

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

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H2701
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The Centers for Medicare & Medicaid Services (CMS) conducts call center monitoring of Medicare Part C and Part D customer service call centers throughout the year. This letter contains results for the 2012 Accuracy and Accessibility study, as well as suggestions for how your organization can improve its performance. This letter also identifies any areas where your organization was non-compliant. Based on your contract's results, as shown in Table 1, this communication serves as the following type or types of formal CMS notifications placeholders ("Compliant" denotes an informational memo for a measure):

Compliant- Interpreter Availability
Corrective Action Plan- TTY
Compliant- Accuracy

Pursuant to the CMS regulations and the Medicare Marketing Guidelines¹, all organizations must have call centers that serve current and prospective enrollees. These call centers must be able to provide interpreters for limited English proficient (LEP) callers, TTY/TDD services for the hearing and speech impaired, and accurate Part C and/or Part D benefit information.

CMS advised Medicare Part C and D organizations of the call center monitoring efforts for 2012 in a December 9, 2011 Health Plan Management System (HPMS) memorandum entitled *2012 Part C and Part D Call Center Monitoring and Guidance for Providing Services to Limited English Proficient Beneficiaries*. Consistent with the memo, earlier this year, CMS' contractor, RTI, Inc., conducted an extensive call center monitoring study to determine whether each sponsor:

¹ Medicare Marketing Guidelines (Medicare Managed Care Manual, Chapter 2 and Medicare Prescription Drug Benefit Manual, Chapter 3) (May 17, 2011), sections 30.8, 40.11, 80.1, 80.1.3. and 42 C.F.R. § 422.111, 42 C.F.R. § 423.128(d)(1) (2011).

- Provided interpreters for limited English proficient (LEP) callers.
- Communicated with hearing-impaired callers via TTY/TDD.
- Provided accurate answers to plan-specific and general Medicare Part C or Part D questions.

From January 30, 2012-May 18, 2012, RTI placed calls to your organization’s *prospective* enrollee customer service phone number or TTY/TDD phone number Monday through Friday from 8 a.m. to 8 p.m. Each week during the study, CMS obtained for RTI the appropriate phone numbers from the HPMS system. Data related to your organization’s compliance results are provided in this letter. You can also find more detailed results for your contract in HPMS by following the paths below:

1. For Part C results, from the HPMS home page (<https://www.hpms.cms.gov>): Quality and Performance > Part C Performance Metrics > Prospective Beneficiary Customer Service Call Center Performance Metrics > [enter the contract number].
2. For Part D results, from the HPMS home page (<https://www.hpms.cms.gov>): Quality and Performance > Part D Performance Metrics > Prospective Beneficiary Customer Service Call Center Performance Metrics > [enter the contract number].

Your Organization’s Results

Table 1 below summarizes your organization’s results and indicates whether the contract indicated at the top of this letter is in compliance with CMS’ standards. For example, if “Non-Compliant” appears in the column labeled “Part C Results Compliant with CMS Standards?”, then your organization was out of compliance for the measure listed in the far left column. If “Compliant” appears in the “Part C Results Compliant with CMS Standards?” column, then your organization was in compliance with the measure. If “N/A” appears in the table below or elsewhere in this letter, then that measure did not apply to your organization (e.g., PDP sponsors will have “N/A” listed in Part C results areas).

Non-compliant results are based on a modified outlier analysis. For those areas marked “no” in Table 1, your organization was deemed non-compliant because it was either an outlier with respect to other sponsors for a particular measure, or so far below CMS’ reasonable expectations that notice to your organization was warranted in order to ensure your organization provides beneficiaries with the services to which they are entitled. For interpreter availability, the cut point for receiving a compliance action was 70%. When incorporating the margin of error for interpreter availability, which was 1%, the cut point for non-compliance shifted to those organizations below 69%. For TTY service, the cut point for receiving a compliance action was 60%. When incorporating the margin of error for TTY service, which was 2%, the cut point for non-compliance shifted to those organizations below 58%. For information accuracy, the cut point for receiving a compliance action was 75%. When incorporating the margin of error for information accuracy, which was 1%, the cut point for non-compliance shifted to those organizations below 74%.

