Centers for Medicare & Medicaid Services

OFFICE OF THE MEDICARE OMBUDSMAN

2007–2008 REPORT TO CONGRESS

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Daniel J. Schreiner
Medicare Beneficiary Ombudsman

A MESSAGE FROM THE MEDICARE BENEFICIARY OMBUDSMAN

I am pleased to present the combined 2007–2008 Office of the Medicare Beneficiary Ombudsman Report to Congress and to the Secretary of Health and Human Services. Section 923 of the Medicare Modernization Act added Section 1808(c) to the Social Security Act, which calls for the Medicare Beneficiary Ombudsman to advocate for people with Medicare. The primary function of the Medicare Beneficiary Ombudsman is to provide assistance to people with Medicare on Medicare-related issues, such as complaints, grievances, inquiries, and appeals, and to provide recommendations for improvements in the administration of the Medicare Program. Although the Office of the Medicare Ombudsman (OMO) is relatively new, it has made considerable progress advancing its advocacy mission, as described in this report. We would not have made this progress without the continued efforts of a dedicated staff and the support of many throughout the Centers for Medicare & Medicaid Services' (CMS) Central and Regional Offices—especially those in the CMS Office of External Affairs.

During 2007 the OMO directly handled nearly 22,000 Medicare related inquiries and complaints, and handled nearly 16,000 in 2008, many of which were complex questions or concerns, from or on behalf of people with Medicare or their representatives. A major focus of the OMO over the past two years has been the continued development and implementation of an issue-management process. This process identifies systemic Medicare Program issues impacting the ability of people with Medicare to access or fully utilize Medicare benefits and services, and enables the OMO to track issues and trend relevant data and information from multiple CMS sources.

One of the outcomes of the issue-management process is the regular reporting of complaint trends and associated issues to CMS Senior Leadership and the Administrator. Much of this work is accomplished in collaboration with colleagues from the CMS Consortium for Health Plans Operations, Consortium for Financial Management and Fee-for-Service Operations, and the Office of Beneficiary Information Services through regular meetings with the CMS Chief Operating Officer. The OMO will continue to build on its ability to gather information on Medicare Program issues and their impacts on people with Medicare. Various tools will be used to capture this

information, such as the Medicare Administrative Issues Tracking and Reporting of Operations System (MAISTRO) for tracking Medicare Fee-for-Service inquiries and complaints and the OMO Beneficiary Contact Trend (BCT) report that consolidates data on inquiries, complaints, and appeals from several CMS data sources.

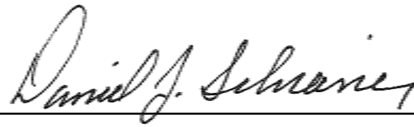
CMS has made significant strides toward improving service to people with Medicare. However, with such an expansive program that serves over 44 million people, there still is work to be done. As identified in this report, there are several key areas for improvement, such as implementing best practices to serve Medicare beneficiaries optimally, addressing system issues that impact people with Medicare, mitigating further Medicare private fee-for-service marketing abuses, improving communications about Medicare to target populations, and addressing coverage issues that result from inpatient/outpatient services. This report includes a review of these areas, as well as recommendations for improvements.

As the population that is served by the Medicare Program continues to expand, CMS must continue to work to ensure that adequate assistance and protections are in place for Medicare beneficiaries. The implementation of Medicare Part D highlighted the need for the Medicare Program to focus on individuals. In the beginning of Part D implementation, CMS focused on group-based or population-based outreach in efforts to reach as many Medicare beneficiaries as possible, with a particular emphasis on meeting their specific needs. Now the differences among Medicare drug plans in a particular state or region and the level of service a person with Medicare receives within a given drug plan add to the complexity and the need to provide individualized information and assistance based on the various options.

The OMO is located within CMS as a part of its organizational structure and simultaneously is charged with making recommendations for Medicare improvements. This creates special challenges because, to be effective, the OMO needs to maintain a level of independence as a best practice. Currently, the OMO reports directly to the Office of External Affairs and the Office of the Administrator. This structure has allowed the OMO to have a "place at the table" in discussing needs for change and recommendations for improvements. One key to the success of the OMO within this structure is to walk the fine line between playing a primary advocacy role for people with Medicare while still maintaining the distance required for an Ombudsman effectively to recommend improvements to the Agency. This Office remains intensely dedicated and will continue to work with CMS components and partners external to CMS to advocate for continuous improvement on behalf of people with Medicare.

As the Medicare Beneficiary Ombudsman, I am proud of the accomplishments of this Office and look forward to the continued challenges, as we continue to track and trend complaint data on all parts of Medicare. This Office also will work to assist in the development of a framework to provide information to future Medicare beneficiaries, and is focused on providing information,
education, and guidance though a variety of media outlets, including web-communities. Through

all these activities and initiatives, we will continue to maintain our focus as an advocate for people with Medicare and those who act on their behalf.



Daniel J. Schreiner
Medicare Beneficiary Ombudsman

TABLE OF CONTENTS

EXECUTIVE SUMMARY **1**

Structure of the Report 1
Synopsis 2
The OMO's Activities 3
Key Issues 4
Looking to the Future 4

THE ORGANIZATION **5**

Provisions of Section 923 of the Medicare Modernization Act of 2003 5
Networking to Listen for and Identify Issues 6
Monitoring Feedback from CMS Partners 7
Collaboration with Internal CMS Components 8
Accomplishments 9
The Scope of the Medicare Program 10
Change of Medicare Program Focus from Payer of Claims to Beneficiary Services 11
Statutory History 11
Administrative Developments 12
The Medicare Program Today 13
Key Challenge – Developing a Customer Assistance Program for People with Medicare 14
Ultimate Responsibility for Beneficiary Services and Interests 15
Key Challenge – Enhanced Prevention Efforts to Improve the Health of Medicare Beneficiaries 16
Key Challenge – Ombudsman Independence 17
Office of the Medicare Ombudsman Structure 19
Organization 19
Key Focus Areas 21

ACTIVITIES **23**

Partnering Initiatives 23
State Health Insurance Assistance Program: Technical Assistance Program (SHIP TAP) 24
Medicare Ombudsman Webpage 25
Issue Management 28
Medicare Administrative Issue Tracker and Reporting of Operations System 39
Complaints Tracking Module Weekly Summary Reporting 41
Beneficiary Contact Trend Reporting 41
Medicare Beneficiary Casework Management 66
CMS National Casework Call 66
HHS Portal 68
Training 69
Providing Services to People with Medicare 70
Division of Medicare Ombudsman Assistance Casework 70
Beneficiary Customer Service Feedback Survey 72
Casework Collaboration 73
Outreach and Education 73
Division of Ombudsman Exceptions 73

ISSUES AND RECOMMENDATIONS **76**

Issue: Need to Implement Best Practices to Serve Medicare Beneficiaries Optimally 76
Multiple Points of Contact for People with Medicare 78
No Formal Integration Process 78
Multiple Customer Service Correspondence Management Tools 79
Need for Comprehensive Oversight of Medicare Contractor and Health Plan Customer Service 80
Issue: System Issues that Impact People with Medicare 82

ISSUE: MEDICARE ADVANTAGE MARKETING ABUSES 85
ISSUE: IMPROVING MEDICARE COMMUNICATIONS TO TARGET POPULATIONS 89
ISSUE: COVERAGE ISSUES THAT RESULT FROM DETERMINATIONS AND BENEFICIARY UNDERSTANDING OF WHETHER SERVICES ARE INPATIENT OR OUTPATIENT 91
Use of Observation Services and the Effects it has on Beneficiaries 91
Meeting Qualifications for Covered Skilled Nursing Facility Admissions 93
Beneficiaries Billed for Self-Administered Drugs 93
Condition Code 44 95
Medicare Notifications 96

