs.gov or your Account Manager.

Thank you for your prompt response to this request.

Attachment:

2010 ANOC/EOC Timeliness and Accuracy Assessment

Instructions:

- Using the online tool as described in the attached HPMS memo, please submit the 2010 ANOC/EOC Timeliness and Accuracy Assessment by **Thursday, February 18, 2010.**
- Cost Contracts and PACE organizations need not respond to this request.
- Contracts that exclusively offer employer (800-series) plans or Special Needs Plans (SNPs) need not respond to this request. However, if your contract offers both non-SNP individual market plans as well as SNP and/or employer plans, you must respond and provide data only for your non-SNP and non-employer PBPs.
- Contracts that are new for 2010 and contracts that were active in 2009 but had no enrollment need not respond to this request.
- This assessment focuses only on ANOC/EOCs due to members by October 31, 2009. Therefore, do not include information pertaining to your members with November 1, 2009 or December 1, 2009 enrollment effective dates.
- When reporting accuracy errors, include inaccuracies pertaining to supplemental benefits.
- If one ANOC/EOC document contained multiple inaccuracies, be sure to correctly identify all types of inaccuracies in the various categories we ask about (medical costs, prescription drug costs, medical benefits, prescription drug benefits).
- Similarly, if a single ANOC/EOC was both late and inaccurate, be sure to report both types of problems for the same document.
- Submit a separate assessment for each contract for which you are the compliance officer and which otherwise meets the criteria for completing this exercise.

Background Information

1. Name and Title of Respondent on Behalf of Contract
   _____

Timeliness of ANOC/EOCs

2. Provide the date the ANOC/EOCs were originally received by beneficiaries (If you sent ANOC/EOCs in waves, provide the date received by the last wave). _____ (Continue to question 3 if the last wave was received on or after 11/1/2009. Otherwise skip to question 5.)
3. Provide the number of beneficiaries that did not receive their original ANOC/EOC until sometime during the week ending:
   a. November 7, 2009 _____
   b. November 14, 2009 _____
   c. November 21, 2009 _____
   d. November 28, 2009 _____
   e. Later than Nov. 28, 2009 _____
4. Identify the plan benefit packages (PBPs) associated with the late ANOC/EOCs. _____ (List plan numbers separated by commas, e.g., 001, 002, 003)

Overall Accuracy of ANOC/EOCs

5. Were there any inaccuracies in any of the ANOC/EOCs issued to your enrollees? (yes or no) _____ . (If yes, continue to question 6. Otherwise skip to question 21.)
6. Provide the total enrollment that received ANOC/EOCs with at least one error. _____
7. Provide the latest date that any of the above enrollees received an errata sheet correcting these errors. _____

Inaccurate Medical Costs

8. Provide the number of beneficiaries that received ANOC/EOCs with at least one error that reported lower medical costs than will actually be incurred. (Costs include premium, co-pay, co-insurance, deductible, and out of pocket costs) _____ (Answer could be zero if ANOC/EOCs contained only different types of errors, such as prescription costs, medical benefits, or prescription benefits, or if medical cost-type errors reported higher costs than will be incurred. If answer is greater than 0, continue. Otherwise skip to question 12.)
9. Identify the type of cost(s) where the error occurred (check all that apply):
    a. Premiums
    b. Co-pays/co-insurance
    c. Deductible
    d. Maximum out-of-pocket
    e. Other (specify):_____
10. Identify the plan benefit packages (PBPs) affected by these types of inaccuracies. _____(List plan numbers separated by commas, e.g., 001, 002, 003)
11. Of the beneficiaries identified in question 8 above, how many beneficiaries received materials where the cost differential was at least $10 per service or $10 per month more (assuming average utilization) between what was on the ANOC/EOC versus the actual cost the beneficiary will incur? _____

Inaccurate Prescription Drug Costs

12. Provide the number of beneficiaries that received ANOC/EOCs with at least one error that reported lower prescription drug costs than will actually be incurred. (Costs include premium, co-pay, co-insurance, and deductible) _____ (Answer could be zero if ANOC/EOCs contained only different types of errors, such as medical costs, medical benefits, or prescription benefits, or if prescription drug cost-type errors reported higher costs than will be incurred. If answer is greater than 0, continue. Otherwise skip to question 16.)

