DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR BENEFICIARY CHOICES

TO: All Part D Plan Sponsors

FROM: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

RE: Expectations for Customer Service Call Handling

DATE: September 14, 2006

Part D Sponsors have made substantial progress over the past three months in reducing the number of complaints voiced by beneficiaries to 1-800-MEDICARE. However, 1-800 MEDICARE continues to handle a large number of calls. Based on our analyses of these calls, we believe that many of the calls referred to 1-800-MEDICARE can be resolved by the Part D Sponsor. In an effort to relieve the backlog of beneficiary complaints and to assist Part D Sponsors in resolving these complaints, we are providing specific information on these call areas.

If you have any questions regarding this memo, please contact your account manager. Thank you for your continued assistance with the implementation of the Part D benefit.

Issue 1: Communication to Plan Members

Problem: A very large percentage of complaint calls are from beneficiaries who have submitted multiple complaints and have yet to receive any communication as to the status of their issue. Often the complaint has been resolved, but the plan member remains unaware of the resolution.

Solution: We believe that immediate communication by letter or phone call on the status of the resolution of the complaint would result in a reduction in the overall numbers of complaint requiring actions by 1-800-MEDICARE, CMS, and the Part D plans. Once the complaint is resolved, we encourage Part D Sponsors to communicate the resolution of these complaints to the member.

Issue 2: Training of Customer Service Representatives

Problem: Customer service representatives (CSRs) located at the Part D Sponsor are not trained in the appropriate process for handling issues.

Solution: Part D Sponsors should ensure that all of its CSRs are trained in the appropriate process for handling issues. The Sponsor should also take appropriate steps through quality assurance and other efforts to ensure that these calls are handled using their internal processes or,

when necessary, the Part D Sponsor may need assistance from the Regional office (RO) staff. If training and other quality assurance efforts do not fully resolve the issues of inappropriate referrals to 1-800-MEDICARE, the Part D Sponsor should take further actions such as requiring prior approval by supervisory customer service staff located at the plan to ensure that their CSRs comply with the Sponsor's processes.

ISSUE 3: Medicare beneficiary wants to enroll in the Part D plan.

Problem: We are receiving a number of calls daily referred by Part D plans to 1-800-MEDICARE to "get approval to enroll" a beneficiary.

Solution: In no instance is it necessary to refer a prospective member to 1-800-MEDICARE for "approval to enroll" or to enroll the member on behalf of the plan. In many instances, the Medicare beneficiary clearly qualifies for a special enrollment period (SEP). The Part D Sponsor should determine whether a SEP applies following existing enrollment guidance (see Attachment 1). If a SEP applies, the plan should enroll the Medicare beneficiary following that guidance.

There are 2 situations which could warrant an "enrollment exception", including situations where:

- A serious medical emergency, such as an unexpected hospitalization that caused a person to miss enrolling in a Part D plan during an enrollment period.
- The caller joined a Medicare Advantage Prescription Drug Plan, thinking that it was a Prescription Drug Plan. The caller wants to return to Original Medicare and to join a stand-alone Prescription Drug Plan.

The Part D Sponsors should develop a process where their CSRs can internally escalate a request for an enrollment exception where a SEP does not apply but one of the exceptions may apply. The plan staff can work directly with their designated regional office staff via email to request an "enrollment exception". A list of Regional Office email addresses is shown in Attachment 2. The regional office staff would determine whether an enrollment exception is warranted. If granted, the Part D Sponsor can contact the beneficiary and enroll him/her in the desired plan. This will expedite the processing of these enrollment requests and shorten the timeframe in which the beneficiary is waiting for resolution.

You can find the scripts that the 1-800-MEDICARE CSRs use when discussing Prescription Drug Coverage (including Special Enrollment Period and Enrollment Exception options) with callers at the following url:
http://www.cms.hhs.gov/Partnerships/PDI/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS056395

ISSUE 4: There are discrepancies in LIS status.

Problem: We are receiving calls from Medicare beneficiaries who were referred to 1-800-MEDICARE to resolve issues with LIS status. In the vast majority of these calls, the CMS system reflects the correct LIS status.

Solution: The Part D Sponsors should not be referring callers to 1-800-MEDICARE to resolve LIS issues. Instead, they should be using existing data sources to resolve these discrepancies, such as the bi-weekly low income subsidy report data file. Part D Sponsors are required to use this file to match against the LIS data in the plan's system. (See the letter entitled: Bi-Weekly Low Income Subsidy Report Data File, dated August 30.) This process should eliminate discrepancies between LIS information in the sponsor's system and that reflected in the CMS system.

Other possible sources of assistance are:

- Sponsors are also able to query the CMS systems on a member-by-member basis to determine the LIS status.
- If the Part D Sponsors CSRs do not have direct access to the MBD data sources but do have internet access, they may use the Medicare Prescription Drug Plan Finder to verify the LIS status of a plan member.
- If the CSRs do not have access to any of these other data sources, the Part D Sponsor should develop an internal escalation process to handle these calls.
- The sponsor may also work via email with their designated regional office staff if additional assistance is required.