SUMMARY OF THE MEDICARE OMBUDSMAN'S RECOMMENDATIONS 99

RECOMMENDATIONS FOR THE NEED TO IMPLEMENT BEST PRACTICES TO SERVE MEDICARE BENEFICIARIES OPTIMALLY 99
RECOMMENDATIONS FOR SYSTEM ISSUES THAT IMPACT PEOPLE WITH MEDICARE 99
RECOMMENDATIONS FOR MEDICARE ADVANTAGE MARKETING ABUSES 100
RECOMMENDATIONS FOR IMPROVING MEDICARE COMMUNICATIONS TO TARGET POPULATIONS 100
RECOMMENDATIONS FOR COVERAGE ISSUES THAT RESULT FROM DETERMINATIONS AND BENEFICIARY UNDERSTANDING OF WHETHER SERVICES ARE INPATIENT OR OUTPATIENT 101

CMS' EFFORTS THAT ADDRESSED THE MEDICARE OMBUDSMAN'S RECOMMENDATIONS FROM THE 2005–2006 REPORT TO CONGRESS 102

EXECUTIVE SUMMARY

This report is submitted pursuant to Section 1808(c) of the Social Security Act, which was added to the Social Security Act by Section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As required by the statute, this report provides details on activities undertaken by the Medicare Beneficiary Ombudsman from January 1, 2007 through December 31, 2008, and includes the corresponding Medicare Ombudsman's recommendations for improvements to the Medicare Program.

Structure of the Report

This report consists of seven primary sections, as follows:

1) The **Message from the Medicare Ombudsman** is a personal introduction by Daniel J. Schreiner, the Medicare Ombudsman, in which he reviews the main activities and achievements of the Office of the Medicare Ombudsman (OMO) during 2007 and 2008, and outlines the Office's future priorities;

2) The **Executive Summary** provides a high-level synopsis of the report;

3) **The Organization** discusses the primary functions of the OMO, how it is positioned within CMS, and how it works within that structure, as well as an overview of a key change in the focus of the Medicare Program itself over recent years;

4) **Activities** describe the various activities and efforts in which the OMO has engaged during 2007 and 2008;

5) **Issues and Recommendations** outlines several key issues within the Medicare Program, and provides the OMO's corresponding recommendations for improvements;

6) **Summary of Medicare Ombudsman Recommendations** provides a summary list of each recommendation provided within the report; and

7) **CMS Efforts That Addressed the Medicare Ombudsman's Recommendations from the 2005–2006 Report to Congress** provides a listing of the Medicare Ombudsman's recommendations from the initial report to Congress and a summary of efforts that addressed those recommendations.

Synopsis

The Office of the Medicare Ombudsman (OMO), within the Centers for Medicare & Medicaid Services (CMS), operates as an advocate within CMS for Medicare beneficiaries, and works to make certain that the tasks mandated by Section 923 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) are accomplished to ensure the continuous improvement of the Medicare Program. The legislation requires the Medicare Ombudsman to receive and provide assistance with complaints, grievance and inquiries from Medicare beneficiaries with regard to any aspect of the Medicare Program; submit an annual report to the Secretary of Health and Human Services and to Congress describing the activities of the office and providing recommendations for improvements to the Medicare Program; and to work with the State Health Insurance and Assistance Programs in providing assistance to Medicare beneficiaries.

The legislation also states that the Ombudsman cannot serve as an advocate for increases in payments or new coverage of services, but may identify issues and problems with existing payment and coverage policies. This is a key provision of the statute.

During the reporting period, the OMO continued to provide assistance to people with Medicare and to identify systemic problems that impact people with Medicare. The report examines how several systemic problems in the Medicare Program have affected Medicare beneficiaries, and provides recommendations for CMS to consider about how to resolve these issues.

Through various activities, the OMO has worked to meet its legislative requirements, assisting people with Medicare and engaging in efforts to improve the Medicare Program.

The OMO's Activities

To fulfill its mission, the OMO's approach is to:

- Assist people with Medicare to resolve their inquiries and complaints regarding Medicare;
- Listen to people with Medicare and those who work closely to assist or advocate for them in an effort to capture and incorporate their concerns into the development of new, and the improvement of existing, Medicare Program benefits and services;
- Identify and facilitate the resolution of systemic issues that affect people with Medicare through an established issue-management process;
- Escalate identified, systemic issues to CMS Leadership; and
- Recommend solutions for necessary and actionable Program improvements to CMS.

Both 2007 and 2008 brought new challenges and opportunities for ongoing and new OMO activities. During the reporting period, the Medicare Ombudsman planned and completed multiple tasks and initiatives in support of the Ombudsman's statutory duties to assist people with Medicare, and to support the OMO's efforts to identify and facilitate the resolution of Medicare Program issues that affect them. These activities can be grouped as follows:

- Partnering Initiatives;
- Issue Management;
- Casework Management; and
- Direct Assistance to People with Medicare.

Key Issues

Several key issues were evaluated by the OMO in 2007 and 2008; a discussion of these issues and corresponding recommendations for improvements to the Medicare Program are provided in this report. The issues include:

- The Need to Implement Best Practices to Serve Medicare Beneficiaries Optimally;
- Systems Issues that Impact People with Medicare;
- Medicare Advantage Marketing Abuses;
- Improving Communications about Medicare to Target Populations; and
- Coverage Issues that Result from Determinations and Beneficiary Understanding of Whether Services are Inpatient or Outpatient.

Looking to the Future

The healthcare industry has experienced some dramatic changes and challenges over recent years; the Medicare Program is no exception. To add to this, the population of Medicare beneficiaries is large, and the number of those who will become Medicare beneficiaries is growing rapidly. As new legislation is adopted and as technology and the range of benefits and services become more complex, so, too, has the administration of the Medicare Program. In 2009, the OMO will continue to advocate for and assist people with Medicare and build upon the early groundwork it has established and the accomplishments it has achieved since 2005.

The Office has grown steadily over the past few years and now consists of a dedicated team of individuals who help people with Medicare and those who act on their behalf to navigate a wide variety of Medicare services and experiences each and every day. As processes and procedures are developed and refined, the Medicare Ombudsman will continue to develop key relationships and work with CMS Leadership, CMS Regional Offices, and other components to make certain that the Medicare Program is meeting the needs of all people with Medicare.

THE ORGANIZATION

Section 1808(c) of the Social Security Act, which was added to the Social Security Act by Section 923 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Pub L. 108-173), requires the Secretary of the Department of Health & Human Services (HHS) to appoint a Medicare Beneficiary Ombudsman within the Department. The Centers for Medicare & Medicaid Services (CMS) appointed Daniel J. Schreiner as the first Ombudsman on March 22, 2005. This report to Congress and the Secretary of HHS is submitted pursuant to Section 1808(c) of the Social Security Act, and covers the activities of the Medicare Ombudsman from January 1, 2007 through December 31, 2008.

Provisions of Section 923 of the Medicare Modernization Act of 2003

The statute requires the Medicare Ombudsman to:

- Receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under Medicare Part A (hospital insurance) or enrolled under Medicare Part B (medical insurance), or both, with respect to any aspect of the Medicare Program;

- Provide assistance with respect to complaints, grievances, and requests for information, including:
  - Assistance in collecting relevant information for people with Medicare for the purpose of seeking an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare Advantage (MA) Plan, or the Secretary;
  - Assistance to people with Medicare with any problems arising from disenrollment from an MA plan under Medicare Part C;

- Assist people with Medicare in presenting information related to income-related premium adjustments;

- Submit an annual report to the Secretary of the Department of Health and Human Services (HHS) and to Congress that describes the activities of the Office of the Medicare Ombudsman and provides recommendations for improvements to the Medicare Program; and

- Work with the State Health Insurance Assistance Programs to the fullest extent possible.

The legislation also states that the Ombudsman cannot serve as an advocate for increases in payments or new coverage of services, but may identify issues and problems with existing payment and coverage policies.