While these compliance action cut points serve to delineate organizations with performance sufficiently unsatisfactory to receive a CMS compliance notice, CMS fully expects all organizations to work toward full compliance whereby all (i.e., 100%) of beneficiaries will receive the highest level of customer service. Furthermore, as Part C and D sponsors continue to gain experience with providing these services, the cut points for compliance will likely shift higher over time. At a minimum, consistent with the CMS Strategic Language Access Plan, the cut point for compliance for interpreter availability will move to 75% in 2013.

Table 1: 2012 Call Center Monitoring Accuracy & Accessibility Study Results for H2701

Measure	Part C	Part C Results Compliant with CMS Standards?	Part D	Part D Results Compliant with CMS Standards?
Interpreter Availability	95%	Compliant	89%	Compliant
TTY/TDD Functionality	31%	Non-Compliant	19%	Non-Compliant
Information Accuracy	88%	Compliant	79%	Compliant

Descriptions of Measures, Results, and Tips for Improvement

In the following paragraphs, CMS provides your organization’s individual results at the contract level, as well as the average results for all Part C and Part D sponsors for each measure. This information will help your organization assess the degree to which it was or was not an outlier.

1. Interpreter Availability

CMS tested sponsors’ ability to provide interpreters by having foreign language speakers call the prospective customer service phone lines. Our contractor placed calls in Spanish, Russian, Vietnamese, Mandarin, Cantonese, and Korean, which are the languages most frequently requested by 1-800-Medicare callers. The results below are given in terms of percent of time that a caller was able to reach someone who could speak their non-English language and ask that person questions. For the Accuracy and Accessibility study for Part C and Part D combined, on average, 128 calls were made to each call center in a non-English language, and there were approximately 21 calls made in each of the aforementioned languages.

Across all Medicare Part C and Part D contracts in the program, the average Part C result for all non-English languages combined was 84% and the average Part D result for all non-English languages was 84%. CMS was pleased to see these percentages increase from 2011.

a. Part C Interpreter Availability Results

- Your Part C interpreter availability result: 95%

b. Part D Interpreter Availability Results

- Your Part D interpreter availability result: 89%

c. Tips to Improve Your Organization's Interpreter Availability Results

- Ensure your initial phone greeting system or IVR or TTRS defaults to a live CSR if the caller does not make a selection. Ensure the live CSR is trained to connect foreign-language speakers with an interpreter. We are recommending this approach because callers that do not speak English cannot understand the greeting or IVR messaging if it is not in their language.
- Contract with a service that provides interpretive services over the phone via three-way calls or have CSRs on staff who speak foreign languages at your call center.
- Train all CSRs how to transfer calls swiftly to an interpreter service or to a foreign-language speaking CSR.
- Ensure your organization's CSRs are trained to stay on the phone after they successfully connect the beneficiary with the correct interpreter.
- Remind CSRs not to hang up on callers who speak foreign-languages.
- Prior to the start of CMS call center monitoring (e.g., at the end of January), remind CSRs of the upcoming CMS study and train or re-train them on how to connect foreign language callers with interpreters.

2. TTY/TDD Service

Our contractor used TTY/TDD devices to place calls to your organization's prospective enrollee TTY number or the state relay phone number your organization entered into HPMS. The results below indicate the percent of the time a caller using a TTY device was able to communicate with someone who could answer questions either at the sponsor's call center or via the state relay operator. CMS guidelines permit sponsors to use state relay services in lieu of having in-house TTY/TDD equipment. When this option has been selected by an organization, our caller calls the state relay, and then the state relay attendant calls the TTY/TDD sponsor customer service phone line. For the Accuracy and Accessibility study, on average for Part C and Part D combined, 32 calls were made to each TTY phone number using a TTY device.

