

Date: December 7, 2001

To: All Medicare+Choice Organizations

From: Gary A. Bailey, Director /s/

Re: **Instructions for Corrections to 2002 Annual Notices of Change and Summaries of Benefits**

In early November, the CMS regional offices (ROs) conducted a retrospective review of 2002 Annual Notices of Change (ANOCs) and Summaries of Benefits (SBs). The purpose of the review was to evaluate the effectiveness of the streamlined marketing review process in order to determine its applicability to future marketing reviews. The purpose of this memorandum is to outline the process that Medicare +Choice organizations (M+COs) must take to correct any errors identified either through the evaluation of the M+CO by the RO or by the M+CO itself. As outlined in my June 14 memorandum (“Instructions for Delay in ACRP and Outpatient Hospital and Physician Encounter Data Submissions”), M+COs are expected to send errata sheets in cases of errors to ANOCs and SBs.

The evaluation conducted by the ROs generally focused on the benefits and cost sharing information contained in the ANOCs and SBs. For background information on the evaluation, please refer to Attachment A, which briefly outlines the evaluation process and preliminary findings. Attachment B contains a list of Questions and Answers intended to supplement the description of the process.

Categorization of Errors

The preliminary results of the evaluation have enabled CMS to organize errors into two categories:

Category 1: Errors that may influence beneficiary decision-making. This category includes errors that the reviewer believes could impact beneficiary decision-making and that:

- Incorrectly described 2002 benefits,
- Incorrectly described benefit changes between 2001 and 2002 (or failed to do so altogether), and/or,
- Resulted in having benefits described in the ANOC and/or SB that were not supported/approved in the ACR.

The following errors would also be Category 1 errors if they are considered to be severe enough that they may influence decision-making:

- Errors that, depending on their severity, include vague, unspecific reference to benefit changes in the ANOC;

- A failure to follow the SB instructions (including benefit description language in the SB that varies from the mandated language);
- Misleading or confusing language; and,
- Other miscellaneous language problems.

Example 1: The M+CO erroneously states in the ANOC that the prescription drug maximum was increasing from \$1,000 to \$1,500, but in fact it was really decreasing from \$1,000 to \$500.

Example 2: In the ANOC, the M+CO omits a change in the comprehensive outpatient rehabilitation facility (CORF) copay from \$5 to \$10.

Category 2: Errors that probably would not influence beneficiary decision-making. This category includes:

- Footnote errors;
- Language in the SB that varies from the mandated language (as long as it doesn't affect the description of a benefit); and,
- Language that is prohibited in the marketing chapter of the M+C manual, including value added items and services.

Required Corrective Action

Your organization will be notified by your RO by December 11 of which materials were reviewed during the evaluation process and of any errors/error categories. The M+CO should also review its materials for accuracy.

Please note that not all regions reviewed 100% of ANOCs and SBs. Your region will let you know if you have ANOCs/SBs that were not reviewed. Whether your ANOCs and SBs were reviewed or not, you are expected to review those materials for errors and to take the appropriate corrective action as outlined below.

The corrective action your organization must take will depend on the error category identified by the RO reviewer. In all cases, correction materials will require prior approval from the ROs.

Note: If you made any changes in the cost sharing of your benefits based on recent discussions with CMS and subsequently received a letter from CMS outlining notification to members of changes in cost sharing amounts, you will still need to follow these instructions if other errors were identified on your ANOC/SBs. If your errors require you to send a notice to members (as outlined below), you may combine the notice with any notice about changes in cost sharing amounts.

Category 1 Corrective Action

If a Category 1 error is identified, the M+CO must:

1. Notify current members with errata sheets by December 18, 2001. The errata notice must state that if the member has already sent an enrollment form to a new plan or sent in a request to disenroll to Original Medicare because of the information that was in the original ANOC/SB sent to the member, the member still has time to switch back and remain a member of your plan. Provide instructions for how to “switch back.

Exception: If the M+CO is able to identify the specific population that is affected by the error(s) (e.g., ESRD members), then it may send this notice only to those affected members. In this case, the M+CO must also notify all current members in the next issue of the member newsletter or the next mass mailing to members.

2. Correct SBs for distribution to new prospects with redline/strikeout, errata sheets, or reprinting by December 18, 2001. Also for new prospects, the M+CO must immediately print errata sheets for use with SBs that are distributed prior to the corrections due by December 18, 2001.

NOTE: If the materials contain both Category 1 and Category 2 errors, corrected materials must correct both types of error(s) identified by the reviewer.

In addition, all of the above-mentioned materials must receive RO approval prior to distribution. The ROs will provide an expedited 5-business day review of the materials.

Category 2 Corrective Action

If a Category 2 error is identified (with no Category 1 errors), the organization must:

1. Correct SBs for distribution to new prospects with redline/strikeout, errata sheets, or reprinting by January 11, 2002.
2. Develop an errata sheet to the ANOC and/or SB in the form of a cover letter to accompany the mailing of the 2002 EOC to current members.

The above-mentioned materials must receive RO approval prior to distribution. The ROs will provide an expedited 5-business day review of the materials.

If you have any questions, please contact your RO Plan Manager.