The Medicare Ombudsman has endeavored to serve as a dedicated advocate within CMS for individuals who encounter problems with the Medicare Program. In addition, the Medicare Ombudsman works with external partners as well as others within CMS to identify CMS regulations and practices that create problems for beneficiaries, and to suggest clarifications and changes. While the statute prohibits the Medicare Ombudsman from seeking increases in payments or new coverage of services, it does allow the OMO to bring to CMS' attention problems with existing payment or coverage policies. This is one way in which the OMO exercises its independence to address beneficiary concerns while adhering to its legislative mandate concerning payment and coverage issues.

Networking to Listen for and Identify Issues

The Medicare landscape is expansive and complex, with over 44 million Medicare beneficiaries during 2008 served by a broad assortment of Government and other organizations and groups. Because the Medicare Program is so large and complex some people with Medicare have difficulty and may encounter issues due to their lack of understanding of their Medicare benefits and services.

The OMO recognizes these challenges and engages in efforts to identify and understand these issues. An essential component of identifying the root causes of many issues is a better understanding of the experiences of people with Medicare and the resulting outcomes associated with those experiences. To this end the OMO collaborates with various CMS components, and with external partners that represent or advocate for Medicare beneficiaries in order to identify and understand issues that are affecting people with Medicare. This gives the Medicare Ombudsman a broad view of beneficiary issues, which makes it easier to identify the types of individual problems

faced by Medicare beneficiaries, as well as trends in how widespread and frequent the problems are, and whether they are systemic Medicare Program issues. The OMO supports the efforts of CMS components to resolve the problems , works to ensure that information and educational materials are available for people with Medicare and those who act on their behalf, and makes formal recommendations to CMS Leadership, as needed.

Monitoring Feedback from CMS Partners

The OMO attends CMS-sponsored and/or supported conferences, weekly and bi-weekly CMS teleconferences, and other forums that include participation from some of the various groups that have interests in the Medicare Program—in particular people with Medicare, their advocates, caregivers, and State Health Insurance Assistance Programs (SHIP). Through ongoing collaboration with CMS' Partner Relations Group (PRG), the CMS component that is responsible for developing and maintaining partnerships with external organizations, the Medicare Ombudsman is able to leverage the existing CMS partnership network in order to listen for new and pervasive issues within the Medicare Program that affect people with Medicare. These relationships provide the OMO with opportunities to gain a better understanding of how the Medicare Program impacts people with Medicare.

One of the OMO's most successful partnership efforts, which was detailed in the OMO's Report to Congress for 2005-2006, involved several organizations that partner with CMS to provide mental health information and services to people with Medicare. In 2007 and 2008, the OMO continued its working relationships with national mental health partners and advocates in order to begin the development of additional mental illness tip and fact sheets to add to the training materials developed for the SHIP Technical Assistance Program (TAP), which was established in 2006. These materials are used to ensure that SHIP counselors are aware of and sensitive to the needs of people in the Medicare population who have mental illnesses. They include topics such as Alzheimer's disease, Schizophrenia, Obsessive Compulsive Disorder, Bi-polar Disorder, and cultural competency regarding mental illness. In 2008, work continued on the development of materials to raise awareness of mental health conditions and their impacts on counseling sessions. In addition, the OMO participated in the SHIP Conference, at which it presented the partner tool kit, a mechanism with which the SHIPs can reach out to mental health partners at the local level.

Collaboration with Internal CMS Components

The OMO has collaborated with the CMS components that deal most directly with educating beneficiaries about the Medicare, and resolving their problems with access to services. This enhances the OMO's ability to contribute to issue identification and to help in resolving them, as well as the development of formal recommendations regarding service to beneficiaries.

As an example of such collaboration, the OMO has worked closely with the CMS Consortium of Medicare Health Plan Operations, the Division of SHIP Relations within the CMS Office of External Affairs, and the CMS Center for Drug and Health Plan Choice (formerly the Center for Beneficiary Choices) to facilitate a pilot for the SHIPs to obtain access to the Complaint Tracking Module, which is the CMS system for tracking Part C and Part D (Medicare Advantage and Medicare prescription drug coverage) complaints. The SHIPs provide invaluable assistance to many people with Medicare by providing information and assistance to beneficiaries and helping them resolve their individual Medicare issues. Providing the SHIPs with the means to input Part C and Part D complaints allows them to file complaints directly into the system, instead of forwarding those complaints to the CMS Regional Offices or calling 1-800-MEDICARE, freeing more time for them to assist other beneficiaries. The access also allows the SHIPs to view the status of complaints that they file through the MA and Part D Complaints Tracking Module, providing an opportunity for more timely and direct assistance to people with Medicare. Seven states actively participated in the pilot, which began in March of 2007. Plans are underway to begin rolling out this access to the other SHIPs during 2009.

The following table summarizes the collaborative relationships that the Medicare Ombudsman and his staff have developed within CMS:

FIGURE 1: THE OMO'S STRATEGIC RELATIONSHIPS

Organization	Purpose
Office of the Administrator (OA)	The OMO elevates primary systemic issues to CMS Leadership and obtains Leadership support for addressing those issues.
CMS Regional Offices (RO)	The OMO collaborates with CMS Regional Offices to identify and facilitate the resolution of systemic issues regarding the Medicare Program and CMS processes, resolve individual complaints, fulfill requests for information from people with Medicare, and develop standard procedures for assisting people with Medicare.
Center for Drug and Health Plan Choice (CPC)	CPC provides assistance with issues regarding health plan operations, policies, and communications.
Office of Beneficiary Information Services (OBIS)	The OMO works with the OBIS to identify systemic issues that impact people with Medicare, and to resolve a small percentage of highly complex beneficiary issues.
Office of Information Services (OIS)	The OMO engages components within the OIS proactively to identify CMS data system changes and updates that may impact people with Medicare.
Office of Legislation (OL)	The OMO collaborates with the OL, as needed, for assistance with issues involving communications to lawmakers and identifying or addressing issues that impact their constituents.
Office of External Affairs (OEA)	The OMO collaborates with other components in the OEA to identify systemic issues that impact people with Medicare and communicate information regarding those issues optimally. Particularly, the OEA's Partner Relations Group supports the OMO in engaging external partners to identify and/or validate issues that impact people with Medicare, and to provide outreach and education regarding such issues when necessary.
Center for Medicare Management	The OMO collaborates with the Center for Medicare Management to assess and address issues regarding the traditional fee-for-service Medicare program, including existing payment policy and concerns or problems involving the Medicare fee-for-service contractors.

Accomplishments

Throughout 2007 and 2008, the OMO collaborated with others, both within CMS and external to CMS, to facilitate process improvements and enhanced service to people with Medicare. The following key accomplishments were achieved during 2007 and 2008:

- Developed and implemented an improved process for identifying and evaluating systemic beneficiary issues from various sources tracked by the OMO;

- Provided assistance to the CMS Consortium for Medicare Health Plans Operations in its efforts to manage Part C and D complaint handling by facilitating coordination, disseminating guidance and information, facilitating training, and obtaining feedback from the staff in CMS Regional Offices that handle the majority of Part C and Part D casework;

- Received and processed a total of more than 63,000 inquiries and complaints from people with Medicare during 2007 and 2008, which involved receiving, reviewing, triaging to CMS Regional Offices and other government entities, and responding to inquiries and complaints;

- Handled and/or directly responded to approximately 22,000 of those inquiries and complaints received by people with Medicare in 2007, and approximately 16,000 in 2008;

- Collaborated with CMS Regional Offices to design and develop a system to track individual beneficiary-related issues associated with Medicare Part A and Part B issues;

- Expanded upon the 2006 SHIP TAP pilot program;

- Completed the design and implementation of the Medicare Ombudsman section of the medicare.gov webpage, to provide an easy way for Medicare beneficiaries to obtain information about the various Medicare inquiry, complaint, and appeals processes; and

- Completed a Report to Congress and the Secretary of Health and human Services through December 2006 that includes key issues and associated recommendations for the Congress and Secretary's review and consideration.

The Scope of the Medicare Program

Over the years, the Medicare Program has faced many changes. This section looks at how the Program has become more focused on customer service for people with Medicare, and provides a current snapshot of Medicare and the environment in which it operates.