Across all Medicare Part C and Part D contracts in the program, the average Part C result for successful TTY/TDD calls was 73% and the average Part D result was 74%, which is an improvement over the 2011 results.

a. Part C TTY/TDD Service Results

- Your Part C result: 31%

b. Part D TTY/TDD Service Results

- Your Part D result: 19%

c. Tips to Improve Your Organization's TTY/TDD Service Results

- If your organization has an in-house TTY/TDD machine, ensure your staff knows how to use the machine, and when to respond to it.
- If your organization has an in-house TTY/TDD machine, develop a staffing plan for monitoring and responding to the TTY machine so that, at all times when your call center is open, at least one person knows it is their responsibility to respond to the calls.
- Edit TTY/TDD messages that scroll across the screen to ensure there are no typos or inappropriate characters outside of customary TTY/TDD short hand.
- If your organization provides beneficiaries with the state relay phone number, on a regular basis, try this phone number from a TTY/TDD machine to ensure that it is a viable pathway for hearing-impaired beneficiaries to use to obtain information.
- If using the state relay, make sure that it can be reached from out-of-state.

3. Information Accuracy

CMS developed twenty Part C and twenty Part D questions for callers to ask CSRs. CSRs were asked three questions per call. The questions were general Part C or D questions or plan-specific questions that pertained to a specific plan benefit package (PBP) associated with the contract ID listed at the top of this letter. Part C prospective customer service call centers were asked the Part C questions (See Appendix A) and Part D prospective customer service call centers were asked the Part D questions (See Appendix B). CMS obtained the answers for plan-specific questions from your organization's plan benefit package (PBP) information, formulary information, and other information submitted to CMS that was made public (e.g., PDP and MA-PD landscape information). Plan sponsors were not penalized if a question was not asked (e.g., if the phone line cut off after the caller asked two questions, we did not count the third, unasked question as incorrect.) The individual question results below are provided in terms of the percentage of the time a CSR answered the question correctly. For the Accuracy and Accessibility study for Part C and Part D, all questions answered by CSRs, regardless of whether the questions were asked in English, a foreign language, or via TTY, were counted toward the information accuracy score.

Across all Medicare Part C contracts, the average Part C result for all questions combined was 86% answered correctly. Across all Medicare Part D contracts, the average Part D result for all questions combined was 80% answered correctly. Some questions were not asked to specific plan types, and those excluded plan types are indicated in the Appendices for each question.

Like last year, CMS' results indicated that, on average, foreign language or TTY/TDD usage did not affect the accuracy of information provided by CSRs. For comparison purposes only, the

percentage of accurate answers to all questions is also provided in terms of those questions asked in a foreign language and those questions asked via TTY.

a. Part C Information Accuracy Results

- Your Part C information accuracy result: 88%
- Part C Foreign language call information accuracy: 86%
- Part C TTY/TDD call information accuracy: 87%

b. Part D Information Accuracy Results

- Your Part D information accuracy result: 79%
- Part D Foreign language call information accuracy: 78%
- Part D TTY/TDD call information accuracy: 100%

c. Tips to Improve Your Organization's Information Accuracy Results

- Ensure your CSRs either know or are provided with accurate information about each plan's benefits.
- Useful items to have accessible to each CSR are each plan's summary of benefits and formulary.
- Make sure CSRs can access each plan's contract ID and plan benefit package (PBP) numbers.

Next Steps

Informational memo:

If your organization was compliant in an area identified at the top of the letter, this memo is for informational purposes with respect to that area. Congratulations and please continue your efforts next year.

Notice of non-compliance:

If your organization was identified as receiving a Notice of Non-Compliance in one or more areas at the top of this letter, please take steps to improve in the non-compliant area(s) identified in Table 1.

Warning letter:

If your organization was identified as receiving a Warning Letter in one or more areas at the top of this letter, please take steps to improve in the non-compliant area(s) identified in Table 1. Should your organization fail to come into compliance, CMS may consider taking additional

compliance actions, including a formal request that your organizations take corrective action, or an enforcement action.