Attachment

Attachment A

Evaluation Process

The following retrospective review protocol was developed:

- Regional office marketing reviewers retrospectively reviewed at least one ANOC and one SB from each of their contracting M+COs. In cases where an M+CO offered more than one benefit package (resulting in more than one ANOC and SB), the RO reviewed 20 percent of all ANOCs and SBs distributed by that M+CO. Some of the regions reviewed 100 percent of all ANOCs and SBs distributed by M+COs in their regions.
- For the ANOCs, the ROs reviewed the ACR-related information that was not reviewed during the original review (i.e., benefit changes from 2001 to 2002).
- For the SBs, the ROs reviewed all of Section 2, including both verbiage and ACR-related information. Additionally, they reviewed ACR-related information in Section 3.
- All errors found by reviewers were categorized into two major error categories (i.e., benefit problems and language problems such as not using standard SB language) and then further broken down into 17 subcategories.
- Each region tallied the total number of errors by category.
- Each region will subsequently organize errors according to Categories 1 and 2 outlined in this letter.

Preliminary Results

At this time, we do not have 100 percent of the results. However, preliminary results demonstrate that a number of SBs and ANOCs to M+C members contained incorrect information.

An analysis of the types of errors in the documents reflects that the majority of errors were made in the description of the benefit package, either through errors in beneficiary cost-sharing amounts (SB or ANOC), omission of benefit changes between 2001 and 2002 (ANOC), or benefits that were not supported in the ACR documentation (SB or ANOC).

Attachment B

Questions and Answers on Correcting Errors In 2002 Benefit Materials

1. Who is required to notify members of corrections to 2002 benefit materials?

A: M+COs were notified on June 14, 2001, that if an M+CO's approved ACR differed from the mailed marketing materials, that the M+CO would be required to mail all enrollees an addendum before January 1, 2002.

The June 14 memorandum can be found at <http://www.hcfa.gov/medicare/instr.rtf>, with supplemental Questions and Answers posted at <http://www.hcfa.gov/medicare/Q&As.rtf>.

All M+COs that distributed materials with errors that would or could influence a beneficiary's enrollment decision will be required to provide errata sheets to members. (See Category 1 errors.)

2. Does this requirement pertain to errors in all materials describing 2002 benefits, or just the ANOC and SB?

A: These instructions only pertain to errors in the ANOC and SB for 2002. Further instructions regarding other beneficiary material may be forthcoming as necessary to ensure accuracy of all materials.

3. Does this requirement apply to cost plans?

A: We did not use the streamlined marketing review process for cost plans, so these requirements do not apply to them.

4. Will approval of the errata sheets and/or newsletter articles go through the normal marketing review process?

A: Errata sheets and any newsletter articles must be submitted to your RO for prior review and approval. However, to expedite the review process so that members may receive corrected information as quickly as possible, CMS will implement a 5 business-day review process.

5. Given that CMS is piloting a streamlined marketing review process for 2002 benefit materials, why are we required to submit errata sheets and any newsletter articles to the regional office for prior approval?

A: We consider these correction notifications to be marketing materials and are requiring RO prior review and approval to ensure that members and prospective enrollees receive correct information.

6. How will we be notified of the corrections that must be made?

A: Your RO will notify you in writing of the necessary corrections identified by the evaluation. You will also need to notify the RO of any errors you identify in your review of materials.

7. What if we disagree with a benefit “correction” required by the regional office? For example, what if they require us to change a copay to an amount we believe is not correct?

A: The RO is conducting retrospective reviews of the ANOCs and SBs from M+COs whose ACRs have been approved by CMS. They are basing their reviews on benefit information in the approved ACR. If you disagree with a correction they are requiring, this may indicate a discrepancy between the benefit in the approved ACR and the benefit you believe you are offering. If there is a discrepancy and your M+CO would want to correct this ACR information, you should contact Phil Doerr (CMS Central Office) at 410-786-1059 or pdoerr@cms.hhs.gov for instructions on how to proceed. If there is no discrepancy and you believe that no correction is necessary, you should contact the RO to resolve the issue.

8. Will we be required to correct information that will not likely cause confusion related to enrollment decisions?

3. A: If you have only Category 2 errors (i.e., you have no Category 1 errors), you are not required to issue correction notices or print newsletter articles to correct the errors. However, you are required to correct SBs for distribution to new prospects with redline/strikeout, errata sheets, or reprinting. You are also required to include a cover letter with your mailing of the 2002 EOC indicating where you made errors in your ANOC and/or SB. Because of this, RO staff will notify you of the errors in Category 2 at the time they notify you of the errors in Category 1.

9. Is there a deadline by which we must send Category 1 correction notices?

A: Correction notices must be sent to members by December 18, 2001.

10. If we identified errors in the ANOCs and SBs prior to notification by CMS and we have already sent materials to members correcting these errors, must we include those corrections in any further notification required by CMS?

A: No. If you have already notified members of some of the errors identified by CMS and have informed members in writing of the corrections, you are not required to include those corrections again in a later notice. However, if you did not identify all of the errors that would or could influence member enrollment decisions, then you are required to prepare a correction notice to inform members of those previously unidentified errors.

11. If an M+CO distributed ANOCs and SBs to its members that contained benefit errors, does this create an SEP for members in that M+CO who would have chosen

to enroll in a different M+CO for 2002 if they had received correct benefit information in the ANOC and SB they received in mid-October?

A: As mentioned in the June 14 memorandum, all beneficiaries were given a Special Election Period (SEP) through the end of December. After December, a beneficiary may have rights to an SEP if s/he can demonstrate to the CMS RO that an M+CO materially misrepresented the plan's provisions [benefits, premiums, copays, rules] in marketing the plan to the individual (as allowed at 42 CFR 422.62(b)(3)(ii)).