Change of Medicare Program Focus from Payer of Claims to Beneficiary Services

CMS' customer focus—primarily the interests of people with Medicare—is the central focus of the Medicare Ombudsman. The OMO has recognized that a key challenge for the Medicare Program, now and in the future, is to develop its customer assistance framework to ensure that CMS maintains and expands on its focus on Medicare beneficiaries.

Statutory History

Medicare and Medicaid were established in 1965 to provide healthcare coverage to people over age 65 (Medicare) and certain individuals and families with low income and limited resources (Medicaid). These Programs were created as titles XVIII and XIX of the Social Security Act (the Act), respectively. Medicare eligibility was expanded in 1972 to provide healthcare coverage to people with disabilities and to those with end-stage renal disease (ESRD). In 1977, the Health Care Financing Administration (HCFA) was established within the Department of Health & Human Services (HHS) to administer Medicare and Medicaid. During this time, the primary focus of the Medicare Program was the administration of coverage and payment policy, and administering payments for the Programs' services.

Medicare originally consisted of Part A (hospital insurance) and Part B (medical insurance), which provided fee-for-service coverage to beneficiaries. The Balanced Budget Act of 1997 (BBA) added new authority for providing Part A and Part B benefits through private health plans that contract with Medicare. This was added as "Part C" of the Medicare statute. The BBA also created Title XXI of the Social Security Act – the State Children's Health Insurance Program (SCHIP), later known more simply as the Children's Health Insurance Program (CHIP), which is a state and federal partnership that targets uninsured children and pregnant women in families with incomes too high to qualify for most state Medicaid programs, but often too low to afford private coverage. In addition to this, the BBA expanded Medicare Program education and information in an effort to help people with Medicare make informed decisions about their healthcare. This was the start of a transition of the Medicare Program's focus from a claims-payment and administration organization to a more customer-focused organization. In 2003, the Medicare Modernization Act (MMA) expanded the choices available from health plans contracting with Medicare under Part C, and added Part D, which created a new Medicare prescription drug benefit.

Administrative Developments

As mentioned above, in 1977, HCFA was established within the Department of Health & Human Services (HHS) to administer Medicare and Medicaid. During this time, the primary focus of the Medicare Program was the administration of coverage and payment policy, and administering payments for the Programs' services. In later years the program began to increase its focus on people with Medicare. In 1998, the HCFA website, www.medicare.gov, was launched to provide updated information about Medicare. In the following year (1999), the toll-free number, 1-800-MEDICARE, was made available nationwide, and the first annual "Medicare & You" handbook was mailed to all Medicare beneficiary households.

In 2001, as part of a package of reforms in response to public concerns about HCFA's general lack of responsiveness to its various customers, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS). Changing HCFA's name was viewed by those who were responsible for administering these Programs during that time as the first visible sign of the several steps taken to change the Agency and drive it to become more responsive and effective. Its new name was adopted to reflect better the scope of CMS' mission—to serve people with Medicare and Medicaid and the Children's Health Insurance Program. In addition, it was adopted to help people with Medicare and Medicaid identify the Agency that administers their health insurance, and to help to develop a more consumer-friendly association with CMS.

During the time of this name change, there were several other initiatives underway to address findings that fewer than half of Medicare beneficiaries knew of the basic coverage and services provided by Medicare, and to address further the need to become more customer-focused. The launching and enhancement of the Medicare education campaign helped people with Medicare and their caregivers become active and informed participants in their healthcare decisions. Expanding 1-800-MEDICARE call center services, developing a web-based decision tool on www.medicare.gov for selecting Medicare health plans (and eventually with the roll-out of the Medicare Part D drug benefit, selection of prescription drug plans), and implementing an extensive national advertising campaign to inform people with Medicare of the expanded services to help them with their choices are a few improvements that CMS has made.

The transformation to a beneficiary- or customer-focused organization versus serving as a claims-payment operations and policy organization will be an ongoing challenge for CMS in the years to come. CMS should continue to work to maintain sight of and focus upon people with Medicare. With over 44 million beneficiaries during 2008, the

Medicare Program has one of the largest consumer populations in both the public and private sectors. The significant number of people with Medicare, which can be segmented into a variety of sub-populations, creates a challenge for implementing the many policies and services within the Program. In addition, programmatic changes, such as Part D implementation, have made it necessary to expand customer-service operations and educational efforts within an already-extensive and sometimes complex Program. With an aging and growing population, the consumer base will grow in the years to come, further increasing demand for Medicare's services and taxing the Program's capabilities and resources.

The Medicare Program Today

Today, the Medicare Program is exemplified by the following:

- A wide-ranging scope of benefits that provides broad choices of services for people with Medicare, sometimes leading to confusion and difficulty in understanding and accessing benefits and services;

- A delivery mechanism that is distributed broadly, and which is supported by a diverse range of private organizations that have contracts with the Medicare Program to administer benefits and provide services to people with Medicare and public-sector entities; and

- The ongoing challenge of providing access and services to such a large Medicare beneficiary population with limited resources.

Medicare is one of the largest public programs in our Nation's history. Its large scale translates into a complex, ever-changing Program, presenting opportunities for breakdowns or problems with access to services for people with Medicare. The challenge is to minimize these risks and to mitigate negative impacts for people with Medicare when breakdowns do occur.

Key Challenge – Developing a Customer Assistance Program for People with Medicare

As stated previously, the Medicare Program serves over 44 million beneficiaries. The healthcare delivery network on which this population relies is equally large, and may be complex to some. According to the 2009 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2009 Trustees' Report), 1.2 million Medicare providers annually submit approximately $300 billion in claims for healthcare services. In addition, the size and complexity of the delivery model creates many opportunities for problems to arise, and makes it difficult to make course corrections quickly when systemic problems arise. To add to this, the Medicare population is continually growing. The 2009 Trustees' Report also indicates that the total number of Medicare beneficiaries is expected to grow to approximately 62 million beneficiaries in year 2020. By adding a focus on beneficiary service to the work of paying or adjudicating claims for service, CMS faces an additional level of complexity that cannot be managed successfully without corresponding changes to the organization itself.

CMS currently provides support for people with Medicare through several internal components, as well as through organizations that have contracts with the Medicare Program to administer benefits and provide services to people with Medicare. While all of these entities work in some manner to serve Medicare beneficiaries, the fact remains that there is no single organizing and operating framework for coordinating these numerous, discrete entities and their various activities into a more seamless and responsive operation. Without this framework, it is much harder to maximize the use of its limited customer-assistance resources and to serve people with Medicare optimally. The need for a more seamless customer-assistance framework for people with Medicare is essential, mainly due to the fact that Medicare is one of the largest Federal Programs with a public-facing customer base.

In terms of meeting the expectations of the public, a formal, effective customer-assistance framework is critical to the success of the Medicare Program, both in the near and the long terms. This framework will need to provide the necessary level of organization and resources to assure a beneficiary experience that is seamless, timely, accurate, and responsive. This issue is discussed further later in this report, with a formal recommendation for addressing this key challenge.

Ultimate Responsibility for Beneficiary Services and Interests

The question of whom or what organization is overall responsible for beneficiary interests and beneficiary services has been raised over the past few years. There is no longer a component within CMS, such as the former Center for Beneficiary Services (established within HCFA/CMS from 1997 to mid-2008), that is responsible for ensuring that Medicare beneficiaries are represented at the executive level. Many CMS components and partner organizations continue to share the responsibility of providing services to beneficiaries and representing their interests. Several CMS Offices—including the Regional Offices, the Office of Beneficiary Information Services (OBIS), the Office of Information Services (OIS), the Office of External Affairs (OEA), and the OMO—have responsibilities for designated beneficiary-service functions, which they perform admirably given their limited resources and budgetary constraints. In lieu of a sole CMS Office- or component, these components collaborate to ensure that Medicare beneficiaries' concerns are heard at the highest levels within CMS and that issues, particularly systemic issues, are identified quickly, addressed properly, and resolved optimally. Collectively, these groups represent the interests of beneficiaries in shaping the development and implementation of policies and operational decisions affecting people with Medicare. However, the fact that there is no CMS Office or component that is ultimately responsible for beneficiary interests and services across the Medicare Program has, at times, contributed to ineffective and inefficient delivery of benefits and services to people with Medicare.

