



CENTER FOR MEDICARE

DATE: December 30, 2020

TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Medicare-Medicaid Plans (excluding PACE contracts, cost contracts, MSA contracts, and employer-only plans)

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SUBJECT: 2021 Part C and Part D Call Center Monitoring - Timeliness and Accuracy & Accessibility Studies

The Centers for Medicare & Medicaid Services (CMS) will continue monitoring Part C and Part D call centers in 2021. This memo describes the elements CMS will monitor and explains how to prepare for the monitoring studies, including updating the Health Plan Management System (HPMS) with critical 2021 call center information **no later than January 4, 2021**.

For 2021, CMS has contracted with Insight Policy Research, and its subcontractors IMPAQ International and Precision Opinion, to monitor the performance of plan sponsors' call centers with respect to the standards adopted to implement 42 C.F.R. §422.111(h)(1) and 42 C.F.R. §423.128(d)(1), as explained in the Medicare Managed Care Manual Chapter 3, Medicare Prescription Drug Benefit Manual Chapter 2, and Medicare Communications and Marketing Guidelines (August 6, 2019), in Sections 30.3 and 80.

The **Timeliness Study** measures Part C and Part D *current enrollee* call center telephone lines and pharmacy technical help desk lines to determine **average hold times** and **disconnect rates**. This study is conducted over four consecutive weeks each quarter, during which an organization is expected to maintain an average hold time of 2 minutes or less and maintain an average disconnect rate of 5% or less. These cut points are unchanged from 2020. Note that thresholds are adjusted for margin of error.

Important definitions for the Timeliness Study:

1. The percentage of calls disconnected is defined as the number of calls unexpectedly dropped by the MA plan or plan sponsor divided by the total number of calls made to the telephone number associated with the contract.
2. The average hold time is defined as the average time spent on hold by the caller following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting and before reaching a live person.

The **Accuracy & Accessibility Study** measures Part C and Part D *prospective beneficiary* call center telephone lines to determine (1) the **availability of interpreters** for individuals, (2) teletypewriter (**TTY**) **functionality**, and (3) the **accuracy of plan information provided by customer service representatives** (CSRs) in all languages. Languages tested in 2021 are unchanged from 2020 and will include English, Spanish, Cantonese, Mandarin, Vietnamese, French, and Tagalog. English will be tested as a foreign language for organizations with a service area exclusively in Puerto Rico. This study will be conducted from approximately February through June 2021.

Important definitions and exclusions for the Accuracy & Accessibility Study:

1. Interpreter availability is defined as the ability of a caller to communicate with someone and receive answers to questions in the caller's language. Interpreters must be able to communicate responses to the call surveyor in the call center's non-primary language about the plan sponsor's Medicare or Medicare-Medicaid benefits. (The primary language is Spanish in Puerto Rico and English elsewhere.) A *call* is considered connected when the caller reaches a CSR. The *measure* is considered *completed* when the CSR, via an interpreter, provides an affirmative response to the introductory question (before beginning the first of three general Medicare or plan-specific accuracy questions) within eight minutes. The percent of completed foreign language calls (number of completed foreign language calls divided by all foreign language calls) is used for star ratings measures.
2. TTY functionality is defined as the ability of a caller using a TTY device to communicate with someone and receive answers to questions at the sponsor's call center directly or via a relay operator. A call is considered connected when the caller reaches a plan. The measure is considered *completed* when the CSR, either directly or via relay operator, provides an affirmative response to the introductory question (before beginning the first of three general Medicare or plan-specific accuracy questions) within seven minutes. An affirmative response to the introductory question must be received back from the CSR, through the TTY or relay operator, in order to confirm that the TTY device is working properly, the CSR is able to communicate through the relay operator, and a connection is made so that all parties can communicate. The percent of completed TTY calls (the number of completed TTY calls out of all TTY calls) is used for star ratings measures.
3. Contracts with *only* Special Needs Plans (SNPs) are excluded from the accuracy measure.
4. Contracts or plan benefit packages (PBPs) under marketing and enrollment sanction are excluded from the study.

