



**Office of External Affairs**

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## **MEDICARE NEWS**

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### **MEDICARE DETAILS STEPS TAKEN TO IMPROVE CUSTOMER SERVICE BY DRUG PLANS Data Shows Improvements in Plan Call Center Wait Times**

Since January, Medicare has taken more than 1,000 compliance actions to improve prescription drug plan service to beneficiaries, and in most cases, these actions have resulted in timely responses by the drug plans. Cases when plans did not resolve issues promptly have resulted in further enforcement actions to achieve compliance, such as restricting plans' ability to enroll beneficiaries. One plan with recurrent service problems has been placed on a track that may result in termination.

"People with Medicare should be confident that their prescription drug plans are providing the highest level of care available," HHS Secretary Mike Leavitt said. "While most beneficiaries report satisfaction with their coverage, we want to make sure that beneficiary complaints are being addressed and resolved quickly."

Mark B. McClellan, M.D., Ph.D., Administrator of the Centers for Medicare & Medicaid Services (CMS) said "We are taking actions to find and fix any problems that beneficiaries may have with their drug plan delivering the level of service required by Medicare. We have tens of millions of beneficiaries with drug coverage, we are filling millions of prescriptions a day at a much lower cost than expected, and we will remain vigilant about quality service throughout the Medicare program."

Medicare's oversight has included monitoring the performance of plans' call centers. In a review of drug plan centers conducted in April and May 2006, CMS and HHS found:

- 92 percent of all calls made to Medicare prescription drug plans are answered within five minutes.
- The average wait time for a beneficiary help line is less than one and a half minutes.

CMS will continue to monitor plans to assure that they maintain low wait times. Updated plan-by-plan reports on call center performance will be reported by CMS ahead of the next open enrollment period in the fall.

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Medicare's oversight actions begin with direct contacts with drug plans, which usually result in resolution of the problem. In cases where this action does not lead to timely resolution, Medicare follows up with a formal notice to the plan. Since the drug benefit began, Medicare has issued:

- 651 warning letters to plans, for topics such as posting errors on the Medicare Personal Plan Finder;
- 152 notices of non-compliance, for topics including failure to meet call center performance requirements, particularly in the early months of the program; and
- 318 requests for specific business plans, on topics such as improving call center performance and the submission of correct information for the Medicare Personal Plan Finder.

In most cases, these compliance actions led drug plans to resolve the problem. In cases where the plan does not effectively resolve the issue, Medicare has taken further enforcement action. These actions include:

- Temporarily restricting plan marketing by removing information about the prescription drug plan from the Personal Plan Finder. Medicare has taken such action on 75 occasions, including cases when plans continued to provide incorrect information about drug prices and formularies. Examples include failing to include required drugs in the plan formulary lists, and restricting access to certain drugs in circumstances where utilization management is not allowed (for example, utilization management restrictions on certain drugs for HIV/AIDS). These actions to "suppress" plan marketing resulted in plans taking action to correct the compliance problem.
- Imposing a corrective action plan (CAP) on one plan. This Medicare Advantage prescription drug plan was required to submit the corrective plan to assure access to "transitional" coverage of all current medications for new enrollees.
- Pursuing the termination of an organization's prescription drug plan and Medicare Advantage plan contracts, for a persistent pattern of failure to comply with Medicare requirements.

Plans are expected to work directly with beneficiaries to resolve their complaints, but for cases where that does not work, CMS has established a complaint tracking process for receiving and resolving individual complaints about plan service. As part of this process, CMS monitors the number and type of complaints from calls to 1-800-MEDICARE and those referred through CMS local offices. These complaints may come from beneficiaries, family members, pharmacists, and others who assist seniors and people with a disability.

In the past month, CMS has received approximately 2.2 complaints per 1,000 Medicare beneficiaries enrolled in prescription drug plans. The complaint rate for stand-alone prescription drug plans has averaged about 2.5 per 1,000 beneficiaries, and the complaint rate for Medicare Advantage prescription drug plans has averaged about 1.6 per 1,000 beneficiaries. Most of these involve complaints about enrollment or disenrollment in a plan (the most common type in recent

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months), complaints about difficulty in getting needed drugs, and complaints about the cost of the drugs or incorrect co-pays at the pharmacy counter. Patterns of complaints, and complaints that cannot be promptly resolved with a drug plan, result in the further enforcement actions described previously.

CMS will continue to monitor the performance of Medicare prescription drug plans and expects to issue plan-level information on complaints about beneficiary service beginning in mid-July. Additional plan-level performance data will be issued well before the annual open enrollment period begins on November 15.

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