In recent years, CMS has focused much of its attention on the implementation of new programs, such as Part D, the expansion of Medicare Advantage, and substantial changes to a range of programs in Original Medicare.

The number of organizations responsible for addressing beneficiaries' needs and their varied scope of services has resulted in a variety of issues that impact people with Medicare. For example, given the multiple points of contact for beneficiaries, the challenge exists for people with Medicare to know to which resource or resources they can or should turn for information or assistance with specific problems. The Medicare Program's toll-free number, 1-800-MEDICARE, was established in order to provide beneficiaries with a central place to call. However, people with Medicare continue to solicit information from a broad range of sources both internal and external to CMS, such as the numerous Medicare health and prescription drug plans, CMS' Regional and Central Offices, and SHIPs. Countless inquiries and complaints are handled by these organizations with regard to a variety of topics that concern beneficiaries, including

enrollment, access to services, coverage, and coordination of benefits (or simply who pays what and who pays first).

The significant number of people with Medicare creates a variety of challenges within the Program. Furthermore, as a result of the Nation's aging population, the Program's consumer base will grow in the years to come, increasing demand for Medicare's services and stressing its capabilities and resources. As CMS works to serve people with Medicare the Agency should continue to enhance efforts to manage all education and assistance services conducted by its Offices and its contractors; ensure adequate resources are provided for these services to operate optimally; ensure that marketing and educational materials from Medicare Advantage, prescription drug plans, and other providers are accurate, informative, and understandable; ensure that consumers receive clear, consistent information explaining policy changes in a timely fashion; and continue to develop and fully integrate partnerships with SHIPs and Medicare consumer groups into its education mission.

Key Challenge – Enhanced Prevention Efforts to Improve the Health of Medicare Beneficiaries

Given the increasingly growing numbers in the Medicare beneficiary population, coupled with the rising costs of healthcare, the Medicare Program must find means to meet these demands. In its efforts to enhance CMS' continuous-improvement efforts and advocate for people with Medicare, the OMO promotes the pursuit and implementation of preventative efforts to improve the health of Medicare beneficiaries and manage the rising costs of the Medicare Program. One way to address the demands on the Medicare Program is to increase promotion and participation in existing prevention benefits and programs, and possibly implement new preventative programs that ultimately will reduce demand and costs in the long term. In this way, the Medicare Program simultaneously can improve the overall health of people with Medicare and sustain itself in meeting increased demands.

One approach to identifying specific preventative measures to pursue is to conduct a study to determine near-term results and long-term cost savings to the Medicare Program if prevention is increased. Based on the study, CMS could research cost data around high-end programs and develop a targeted prevention campaign for one or more illnesses that generate significant costs to the Medicare Program (e.g., Diabetes). CMS then could consider and seek out undiscovered opportunities for effective current and/or new preventative efforts. This could include collaboration with public and

private organizations to leverage their expertise and work on related efforts to reach mutual goals to foster prevention. Prevention (e.g., obesity reduction, wellness promotion, etc.) is one of the most effective ways in which CMS can work proactively to encourage wellness and drive down Medicare costs. It is a long-term solution, and often is overlooked or undervalued because it does not provide a tangible, immediate cost benefit. However, it is a solution that must be pursued.

By targeting specific, high-cost diseases for prevention, CMS can improve the health of Medicare beneficiaries over time, reducing costs and allowing for more funds and resources to be put to work to enhance the Program, provide additional services, and keep pace with population growth. Costs are rising and will continue to increase as the generation of "Baby Boomers" lives longer, stressing the Medicare Program and its resources. The primary goal would be to improve the health of Medicare beneficiaries, with the possible additional benefit of maintaining or reducing the costs to serve Medicare beneficiaries in the long term.

Key Challenge – Ombudsman Independence

The traditional role of an Ombudsman is based upon the independence of the function—the ultimate contribution of which is to provide objective and unbiased feedback to senior leadership on key issues associated with organizational performance, either operationally or as they relate to consumers. That independence requires that the Medicare Beneficiary Ombudsman and the associated activities of the OMO be independent and not aligned organizationally with any group inside of CMS. An Ombudsman typically is external to an Agency's or organization's line of management and authority that it supports (as is the case for the United States Bureau of Citizenship and Immigration Services Ombudsman). Reporting lines between the Medicare Ombudsman and the Administrator (or various higher levels of administration up to the Secretary level) are direct, and do not route through other Agency components. The less emphasis there is on the Ombudsman's independence, the more constraints the Ombudsman must overcome in order to be an effective advocate for Medicare beneficiaries. The Medicare Ombudsman's independence within CMS is critical to the OMO's ability to serve in this manner.

The OMO works within the Medicare Program's complex and expansive operating environment to ensure that CMS maintains a focus on the beneficiary experience. The role of the Medicare Ombudsman focuses on policy and operations and their impacts on people with Medicare. The Medicare Ombudsman works to be responsive to the

concerns of Medicare beneficiaries and those who work in their behalf, and to work with the responsible components within CMS to determine if there are policy and/or operational changes that can be implemented to address systemic issues and position the Medicare Program to serve people with Medicare better. This function of representing the interests of the public is similar to the role of most Ombudsmen; however, the alignment of the Medicare Ombudsman within the organization, versus serving independently of CMS, differs significantly from the roles of most other Ombudsmen (or similar positions) in the private and the public sectors. While this unique position has contributed, in some part, to the Medicare Ombudsman's success in 2007 and 2008, it also serves as a key constraint, in some regards, for the OMO.

Since 2006, the Medicare Ombudsman has been organizationally aligned with CMS' Office of External Affairs (OEA) and Office of the Administrator. As such, the Medicare Ombudsman carries an organizational line of authority from within the OEA, as well as from the Administrator. As issues and concerns regarding beneficiary issues are brought to the attention of the OMO through its issue-identification activities, the Medicare Ombudsman must walk a "fine line" between his role as an independent and objective observer of CMS activities, and his position within the organization, observing delivery, recommending and facilitating improvements, and constantly advocating on behalf of beneficiaries.

Although there are inherent challenges in working to act independently on the behalf of people with Medicare while serving within CMS, the constraints associated with the OMO's organizational alignment in CMS do not impede it from serving people with Medicare. The OMO has realized some significant success in the past two years, largely due to the strategies devised and implemented by the Medicare Ombudsman to work around the constraints of the OMO's position within the Agency. As a result of the current organizational structure, the Medicare Ombudsman is in a unique position to help CMS address the issues experienced and complaints communicated by people with Medicare by collaborating with other groups inside of CMS. Optimizing his position within CMS, the Medicare Ombudsman has the opportunity to interact with CMS Leadership and have a "place at the table" when issues are addressed. This better enables the Medicare Ombudsman to develop and make formal recommendations for policy and operations changes that are aimed at addressing key, systemic issues within the Medicare Program. Unlike other Ombudsmen who are limited to highlighting issues and problems and making recommendations for improvement, the Medicare Beneficiary Ombudsman has the opportunity to participate directly in the resolution of the issues cited by the OMO.