Compliance

The standards described above represent CMS' statement of the level at which we expect an organization's call center to perform in order to provide a level of service consistent with standard business practices. We believe the results of the monitoring study are a useful tool for organizations to track the effectiveness of their call center operations. CMS may use the results

of the monitoring study to make determinations concerning the issuance of compliance notices to organizations that fail to meet the regulatory requirements of 42 C.F.R. §§422.111(h)(1) and 423.128(d)(1). As part of that analysis, CMS may exercise our authority to determine non-compliance through the identification of performance outliers, pursuant to §§ 422.504(m)(2) and 423.505(n)(2).

In the event that a plan sponsor believes that CMS may have miscalculated its call center results, the sponsor may bring the relevant information to CMS' attention and ask for a review of the results. Generally, CMS may revise call center results when they are shown to be based on incorrect data. CMS will not revise results based on challenges to the methodology, which has been applied to all subjects of the study.**IMPORTANT ACTION: Verify 2021 Call Center Information**

All applicable Part C and D sponsors and Medicare-Medicaid Plans (MMPs) should prepare for this monitoring effort by verifying the accuracy of their 2021 Part C and Part D call center telephone numbers in HPMS by **January 4, 2021**. Organizations are encouraged to review and update their current and prospective enrollee **toll-free** beneficiary call center telephone numbers, **toll-free** pharmacy help desk numbers, and current and prospective enrollee **toll-free** TTY numbers. Telephone numbers are extracted from HPMS on a weekly basis and updated in the monitoring contractor's automated dialing software. As a best practice, if any of the telephone numbers change during the year, sponsors must update their telephone numbers in HPMS immediately. §§ 422.504(f)(2) and 423.505(f)(2)(vii). CMS strongly encourages all organizations to keep these telephone numbers up to date in HPMS at all times. **If an organization achieves poor results on the measures due to inaccurate telephone numbers, the calls will not be invalidated and the results will not be negated. It is very important that accurate information is available in HPMS prior to the launch of the studies.** Use the paths outlined below to verify and/or update the telephone numbers.

Verify your pharmacy technical help desk number, which is a contract-level contact and not a bid-level contact, using the following path: HPMS home page: - Contract Management - Basic Contract Management - [select contract number] - [enter the contract number] - Contact Data - Pharmacy Technical Help Desk Contact. There are primary and secondary contacts collected in this section. The primary contact is mandatory and the secondary contact is optional. Please note that for call center monitoring purposes, we call only the primary contact.

Verify current and prospective enrollee numbers and TTY numbers through the following path: HPMS home page: - Plan Bids - Bid Submission - CY 2021 – Manage Plans - Edit Contact Data.

Follow these steps when editing contact information in the HPMS:

1. On the Select a Contract screen, enter a contract number into the field provided (Option 1) or select a contract number (Option 2). Click Next to advance to the Update and Save Data screen.
2. On the Update and Save Data screen, select a plan, and select a contact tab.

3. Edit the mailing address, telephone numbers, and e-mail address for applicable contracts.
4. After entering data for the first contact type, the user can complete data entry for other contact types under the same plan.

Notes:

- The required fields (denoted with an asterisk) vary depending on the type of contact. For example, the toll-free telephone number is required for Medicare Part D contact types, but is optional for other types in HPMS. The regulations, at §§ 422.111(h)(1) and 423.128(d), require the operation of a toll-free customer call center; the Medicare Communications and Marketing Guidelines, Section 80.1, provides guidance on this requirement for Medicare Part C organizations, Medicare Part D organizations, and MMPs. MMPs also have state-specific marketing guidance that requires the toll-free number. The Part D regulation, at § 423.128(d)(1)(ii), requires the toll-free call center to also provide service for pharmacists; our guidance, in the Medicare Communications and Marketing Guidelines (August 6, 2019), Section 80.5, explains how this means that Part D Sponsors and MMPs must operate a toll-free pharmacy technical help call center. MMPs also have state-specific marketing guidance that requires the toll-free number. ***Even if HPMS does not denote this as a required field in your view, having toll-free numbers available is required.***
- **All TTY numbers must be either three numeric characters or ten numeric characters and entered into HPMS.**

Please make certain you have entered into HPMS the **TTY local telephone number** and the **TTY toll- free telephone number**. If your plan does not use a dedicated, in-house TTY device, you may enter 711 in both fields, or you may enter the toll-free ten-digit number for a specific state relay service. The toll-free TTY telephone number must be populated, as this is the telephone number we pull for the Accuracy & Accessibility Study. All TTY telephone numbers must be either three numeric characters or ten numeric characters to be entered into HPMS.