ISSUE 5: Reason for Disenrollment

Problem: Part D Sponsors are referring members to 1-800-MEDICARE to determine why the member was disenrolled from the plan. Because the 1-800-MEDICARE CSRs do not have access to disenrollment reasons, they are unable to help these callers. As a result, the calls are entered as complaints but are then returned directly to the plan for resolution. Referring these complaints to 1-800-MEDICARE simply prolongs the resolution of the issue for the plan member.

Solution: The transaction reply report (TRR) shows the disenrollment reason for the beneficiary. In situations where the plan has issues or concerns about the disenrollment reason, the plan should work via email with its designated regional office. If the Part D Sponsor customer service representatives do not have access to the disenrollment reasons reflected in the TRR, the Part D Sponsors should develop an internal escalation process to handle these calls.

ISSUE 6: Enrollment is "pending" at CMS

Problem: Part D Sponsors are telling beneficiaries that their "enrollment is pending at CMS" and that they should contact 1-800-MEDICARE to find out the status. The 1-800-MEDICARE CSRs only have access to processed enrollments - not any ability to see the status of pending transactions.

Solution: The Part D Sponsors have information on the status of beneficiary enrollments and should be able to respond to these calls. Where Part D Sponsors need additional assistance on specific situations involving enrollment processing, they should work via email with their designated regional office. If there is a system issue or concern, the plan should open a trouble ticket with the CMS helpdesk.

ISSUE 7: Transaction Reply Code 127, Employer Subsidy

Problem: Part D plans are telling beneficiaries to call 1-800-MEDICARE when the plan enrollment has been rejected with a reply code "127" for employer subsidy. In some cases, the plan is telling the beneficiary that they must have "Medicare" remove the employer/union subsidy indicator from their record before the enrollment can be processed.

Solution: 1-800-MEDICARE should not be involved in this process. There is an established process Part D plans are to follow to verify that the beneficiary understands the implications to employer/union coverage if he/she joins a Part D plan. They must verify that the beneficiary wants to enroll in the Part D plan. The Part D plan then resubmits the enrollment with the Retiree Drug Subsidy (RDS) override.

In some cases, the beneficiary informs the plan that they no longer have employer/union coverage. In those instances, the plan can follow the above protocol, validating that that beneficiary does want to enroll in the plan and resubmitting the enrollment with the RDS override.

ISSUE 8: Part D Sponsor cannot find an enrollment that was either processed by 1-800-MEDICARE or the Plan Finder online enrollment center.

Problem: Part D plans are referring beneficiaries to 1-800-MEDICARE when the caller states that they enrolled either online at www.medicare.gov or through 1-800-MEDICARE. The caller has an online enrollment center confirmation number and date of enrollment, but the Part D plan has no record of that enrollment.

Solution: Part D Sponsors have access to information to validate the confirmation number. Where necessary, they can have the enrollment re-set so that they can again download the enrollment. All valid online enrollment center confirmation numbers are 14 digits in length and will always start with the number 1. The Sponsors should first ensure that the number meets this format. If not, probe the caller for the correct confirmation number and/or validate that he/she did enroll online at www.medicare.gov or through 1-800-MEDICARE.

If the caller does have a valid online enrollment center confirmation number, the Part D plan can verify the enrollment through the Destination Rx administrative console. The url is: https://enrollmentcenter.medicare.gov/AdministrativeConsole/PlanFinder/login.aspx

Log in ID: cms_readonly
Password: admin_read

If the enrollment has not been downloaded, the Part D plan should download the enrollment through its usual procedures and process the enrollment. If the enrollment has already been downloaded, the Part D plan should send an email to plancompare@destinationrx.com that contains the online enrollment confirmation number and a request that the enrollment be reset so that it can be downloaded again.

If the plan is unable to find the enrollment in the administrative console and the caller indicates that he/she has enrolled through 1-800-MEDICARE, the plan can work via email with its designated regional office. The regional office staff can work with CMS central office to try to locate the call record and validate the enrollment.

ISSUE 9: Beneficiary Understanding of his/her Decision

Problem: Although many safeguards exist, we have a number of CTM complaints because the beneficiary asserts he or she did not understand the effects of his or her request.

Solution: CMS recommends that you review marketing and sales information packets and customer service scripts to ensure that critical issues are addressed.

For example, these materials should discuss the effects a change in a beneficiary's enrollment would have on other health or drug coverage. The plan might want to recommend that the beneficiary contact their other insurers, if they have one, before enrolling in a Part D plan. If the beneficiary wants to disenroll from a plan, ensure that they understand the effect of the lock-in rules. If the beneficiary intends to enroll in an employer/union group, the beneficiary might want to call the employer/union group to be sure that they will be allowed to re-enroll in the employer/union plan before they disenroll from the Part D plan.