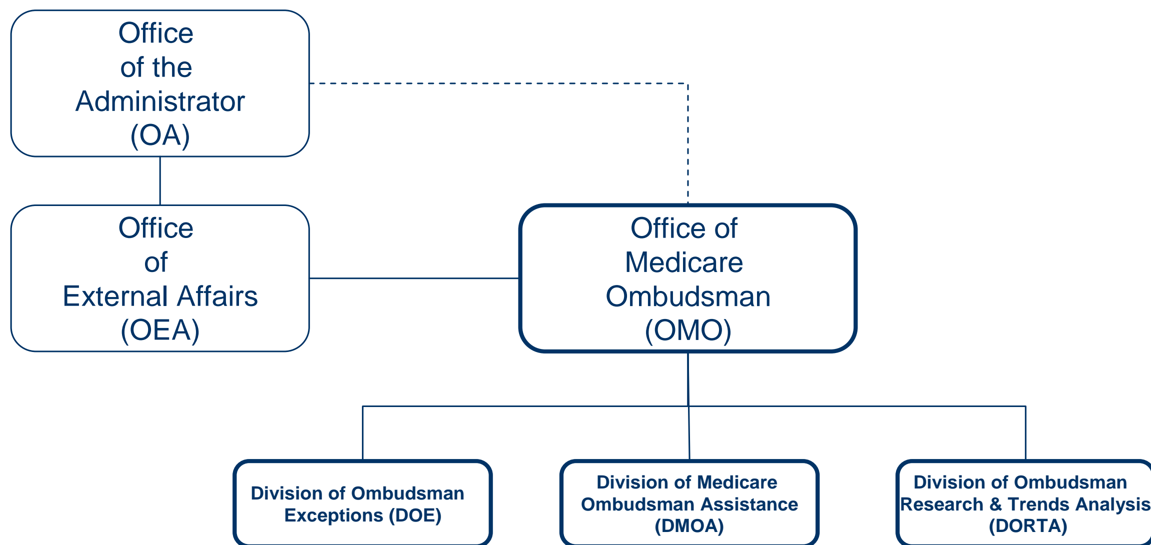
Office of the Medicare Ombudsman Structure

The OMO is a unique entity within CMS that works to ensure that improvements to the Medicare Program are made to provide the best information and service to people with Medicare. This section describes the Office and its various focuses and areas of interest in more detail.

Organization

The functions of the OMO include working to identify and facilitate the resolution of issues within Medicare Program policy and operations that adversely impact people with Medicare; engage CMS and partner organizations proactively to identify potential systemic issues within the Medicare Program; ensure that the perspectives of people with Medicare are represented; and collaborate with those responsible for the administration of the State Health Insurance Assistance Programs (SHIP) to enhance their efforts to provide information and assistance to people with Medicare. Figure 2 reflects the current organizational alignment of the Medicare Ombudsman within CMS:

FIGURE 2: OFFICE OF THE MEDICARE OMBUDSMAN ORGANIZATION CHART



Within the past two years, there have been several inquiries, including those from members of Congress, regarding whether or not the Medicare Ombudsman has sufficient resources to carry out his functions. The answer to that question depends upon what role the Medicare Ombudsman is expected to fulfill. There are Ombudsmen

who are positioned as independent organizations and have staff in positions nationwide, such as the Internal Revenue Service (IRS) Taxpayer Advocate Service (TAS), within the Office of the Taxpayer Advocate. The Office of the Taxpayer Ombudsman was created by the IRS in 1979 to serve as the primary advocate within the IRS for taxpayers, and was changed to the Office of the Taxpayer Advocate in 1996. Like the OMO, the TAS helps its customers resolve problems and recommends changes that will prevent future problems. However, the TAS is an independent organization, and there is at least one local advocate in each state, the District of Columbia, Puerto Rico, and at every IRS campus. It is a relatively large organization that has a separate office, the Office of Systemic Advocacy, which is dedicated to addressing broad issues that impact taxpayers within the larger TAS organization.

Unlike the Office of the Taxpayer Advocate, the OMO does not have staff within each state or at each of CMS' 10 Regional Offices. The OMO works closely with CMS Regional Office staff, primarily the Consortium for Medicare Health Plan Operations and the Consortium for Financial Management and Fee-for-Service Operations, but does not have any authority or actual physical representation at these Offices. The efforts and contributions of CMS Regional Offices are invaluable, and the OMO's close work with the CMS Regional Offices better enables the OMO to carry out its mission.

As of the time of this report, the OMO staff totals 55 full-time employees within CMS' Central Office, distributed in support of several key focus areas (see next section). Due to the staffing levels and the scope of the Medicare Ombudsman's efforts, most of these staff members contribute across multiple, and sometimes all of, these focus areas. Since the inception of the OMO, staffing has been a challenge. Because the OMO is organizationally positioned within the OEA, it is subject to the hiring limitations and restrictions of this CMS component, and has to compete for resources along with the other components within the OEA.

The OMO's staff handles a broad range of activities, including the resolution and tracking of complex inquiries and complaints; outreach and partnership activities; issue-identification and management efforts; researching and reviewing Medicare Program beneficiary contact data; and the analysis and resolution of data discrepancies related to Medicare enrollment, direct premium billing, third-party premium billing, and Medicare Advantage and Part D data transactions. Since 2005, the OMO's staff has grown; however, so, too, has its responsibilities. The OMO has been challenged by greater demands on its staff over the past few years, and has worked diligently to meet its goals.

Key Focus Areas

Defining the role and the expectations of the OMO is critical to determining the staffing necessary to support these focus areas; the budget necessary to support this work; and, in turn, measuring its success.

The OMO's activities can be grouped into four key focus areas. Each area in some way enables the OMO to listen, learn, collaborate, and provide assistance to people with Medicare in fulfillment of the functions of the Medicare Ombudsman, per Section 923 of the MMA. The four key focus areas include:

Partnerships – The Medicare Ombudsman focuses on developing and maintaining partnerships with other CMS components and entities external to CMS that provide to identify and understand the key issues that are affecting people with Medicare. The partnerships better enable the OMO to facilitate resolutions to issues and develop corresponding recommendations for improvements to the Medicare Program.

Issue Management –Once issues are identified the Medicare Ombudsman focuses on determining whether they are systemic issues that impact Medicare beneficiaries, identifying their root causes, and facilitating resolutions to those issues or making recommendations for improvements. Due to the complexity of the Medicare Program, many systemic issues have more than one underlying cause, and require a number of activities and collaboration to support resolutions or recommendations for resolving these systemic issues.

Casework Management –The Medicare Ombudsman also focuses on collaborating with CMS Regional Offices to support the development of strategies and processes to handle the individual questions and concerns from Medicare beneficiaries. These efforts, in turn, help the OMO to identify new or assess known systemic issues and concerns that affect people with Medicare.

Direct Assistance to People with Medicare – The Medicare Ombudsman not only tracks the development of beneficiary issues, but also serves people with Medicare on a more personal level through a dedicated staff who respond to individual inquiries and complaints from the general public, as well as complex inquiries and complaints that may have been directed from various high-level sources (e.g., the CMS Office of the Administrator and Congressional offices). In addition, the OMO remains available to handle issues, on occasion and as needed, that are forwarded to CMS Central Office by the White House and the Secretary of Health & Human Services. This day-to-day work

provides the OMO with a more detailed and personalized view of issues beyond that which is gained through addressing systemic issues.

ACTIVITIES

The Office of the Medicare Ombudsman (OMO) engages in several core activities that enable it to provide assistance to people with Medicare and function as an advocate for Medicare beneficiaries. This section of the report describes those activities.

Partnering Initiatives

The statute requires the Medicare Ombudsman to report recommendations for Medicare Program improvements to the Secretary of Health & Human Services (HHS) and Congress. This legislative mandate underscores the importance of the OMO's ability, as a proponent for Medicare beneficiaries, to identify and understand the primary issues that affect people with Medicare. One of the ways in which the OMO accomplishes this goal is to participate actively in initiatives, conferences, and meetings at which Medicare advocacy groups or partners raise such issues. Furthermore, as the OMO increases its visibility among these groups, Medicare partners, advocacy groups, and other Medicare stakeholders expect the Medicare Ombudsman's participation and involvement in discussing and addressing beneficiary issues.
In 2007, the OMO took on a broad initiative to leverage the current CMS partnership network by working with the CMS Partner Relations Group (PRG). The PRG initiates and maintains external relationships with providers, pharmacists, advocates, and other organizations. The OMO's goal for this partnership was to focus on organizations that address the needs of people with Medicare, including mental health, cultural disparities, and general disabilities partners. The OMO participates in CMS-sponsored or supported forums to interact directly with organizations that work closely with and/or serve these underserved populations. Participating in PRG-sponsored meetings, supporting local and national PRG conferences, and collaborating with the PRG to capture outstanding issues affords the opportunity for the OMO to gain improved visibility into the needs of people with Medicare.