This information can be found in Chapter 1 of the CY2021 Bid User Manual (*HPMS home page - Plan Bids - Bid Submission - CY2021 - View Documentation (under “Documentation” Section) -Bid Submission User manual for Contract Year 2021*).

Tips for Success/Best Practices

Based on several years of study results, CMS provides the following tips to help improve results.

General:

- Provide basic services and information to individuals with disabilities, upon request.
- Make available all plan materials and information, including those produced or distributed by contracted providers, in alternate formats (e.g., braille, large print, and

audio and data CDs) to individuals with disabilities upon request.

We monitor thousands of plans whose IVR options are all unique. This means it is not practical or possible to train our interviewers to always make the same selection in an IVR, and we cannot program what options they should select for each plan. We train them to listen for options such as “current members,” “pharmacy,” or an option for those “interested in learning more about enrolling” for prospective calls, for example. When you are setting up your IVR options, please keep this in mind. We suggest that you train your representatives to offer a warm transfer to the correct department if a caller is misdirected. Successful call outcomes may occur if the representative will offer a warm transfer, allowing us to reach a representative who can answer our question. Simply saying, “You need to call another number” or answering “no” to the introductory question, “Are you the right person to answer questions about....” will result in an unsuccessful call outcome. We call the telephone number listed in the HPMS as provided by the plan and make the most reasonable selection in the IVR, so we expect to reach a CSR who can answer questions about the plans, or at least transfer us to the correct party who can answer those questions.

HPMS Entries:

- Current, prospective, and TTY/relay services customer service call center toll-free telephone numbers must be entered in the appropriate locations in HPMS. There is a toll-free field for TTY or Telecommunications Relay Service (TRS) telephone numbers. CMS extracts the values found in the toll-free *and* alternate toll-free fields, so please make sure HPMS reflects accurate contact information and is complete in every field. If you have updates at any time during the year, please enter them into HPMS immediately. A delay in updating the telephone number(s) prior to the start of the study may result in unsuccessful calls attributed to your plan’s performance. Calls of this nature cannot be negated.
- Contact the HPMS Help Desk at hpms@cms.hhs.gov or 1-800-220-2028 if you require assistance.

Ability to Accept Calls:

- Callers to current enrollee and prospective enrollee customer service call centers need to be able to communicate with a live person when they call from 8:00 a.m. to 8:00 p.m. Messages that ask a caller to leave their telephone number are not appropriate, and will not be counted as a successful call.
- CMS’ monitoring reveals that our callers experience longer-than-normal hold times at the beginning of the year. Generally speaking, CMS also notes longer hold times at the beginning of a week with improvement as the week progresses. Call centers should evaluate their own needs and consider increased staffing during busier times.
- If your organization intends to implement any new technology affecting telephone systems, ensure it will not interfere with the organization’s ability to accept calls,

including TTY communications.

- CMS makes the following suggestions for self-monitoring your call centers on a regular basis:
 - Test every telephone number supported by the call center.
 - Pull the telephone numbers from HPMS and ensure they ring to the intended location.
 - Test by making calls from outside the organization's telephone systems. If the plan is located off the mainland, have someone place test calls from the mainland to the plan.
 - Test with more than one caller at the same time.
 - See TTY section below for specific TTY testing suggestions.
- CMS will occasionally solicit volunteers for abbreviated training periods prior to the beginning of an actual study launch. This is done by randomly selecting organizations to ask if they wish to volunteer. If you are launching new technology in your call center, consider joining a pilot or interviewer training session to ensure your equipment is working as expected. Contact CallCenterMonitoring@cms.hhs.gov to discuss your desire to participate in the next pilot or interviewer training session.
- **Ensure that your organization does not employ IVR logic or other functions that will block calls at certain times based solely upon the area code of the caller.** CMS calls from the Columbia, Maryland, area in the Eastern time zone, and we call from the Las Vegas, Nevada, area in the Pacific time zone. We call regions from the Atlantic time zone as far west as Guam. We will call you during the business standard hours of operation (8:00 a.m. to 8:00 p.m. in the time zone(s) the plan serves). If our call cannot reach a live representative due to programming on your end, and we hear messages stating the office is closed during the required hours of operation, the call will be counted as unsuccessful.
- Carefully review your service areas to ensure you are covering the call center is open and provides services at least in accordance with standard business practices. This means that the current and prospective enrollee call centers are open minimally from 8:00 a.m. to 8:00 p.m. for all of your plans' local service areas. Check carefully to verify your coverage for any counties that are split into two time zones or to confirm observance of daylight savings time. For example, some contracts will occasionally serve counties that are split into two time zones. Also, most of Arizona is exempt from daylight savings time. However, the Navajo Nation lands, which extend to the states of Arizona, New Mexico and Utah, observe daylight savings time. Regardless of whether two time zones are served or daylight savings time is or is not observed, call centers are required to be open minimally from 8:00 a.m. to 8:00 p.m. in all local service areas for all of its current or potential enrollees.
- **Ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu. This is important for both studies.** Every year CMS encounters plans that offer limited IVR options without a clear