Warning letter with a request for business plan:

If your organization was identified as receiving a Warning Letter with Request for a Business Plan in one or more areas at the top of this letter, please take steps to improve in the non-compliant area(s) identified in Table 1. Should your organization fail to come into compliance, CMS may consider taking additional compliance actions, including a formal request that your organization take corrective action, or an enforcement action. Please prepare a brief business plan that describes how your organization intends to improve its performance in the non-compliant area(s), and then, no later than 30 calendar days after the date at the top of this letter, submit the business plan via email to Gregory.Bottiani@cms.hhs.gov. CMS will not provide a formal response to the business plan.

Corrective Action Plan (CAP):

If your organization was identified as receiving a Corrective Action Plan in one or more areas at the top of this letter it is because CMS issued a Warning Letter with Request for Business Plan in 2011 to your organization and it is again non-compliant in 2012. Your organization should submit a CAP in that area for CMS review and approval to Gregory Bottiani at Gregory.bottiani@cms.hhs.

CMS expects your organization to successfully complete the corrective action plan it provides to CMS in response to this letter. If CMS determines that your organization fails to complete the CAP within timeframe established by CMS when we approve the CAP, we may impose intermediate sanctions (e.g., suspension of marketing and enrollment activities) pursuant to 42 C.F.R. 422, Subpart 0 and/or 42 C.F.R. 423, Subpart 0 or pursue the termination pursuant to 42 C.F.R. 422.510 and/or 42 C.F.R. 423.509.

Star Ratings Implications

The interpreter availability and TTY/TDD service results from the Accuracy & Accessibility study are combined into one score as part of the 2012 Part C and D star ratings, which are factored into Quality Bonus Payments (QBPs).

The calculation of this measure is the number of successful contacts with the interpreter or TTY/TDD divided by the number of attempted contacts. Successful contact with an interpreter is defined as establishing contact with a translator and either starting or completing survey questions. Interpreters must be able to communicate responses to the call surveyor in the call center's non-English language about the plan sponsor's Medicare benefits. Successful contact with a TTY/TDD service is defined as establishing contact with a TTY/TDD operator who can answer questions about the plan's Medicare Part C or D benefit.

a. Part C Interpreter and TTY/TDD Service Combined Results

- Your Part C result: 82%

b. Part D Interpreter and TTY/TDD Service Combined Results

- Your Part D result: 74%

2013 Call Center Monitoring

CMS will continue monitoring interpreter availability, TTY/TDD services, and information accuracy in 2013.

If you have any questions about your organization's results, please contact Gregory Bottiani at Gregory.Bottiani@cms.hhs.gov or (410) 786-6920.

Sincerely,



Cynthia Tudor
Director
Medicare Drug Benefit Group

CC via email:

Scott Nelson, CMS
Gregory Bottiani, CMS
ADRIANNE CARTER, CMS

Appendix A – Part C Questions

#	Question
1	<p>My father does not get extra help and he is not on Medicaid. What is the monthly premium for [PART C PLAN NAME]?</p> <p>Source: PBP, MA Landscape</p>
2	<p>What is my Part B premium amount?</p> <p>Source: Summary of Benefits Report- Important information</p>
3	<p>Does the <PART C Plan Name > reduce my Part B premium? If so, by how much?</p> <p>Source: PBP Benefits Report- Plan Level Data</p>
4	<p>What is the most that my mother would have to pay for an emergency room visit?</p> <p>Source: PBP Benefits Report- 4a</p>
5	<p>My Mother is enrolled in <insert plan name> and wants to know if services provided by a non-network doctor would be covered.</p> <p>Source: Medicare Managed Care Manual, Chapter 4, 100.6</p>
6	<p>What is my total maximum out of pocket cost (MOOP) limit?</p> <p>Source: Bid Reports- Plan Level Cost Shares and Limits Report, April 4,2011 –Final Call letter, page 127.</p>
7	<p>What is my cost sharing for preventive services that are covered at no cost sharing under Original Medicare?</p> <p>Source: CFR 42 422.100 (k) and 417.454 (d)</p>
8	<p>How much do I pay for Chemotherapy services?</p> <p>Source: Bid Reports- Plan Level Cost Shares and Limits Report, April 4, 2011 –Final Call letter, page 132. 42 CFR 422.100 (f)(6)</p>
9	<p>What is my cost sharing amount for renal dialysis services?</p> <p>Source: 4 Bid Reports- Plan Level Cost Shares and Limits Report, April 4, 2011 –Final Call letter, page 132. 2 CFR 422.100 (f)(6)</p>
10	<p>What is my cost sharing amount for care at a skilled nursing facility?</p> <p>Source: Bid Reports- Plan Level Cost Shares and Limits Report, April 4, 2011 -Final Call letter, page 132. 42 CFR 422.100 (f)(6)</p>
11	<p>How much do I pay for flu shots?</p>