In 2007 and 2008, the OMO's staff attended and participated in a variety of conferences, including (but not limited to) the League of United Latin American Citizens Convention (LULAC), the World Disability Conference, the National Indian Council on Aging, and conferences for the National Association for Area Agencies on Aging and the American Association of Retired Persons (AARP).

One of the outcomes of the OMO's partnership efforts has been the continued progress in working with several of the SHIPs to implement a technical assistance program that is led by the OMO.

State Health Insurance Assistance Program: Technical Assistance Program (SHIP TAP)

One of the provisions of Section 923 of the Medicare Modernization Act of 2003 (MMA) requires the Medicare Ombudsman to work with health insurance counseling programs to the extent possible to facilitate the provision of Medicare Advantage (MA) Plan information to people with Medicare, and allows for additional Medicare Ombudsman collaboration with health insurance counseling programs. One of the ways in which the OMO fulfills this requirement is to work with health insurance counseling programs to develop technical assistance materials that provide direction and tools to enhance the provision of information to individuals with Medicare in underserved and vulnerable populations. As the OMO continuously communicates with State Health Insurance Assistance Programs (SHIP) about the types of issues that they encounter, one of the most challenging aspects of providing assistance is communicating information to persons with Medicare who have mental illnesses.

The 2004 Medicare Current Beneficiary Survey indicated that 53% of people with Medicare who are under age 65 and disabled report having been told that they have a mental or psychiatric disorder, and that 12% of people with Medicare who are over age 65 and not disabled report having been told that they have a mental or psychiatric disorder. People with a mental illness often need extra support in making decisions about the Medicare Program because depression, cognitive impairment, or other manifestations of mental illness may make decision making more difficult.

In 2006, to address the needs of this population of people with Medicare, the OMO became the catalyst for the planning, development, execution, and implementation of a technical assistance program (TAP) called SHIP TAP. This program was designed to promote sensitivity and awareness among SHIP counselors, and help the SHIPs to provide Medicare benefit counseling to Medicare beneficiaries who suffer from mental illness through training and the facilitation of the expansion of SHIP networks to include mental health partners. By collaborating with the CMS Division of SHIP Relations, a pilot was developed and successfully implemented in 2006 in North Carolina and Texas.

During 2007, the OMO expanded the program by placing special emphasis on conducting training for all SHIP Directors, utilizing the materials produced by the OMO

at the SHIP Directors Conference, which was held in Arlington, Virginia. In conjunction with the CMS PRG and the North Carolina and Texas SHIP Directors, the OMO presented four sessions promoting the use of SHIP TAP materials, such as sensitivity and awareness tip and fact sheets.

Also in 2007, the OMO collaborated with key internal partners, such as the PRG and the Division of SHIP Relations, and conducted an impact evaluation of the SHIP TAP Pilot activities to date. The evaluation process not only confirmed the value of the program to SHIP counselors, but also provided specific feedback on how to refine the SHIP TAP materials to meet the needs of the counselors in providing service to people with Medicare more effectively. Only by continuously engaging the SHIPs can the OMO understand the unique issues that SHIP counselors face every day when assisting and helping individuals to make sound, informed decisions regarding their Medicare benefits.

As a result of the positive feedback it received, the OMO committed to expanding mental illness technical assistance to the SHIPs nationwide, and made it a focus for the SHIP TAP during 2008. In addition, the OMO initiated similar efforts specific to one or more additional underserved populations in need of specialized assistance, as identified during the 2007 SHIP conference.

Another early outcome of the OMO's efforts to engage partners in 2007 and 2008 was the indication from several partners that a single place to obtain clear and concise information on the processes and appropriate places to contact for specific types of inquiries, complaints, or appeals would be helpful for many people with Medicare to obtain assistance in resolving their individual concerns.

Medicare Ombudsman Webpage

As an advocate for Medicare beneficiaries, making sure that people with Medicare have access to information is of great importance to the OMO. Of particular interest is ensuring that people with Medicare understand how to file inquiries, complaints, grievances, and appeals in order to receive the assistance they need. As the OMO participated in CMS outreach events, partnership forums, and worked to handle inquiries and complaints from individuals with Medicare, it discovered that some partners and people with Medicare have difficulty locating information related to their Medicare rights, protections, and the appropriate points of contact.
The comprehensive Medicare website, www.medicare.gov, is an excellent resource for information related to CMS programs; however, it is not always easy for some people with Medicare and CMS partners to navigate the website during their efforts to find

specific information on the appropriate points of contact for filing and resolving inquiries, complaints, grievances, and appeals regarding the various parts of the Medicare Program. As a result, the OMO conducted an assessment of available information regarding CMS processes on how to file inquiries, complaints, grievances, and appeals. This assessment indicated that, while much of the information was located in various places on the Medicare website, specific information was not always easy to locate, or was non-existent. For example, State Survey Agencies and End-Stage Renal Disease were two topics clearly identified on the Medicare website. Contact information for local networks that deal with both of those topics was listed; however, no information was immediately available to inform a person with Medicare about how or when to file a complaint in these areas. The OMO believes that up-to-date, centralized access to information on the various CMS processes to file inquiries, complaints, grievances, and appeals would be an important resource, and a tool through which people with Medicare and those who work closely with them can resolve their individual concerns.

In 2007, the OMO began the Medicare Ombudsman Webpage Initiative by engaging other CMS components in order to verify current processes and procedures on www.medicare.gov. To make this information available for centralized placement on the Medicare Ombudsman webpage, the OMO also worked closely with many of the CMS components to facilitate the development of content for processes where none were documented or where enhancements could be made to information that was already available regarding existing processes. This information was then organized and placed on the Medicare Ombudsman webpage, which can be found on www.medicare.gov, specifically at www.medicare.gov/Ombudsman/resources.asp.

The concept for the Medicare Ombudsman webpage was to include up to three easy links per topic area (e.g., State Survey Agencies, Fraud & Abuse, Medicare Advantage, Appeals, etc.) in order to provide people with Medicare the following information on current CMS inquiry processes:

1. A fact sheet on the inquiry, complaint, grievance, or appeal process;

2. An actionable link to take people with Medicare directly to the information they need to conduct business; and

3. Frequently asked questions about a specific inquiry process.

The OMO worked extensively with CMS subject matter experts and the OEA to ensure that the information being developed for people with Medicare was written in accurate, plain, easily understood language. In addition, the OMO made certain that the original intent of the message, as developed by the subject matter experts, was not altered. This process involved the OMO's working with the subject matter experts to have the information approved, and working with OEA staff to ensure that the information was easy for most readers to understand.

The OMO also worked with the CMS Office of Beneficiary Information Services to develop the layout and design of the Medicare Ombudsman webpage and to ensure that the information developed for the webpage complies with Section 508 of the Rehabilitation Act of 1973, as amended by the Workforce Investment Act of 1998. This statute was enacted to eliminate barriers to information technology in order to provide access for people with disabilities, and to encourage the development of technologies that will help achieve these goals. Under Section 508, CMS and other Federal Agencies must provide persons with disabilities access to information that is comparable to the access available to others. For example, the Medicare Ombudsman webpage has to be user-friendly for sight- and hearing-impaired individuals.

The Medicare Ombudsman's webpage was launched in May of 2008, and allows the OMO to provide an external face of the Office to people with Medicare and their advocates to assist them in accessing CMS processes on how to file inquiries, complaints, grievances, and appeals. Additionally, there are other helpful resources available to people with Medicare, such as links to the most recent "Medicare & You" handbook, information on how to replace a Medicare card, Medicare brochures, fact sheets, and other publications, in addition to information about the OMO and its various activities. The webpage establishes a focal point for Medicare beneficiaries, their caregivers, and providers to access these processes with easy-to-comprehend fact sheets and scenario based questions and answers.