way to select the option to speak with a current member representative or a prospective beneficiary representative, and the IVR message cycles over and over without a live representative answering the telephone. This results in unsuccessful calls due to time-outs. Test your systems. When planning the IVR choices, ask yourself, “If I am calling to get information so I can decide if I want to enroll in this plan, is there an IVR option for me on this prospective beneficiary telephone number?”

- Ensure callers with a private number are able to connect to your plan’s customer service telephone numbers.
- Train CSRs to answer the introductory question asked of them (“Are you the right person to answer questions about...?”) When we call current member customer service lines, we only ask a question intended to determine if we have reached a person who has authority to answer questions about the Medicare plan we are calling. If the CSR insists on first knowing the caller’s name, date of birth, membership ID number, or Social Security Number or refuses to answer the introductory question by stating “no,” the call will be counted as an unsuccessful call unless the party transfers the call to a person who can answer “yes” in a timely manner. Note that we only need to confirm we have reached a CSR who has authority to answer questions so we can measure the average hold time to reach a live CSR, but we do not ask any actual benefit-related questions when we call the *current member* customer service line or the pharmacy technical assistance help line.

Interpreter Availability:

- Utilize an interpretation service to identify the beneficiary’s language.
- Use interpreter services personnel who are familiar with healthcare terms and Medicare benefit concepts.
- Train CSRs to connect foreign-language callers with an interpreter.
- Ensure CSRs stay on the telephone when a foreign-language interpreter joins the call.
- In order to replicate a beneficiary’s actual experience, CMS telephone interviewers who are testing a language other than the primary language will not make a selection in the IVR system if the instruction is only in the primary language. Therefore, ensure IVR systems default to a live CSR/operator if the caller does not push any buttons or make a verbal selection from an options menu. If the IVR instruction is available in the language being tested, the test callers will make an appropriate IVR selection. For example, if the language being tested is French, *and instruction is available in French in the IVR* to select an option for French, the test caller will make that selection. (Please note that the primary language in Puerto Rico is Spanish and English elsewhere. When testing calls in Puerto Rico, English is considered a foreign language.)
- Include a note on the beneficiary’s call center record that indicates his/her preferred language, if other than English. Record and maintain that information in a tracking

system to be used in future beneficiary contacts.

- Monitor CSR calls to ensure that foreign-language calls are being handled according to the plan sponsor's policies and procedures.
- Ensure that interpreters are available within 8 minutes of the caller reaching a CSR.
- Ensure that CSRs are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.

TTY Functionality:

- CMS makes the following suggestions for testing in-house TTY devices:
 - Regularly test your device to ensure that it is working properly.
 - Have outside callers call in and test the system. (If in Puerto Rico, Guam, or island off the mainland, have someone on the mainland call into your TTY system to test.)
 - Have two callers from outside the system call at the same time to make sure there is no disruption on either call, calls don't get disconnected, or garbling does not occur.
 - When testing, check for garbled language on both sides of the call.
 - Whenever you make a telephone system change, retest all TTY systems.
 - If you have an outgoing message on your in-house TTY system that states to callers that if they called this number by accident, they should call the main number instead at xxx-xxx-xxxx, confirm that a TTY-recognized call will roll over to a TTY operator. This should be tested by calling from a telephone line *and* a TTY line.
 - Verify with your telecom provider that TTY calling is supported, in case there are any settings on the carrier side that need to be adjusted.
 - If using TTY Voice over Internet Protocol (VOIP), analyze network bandwidth utilization to confirm no packet loss. If there is packet loss, internet speed will need to be increased.
- If using an in-house TTY device, have a staffing plan that includes coverage for the TTY device during the hours your call center is required to operate with live CSRs.
- If using an in-house TTY device, ensure CSRs always use "GA" for "Go Ahead" after s/he has communicated his or her opening remark or other response via TTY device, so the other party knows it can now safely transmit its next thought. Failure to use "GA" may confuse beneficiaries who are familiar with TTY systems and could result in a plan hanging up on a TTY caller who has not responded, because the caller is waiting for the "GA" as clearance to respond.
- Ensure that beneficiaries using relay services can reach a CSR who has been trained on how to best communicate through a relay operator.
- CMS considers a CSR unavailable if the caller or relay operator is unable to communicate with the CSR.