	Source: Medicare & You 2012, page 43, Flu shots, Hepatitis B and Pneumococcal vaccine are zero-cost sharing preventive services under original Medicare.
12	Can my dad use a Medigap policy to pay for a Medicare Advantage plan's out-of-pocket costs, like co-pays? Source: Medicare & You 2012, pages 68 and 69.
13	My uncle will turn 65 on June 10, 2012. What is the first day he could have coverage with a Medicare Advantage plan? Source: Medicare & You 2012, page 73 and Medicare Managed Care Manual, Chapter 2, 20.1, Entitlement to Medicare Parts A and B and Eligibility for Part D
14	For <PART C PLAN NAME> will my dad need to get a referral for outpatient diagnostic lab services? Source: PBP Benefits Report, 8a
15	What is the in-network maximum out-of-pocket cost for <Part C plan name>? Source: Plan Level Cost Shares and Limits Report – Plan Level Cost Limits: In-network max enrollee out-of-pocket cost, Medicare & You 2011, page 72, CY 2012 Final Call Letter, April 4, 2011.
16	What is the maximum amount my dad would have to pay for ambulance services in <Part C Plan Name>? Source: PBP Benefits Report, 10a Ambulance Services. Benefit Cost Shares
17	Does <PART C PLAN NAME> cover routine eye exams as either a standard or optional supplemental benefit? Source: PBP Benefits Report, 17a – Routine Eye Exams
18	My mother's health is not so good these days but she really wants to live at home. If she qualifies for home health coverage under your plan will the cost of services like cooking and cleaning be covered under your plan? Source: PBP Benefit Report, 6.
19	In 2012, Is <COUNTY NAME> in <STATE> in <PART C PLAN NAME>'s service area? Source: MA Landscape
20	Does a Medicare Advantage plan cover some hospital expenses or is it only for doctor's office visits? Source: Medicare Managed Care Manual, Chapter 4, 10.4. Original Medicare, Part A and B, Covered Benefits

Appendix B – Part D Questions

#	Question
1	<p>Does <PART D PLAN NAME> plan cover Dilantin 100 mg capsules?</p> <p>Source: formulary files</p>
2	<p>In 2012, is Geodon on the formulary for <PART D PLAN NAME>?</p> <p>Source: Part D Chapter 6, 30.2.5., Protected Classes.</p>
3	<p>In 2012, do people in your plan need prior authorization to get Fuzeon?</p> <p>Source: Part D Chapter 6, 30.2.5., Protected Classes.</p>
4	<p>My mother uses Donnatal. Is it on your formulary?</p> <p>Source: Part D Chapter 6 – 10.9, DESI drugs</p>
5	<p>My mom wants to get a preventive tetanus shot. She has not been injured. Is a preventive tetanus shot covered by Part D?</p> <p>Source: Part D Chapter 6, Appendix C, Attachment II, Vaccines, Question 1.</p>
6	<p>What does “quantity limit” for a drug mean?</p> <p>Source: Medicare & You 2011, page 81.</p>
7	<p>My mom thinks it is cheaper to buy some of her prescriptions at Target and pay \$4.00 for a generic drug instead of using her insurance. If she enrolls in your plan, does she have to show her plan card and buy her drugs through your plan or can she continue to pay for drugs on her own? (Plans from Puerto Rico were not asked this question)</p> <p>Source: Medicare Prescription Drug Benefit Manual, Chapter 14, 50.4.2, Beneficiary Cash Purchases</p>
8	<p>Will my Mom receive anything that summarizes which prescriptions she’s received and how much she’s paid?</p> <p>Source: Medicare Marketing Guidelines, 60.6, Part D Explanation of Benefits</p>
9	<p>If my mom joins your plan, and one of her medications is not covered by your plan, can she at least get a one time, temporary supply of her medicine within the first 90 days of her enrollment in the plan?</p> <p>Source: Medicare Prescription Drug Benefit Manual, Chapter 6, 30.4.1, Transition Requirements</p>