13. Identify the type of cost(s) where the error occurred (check all that apply):
    a. Premiums
    b. Co-pay/Co-Insurance
    c. Deductible
    d. Other (specify):_____
14. Identify the plan benefit packages (PBPs) affected by these types of inaccuracies. _____(List plan numbers separated by commas, e.g., 001, 002, 003)
15. Of the beneficiaries identified in question 12 above, how many beneficiaries received materials where the cost differential was $10 or greater calculated on a per year basis based on an average utilization of 4 prescriptions with monthly refills per beneficiary per year? For example, if the inaccurate ANOC/EOC had a co-pay of $3.00, but the co-pay is actually $4.50, then the cost differential, assuming 4 monthly prescriptions filled 12 times over a year is $72.00 ($1.50 x 4 x 12). _____

Inaccurate Medical Benefits

16. Provide the number of beneficiaries that received ANOC/EOCs with at least one error that reported richer or greater medical benefits than will actually be offered. _____ (Answer could be zero if ANOC/EOCs contained only different types of errors, such as medical costs, prescription costs, or prescription benefits, or if medical benefit errors reported lesser benefits than will be offered. If answer is greater than 0, continue. Otherwise skip to question 19.)
17. Identify the medical benefit(s) affected by the inaccurate ANOC/EOC (check all that apply):
    a. Inpatient acute – additional days beyond 90
    b. SNF – waive 3 day hospital requirement
    c. Worldwide coverage for emergency care
    d. Vision – exams
    e. Vision – eyewear
    f. Dental – all combined
    g. Dental – preventive
    h. Dental – comprehensive
    i. Hearing – exams
    j. Hearing – aids
    k. Durable Medical Equipment
    l. Chiropractic
    m. Podiatry
    n. Routine Physical
    o. Health club/fitness classes
    p. Nursing hot line
    q. Smoking Cessation programs
    r. Other (specify):_____
18. Identify the plan benefit packages (PBPs) affected by these types of inaccuracies. _____(List plan numbers separated by commas, e.g., 001, 002, 003)

Inaccurate Prescription Drug Benefits

19. Provide the number of beneficiaries that received ANOC/EOCs with at least one error that reported richer or greater prescription drug benefits than will actually be offered. _____ (Answer could be zero if ANOC/EOCs contained only different types of errors, such as medical costs, prescription costs, or medical benefits, or if prescription drug benefit errors reported lesser benefits than will be offered. If answer is greater than 0, continue. Otherwise skip to question 22.)
20. Identify the prescription drug benefit(s) affected by the inaccurate ANOC/EOC (check all that apply):
    a. Overstated gap coverage
    b. Additional generics listed on formulary
    c. Additional brands listed on formulary
    d. Excluded drugs noted as being offered
    e. Understated prior authorizations, step therapy requirements
    f. Other (specify):_____
21. Identify the plan benefit packages (PBPs) affected by these types of inaccuracies. _____(List plan numbers separated by commas, e.g., 001, 002, 003)

Attestation

22. My checkmark for this item indicates that I attest that, to the best of my knowledge having conducted thorough investigations of this matter, including the actions of all first tier, downstream and related entities as relevant, all of the information provided herein is correct and truthful, including any statements regarding the number of affected beneficiaries, types of errors or lateness of mailings, or statements concerning the timeliness and/or accuracy of this contract's ANOC/EOC mailings.
    a. I attest to the above statement.
    b. I cannot attest to the above statement for the reasons specified in the comment box below.

    Comments:
    _____