- Ensure that CSRs communicating to beneficiaries through relay operators are able to respond promptly to questions. By protocol, each accuracy question has a 7-minute timer.
- The decision to use 711 for the national relay operator or a different 10-digit number for a state relay operator is a business decision made by the plan. If you use a state relay operator, be certain that all callers can successfully connect on that number, regardless of the caller's area code. Our test calls will be placed from the Columbia, Maryland, area (443 area code). It is the plan's responsibility to ensure that calls from this area code can be received via their relay operator.

Information Accuracy:

- Ensure that CSRs are trained on requirements listed in the Medicare regulations, consistent with our guidance in the Medicare Communications and Marketing Guidelines (updated August 6, 2019), Sections 30.3 and 80.
- Review the 2021 edition of *Medicare & You* to ensure your CSRs are trained on new Part C and Part D benefit information for 2021.
- CSRs should have specific plan benefit package (PBP) level benefit and formulary data easily available.
- Because the time is limited to 7 minutes for each of the general accuracy questions, a best practice for CSRs is to speak at a high level first and offer more detail if asked.
 - When we ask our introductory question, ("Are you the right person to answer questions about...?"), it is always best for the CSR to respond "yes" or "no," meaning yes, the CSR is the correct person to answer questions about a specific plan's benefits, or no, the CSR is not the correct person to answer questions about the plan's benefits. The CSR should then offer a "warm transfer" to the caller so that he or she may speak to the appropriate person. If the CSR responds at this high level first, it will save time, especially if the caller needs to be transferred to another party. If the CSR spends a great deal of time trying to get more information from the caller, the timer may expire, resulting in an unsuccessful call in the plan's performance.

Guidance for Providing Services to Limited English Proficient Beneficiaries

CMS reminds organizations of the HHS Office of Minority Health's (OMH) *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)*. Originally published in 2000, an enhanced version of the *National CLAS Standards* was released by OMH in April 2013. The *National CLAS Standards* offer health and health care organizations 15 action steps for providing culturally and linguistically appropriate services (CLAS). The *National CLAS Standards* are intended to advance health equity, improve quality, and help eliminate health care disparities. The Principal Standard is to "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other

communication needs” and serves as the overarching goal for *National CLAS Standards*’ implementation. One key area is Communication and Language Assistance, which includes: offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (Standard 5); informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (Standard 6); ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (Standard 7); and providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (Standard 8). The *National CLAS Standards* are available at ThinkCulturalHealth.hhs.gov/clas. CMS strongly encourages sponsors to review and utilize the *National CLAS Standards* and its guidance document, *The Blueprint*. To learn how to communicate in a way that considers the cultural, health literacy, and language needs of individuals, please visit OMH’s free e-learning program, [The Guide to Providing Effective Communication and Language Assistance Services](#). If you have any questions about the *National CLAS Standards*, please contact AdvancingCLAS@ThinkCulturalHealth.hhs.gov.

Call Center Monitoring Reference Materials

Technical Notes/Frequently Asked Questions and Data Dictionaries for each study are stored in HPMS via links in the lower left corners of the Performance Metrics pages. Please refer to pages 2 and 3 above for the location of the studies’ results. This same location is where you will find these reference materials.

If you have any questions about the 2021 call center monitoring effort, please contact the Call Center Monitoring mailbox at CallCenterMonitoring@cms.hhs.gov. Please do not use secure email when communicating with this resource. CMS monitors thousands of plans and cannot register for secure email with each entity. We never share personally identifiable information on this project. If you need to send something securely, send an email first so we can arrange a call to discuss a mutually agreeable password for the document you wish to send.