10	<p>Would a copy of a Medicaid card that includes my aunt’s name and eligibility date be acceptable best available evidence for low income subsidy? (Plans in Puerto Rico were not asked this question)</p> <p>Source: June 27, 2007 HPMS Memo “Part D Guidance – Low-Income Subsidy (LIS) Status Corrections Based on Best Available Evidence”</p>
11	<p>What is the drug deductible for <Part D Plan Name>? My mom does not get Extra Help and she is not on Medicaid.</p> <p>Source: 2011 Premium File</p>
12	<p>For <Part D Plan Name> what is the maximum cost share for a one-month supply of a Tier 1/preferred generic drug at an in-network pharmacy?</p> <p>Source: Part D Benefits Report, Benefit – Pre-initial coverage limit- Tier 1, Benefit Cost Shares – In Network Pharmacy: 1 Month Copay</p>
13	<p>Does <Part D Plan Name> offer basic or enhanced Part D benefits?</p> <p>Source: 2011 PDP and MA Landscapes</p>
14	<p>My father does not get extra help and he is not on Medicaid. What is the monthly premium for [PART D PLAN NAME]?</p> <p>Source: PBP, MA Landscape</p>
15	<p>I am thinking of joining your plan but have concerns about the cost of my prescription drugs. If my doctor prescribes a brand name drug that is covered by your plan but I go into this donut hole that I’ve been reading about, will I have to pay full price for the prescription while in the coverage gap?</p> <p>Source: HPMS memo “Medicare Coverage Gap Discount Program Beginning in 2011: Revised Part D Sponsor Guidance and Responses to Summary Public Comments on the Draft Guidance;” 2012 Medicare & You page 88.</p>
16	<p>Do my premium payments count toward the coverage gap?</p> <p>Source: HPMS memo “Medicare Coverage Gap Discount Program Beginning in 2011: Revised Part D Sponsor Guidance and Responses to Summary Public Comments on the Draft Guidance”</p>
17	<p>My mom thinks that she may qualify for your Medication Therapy Management program. Can you tell me about your program and what she needs to qualify?</p> <p>Source: Medicare Prescription Drug Benefit Manual, Chapter 7.30 - Medication Therapy Management Program (MTMP); Medicare & You 2012 page 93; HPMS Memo 9/2/2011 “2012 Medication Therapy Management program eligibility information available via</p>

	the Medicare Plan Finder”
18	<p>My aunt thinks she may qualify for Extra Help for prescription drug coverage from the Social Security Administration. Do you know how she could get information about Extra Help? (Plans with a service area in Puerto Rico were not asked this question).</p> <p>Source: Medicare Marketing Guidelines 80.1.3</p>
19	<p>If I am required to pay an extra amount for my prescription drug coverage because of the IRMAA requirements, can I just add it to my monthly premium payment?</p> <p>Source: 42 CFR 423.293(d), 10/10/2010 HPMS memo titled, “Part D-Income Related Monthly Adjustment Amount—Frequently Asked Questions & Answers”</p>
20	<p>How will I know if I have to pay Part D-IRMAA?</p> <p>Source: 42 CFR 423.286(d)(4); 10/10/2010 HPMS memo titled, “Part D-Income Related Monthly Adjustment Amount—Frequently Asked Questions & Answers”</p>