ISSUE 10: Cancellations Prior to Effective Date of Enrollment

Problem: When a beneficiary cancels an enrollment request prior to the effective date of that enrollment, they are not automatically re-enrolled into their "plan of choice" or previous plan, if the sponsor already submitted an enrollment transaction. The result is often that a beneficiary is left with no coverage.

Solution: Although the letter sent to the beneficiary clearly states that the beneficiary must contact their "plan of choice", some beneficiaries expect this action to occur automatically. The "gaining" plan will need to send an enrollment transaction to CMS to ensure the beneficiary remains enrolled in that plan, without a break in coverage.

CMS recommends that when a beneficiary calls to notify you that he or she is canceling their enrollment in your plan, you inform the beneficiary that they should contact their "Plan of Choice" to ensure continued enrollment in that plan. When the beneficiary then explains his or her selection to the "plan of choice", that plan will verify the beneficiary's enrollment status and submit an enrollment transaction, if necessary.

ISSUE 11: Retroactive Enrollment/Disenrollment Transactions

Problem: Retroactive enrollment can change a beneficiary's current choice when the beneficiary does not want it to change.

Solution: Enrollment and disenrollment transactions must meet the requirements specified in the Enrollment Guidance and be processed in a timely manner. Due to systems issues at Part D Sponsors and CMS, we provided a standard procedure related to the submittal and processing of retroactive files. This procedure will be continued and must be followed until further notice. A letter explaining the retroactive adjustment process was sent via HPMS email and was posted on the HPMS homepage on August 30, 2006.

ISSUE 12: No CMS Record of a Transaction

Problem: This situation should be transparent to beneficiaries. In accordance with CMS enrollment guidance, plans are required to begin covering a beneficiary upon acceptance of the enrollment request.

Solution: The plan must submit the enrollment transaction within 30 days. (Please note that this enrollment guidance has been revised to reduce this timeframe to 14 days beginning November 15, 2006.) Customer service representatives should be provided scripts to reassure the beneficiary that the plan will cover them (or has disenrolled them, as appropriate).

In summary, there are some general actions that will improve customer satisfaction:

- Most enrollment and disenrollment transactions are solvable by Part D Sponsors; referrals to 1-800-MEDICARE are not necessary.
- The Plans should submit enrollments, disenrollments and cancellations within 14 days of receipt of the request.
- The Plans should review customer service and sales representatives' materials and scripts to ensure that key information is accurate.

Attachment 1

Exhibit 1a – Optional information to include on or with Enrollment Form -- Information to Determine Enrollment Periods

Referenced in section: 20

Typically, you may only enroll in a Medicare Prescription Drug Plans during the annual open enrollment period between November 15 and December 31 of each year. However, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual open enrollment period.

Please read the following statements and please check the box to the left of the statement(s) and your selected plan will contact you for additional information.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of my current Medicare health plan's or Medicare prescription drug plan's service area.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I was recently approved for extra help paying for Medicare prescription drug coverage.
- ☐ I just moved into a Long Term Care Facility (for example, a nursing home or long term care).
- ☐ I recently left a PACE program.
- ☐ I recently involuntarily lost my coverage that is at least as good as Medicare's (also referred to as "creditable coverage").
- ☐ I am either losing coverage I had from an employer or leaving employer coverage.

If none of these statements apply to you or if you are not sure, please contact us to see if you are eligible to enroll.

Attachment 2

CMS Regional Office Part D Mailboxes

Region	E-mail Address for Part D Complaints
1 – Boston Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont	CMS PartDComplaints_RO1@cms.hhs.gov
2 - New York New Jersey, New York, Puerto Rico, Virgin Islands	CMS PartDComplaints_RO2@cms.hhs.gov
3 – Philadelphia Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	CMS PartDComplaints_RO3@cms.hhs.gov
4 – Atlanta Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	CMS PartDComplaints_RO4@cms.hhs.gov
5 – Chicago Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	CMS PartDComplaints_RO5@cms.hhs.gov
6 – Dallas Arkansas, Louisiana, New Mexico, Oklahoma, Texas	CMS PartDComplaints_RO6@cms.hhs.gov
7 – Kansas City Iowa, Kansas, Missouri, Nebraska	CMS PartDComplaints_RO7@cms.hhs.gov
8 – Denver Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	CMS PartDComplaints_RO8@cms.hhs.gov
9 - San Francisco American Samoa, Arizona, California, Commonwealth of the Northern Mariana Islands, Guam, Hawaii, Nevada	CMS PartDComplaints_RO9@cms.hhs.gov
10 – Seattle Alaska, Idaho, Oregon, Washington	CMS PartDComplaints_RO10@cms.hhs.gov