From its launch in May 2008 through the end of December 2008, the OMO's website recorded more than 84,000 page views. Although this represents a relatively small volume, the OMO's website was not marketed aggressively to external audiences during that time. In addition, many people with Medicare do not have access to or use the Internet. In 2009 and beyond, the OMO will seek to increase awareness of the webpage, and the website will be updated as needed to provide additional information to Medicare beneficiaries and those who act on their behalf.

Issue Management

When Part D (Medicare prescription drug coverage) was implemented in 2006, CMS received an influx of inquiries and complaints from people with Medicare and their advocates. They were experiencing issues and problems related to the new benefit. In the early months of Part D implementation, there often was a need to address or respond quickly to widespread issues that were affecting people with Medicare. In some instances, this led to a resource intensive process of confirming the true impact of the issue, identifying the key stakeholders, and determining what CMS actions had taken place already to mitigate or resolve the issue and/or what further actions were necessary.

During this period, the OMO's ultimate goal was to understand how people with Medicare were impacted by these issues so that it could provide assistance to them. To accomplish this objective, the OMO realized that it needed an effective process to ensure that Part D related issues and problems were identified and resolved as quickly and effectively as possible. The process involved identifying the problem, analyzing the issue to discover the root cause, determining the gaps and opportunities for improvement, and monitoring and tracking the issues toward mitigation/resolution.

The following OMO strategies are key components of its issue management process:

- Solicit or receive potential issues from various stakeholders, including the CMS Regional Offices, other CMS components, health plans, providers, and people with Medicare and their advocates; surface the issues through either verbal or written means; and track the issues in an internal tracking issue-management database;

- Identify what CMS component(s) are responsible for each issue and who within CMS needs to be involved in the decision-making and resolution processes; and

- Document the resolution or course of action and communicate each issue's status and resolutions to CMS leadership and other appropriate stakeholders.

The OMO was successful in working with several CMS components to facilitate the issue-management process and help resolve systemic issues. Drawing from a combination of beneficiary-support operations within CMS, several CMS data and information sources were leveraged to identify issues that impact Medicare beneficiaries. These sources include CMS' Office of Beneficiary Information Services, which is responsible for administering 1-800-MEDICARE and CMS websites; CMS

Regional Offices, which are responsible for various beneficiary assistance and outreach efforts; the Center for Drug and Health Plan Choice, which is responsible for Medicare drug and health plan operations and communications; the Office of Information Systems, which is responsible for CMS systems development, operations, and maintenance; and the Office of External Affairs, which is responsible for CMS' external communications to people with Medicare, partners, and other stakeholders.

In 2007, the process continued, and the OMO refined its internal tracking database that is used to capture systemic issues to provide more robust reporting functions to present issues. The tracking tool, a Microsoft Access database, supports the OMO in its issues tracking and monitoring efforts, and serves as an important tool that supports the OMO's issue management process. Managed internally by OMO staff, the database provides the OMO with the capability to generate user defined reports and snapshots of specific areas of the Medicare Program in which there are systemic issues. As a result, the OMO was able to select and extract specific information to support the elevation of issues and the provision of corresponding recommendations to CMS Leadership. This information consisted of summarized descriptions of the issues, the root cause of each issue, descriptions of any efforts involving the responsible CMS components, the current status of each issue, and preliminary recommendations from the Medicare Ombudsman.

As the year progressed, it was evident that the issue management process was becoming more fluid. It provided the OMO with pertinent information to outline key issues and formulate recommendations regarding the Medicare Program. As the process matured, it allowed for the identification of issues related to Medicare Advantage (Part C) and Original Medicare (Part A and Part B), in addition to those related to Part D. The following sections present examples of how the OMO uses its issue management process.

Issue Review: 1-800-MEDICARE Service

CMS reports indicate that 1-800-MEDICARE responded to over 37 million calls during 2006 and more than 30 million calls in 2007. The Office of Beneficiary Information Services (OBIS), the CMS component responsible for oversight of 1-800-MEDICARE, provides numerous weekly and monthly reports that OMO staff regularly review. This feedback, in conjunction with the OMO's own customer service activities and its work with organizations that partner with CMS, shed light on several key issues impacting the level of service provided by 1-800-MEDICARE.

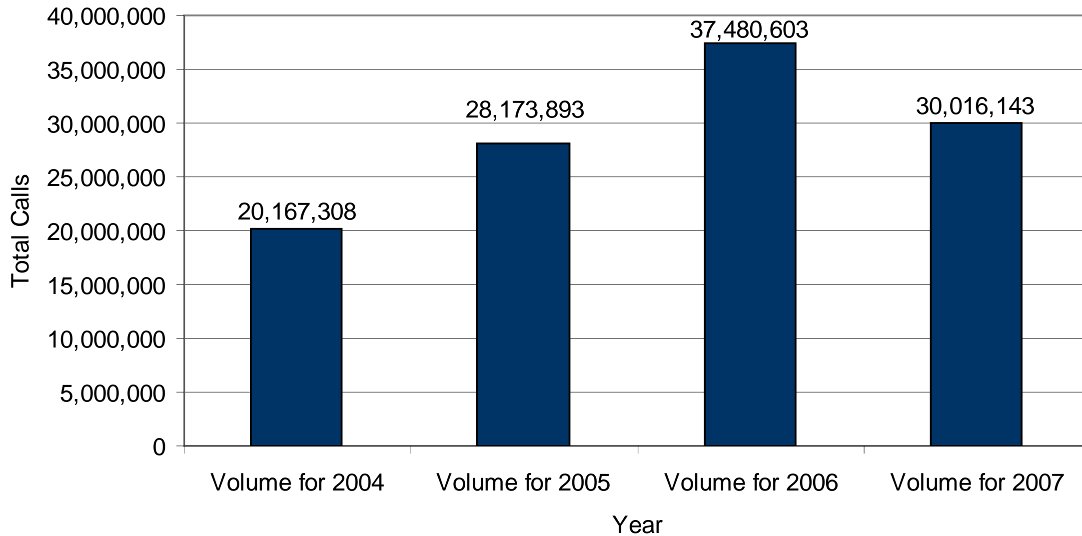
During the several years leading up to and during 2007 and 2008, those in the public who deal with the Medicare Program identified problems experienced by beneficiaries and those acting on their behalf during calls to 1-800-MEDICARE as a primary concern. The OMO is aware of issues and concerns that have been expressed by beneficiaries, advocacy groups, and partner groups, particularly the State Health Insurance Assistance Programs (SHIP). These groups have raised issues with the level of service provided by 1-800-MEDICARE. Specifically, the SHIPs have expressed concerns about periods of long wait times, receiving inaccurate or incomplete information from 1-800-MEDICARE customer service representatives, dropped calls in some instances, and not receiving return calls (known as "call-backs"). Call-backs are offered when calls placed to 1-800-MEDICARE surpass predefined wait time thresholds or require more complex, higher levels of service.

As the Medicare Program's toll-free telephone customer service network for people with Medicare and those acting on their behalf, 1-800-MEDICARE is one of the Program's most visible and prominent consumer-facing operations. For many people with Medicare, their caregivers, and members of the advocacy community, 1-800-MEDICARE is the first contact used to obtain information or receive assistance for accessing, understanding, and addressing individual issues that they may have with an expansive and sometimes very complicated Medicare Program. The importance of 1-800-MEDICARE to people with Medicare and to the Medicare Program cannot be overstated, and the impact of its efficiency and effectiveness is understood by all. This call center network provides numerous levels of support for beneficiaries, including one-on-one assistance from customer service representatives (CSR), as well as support through automated information on the Interactive Voice Response system (IVR), which provides pre-recorded questions and answers on various topics. Through these methods of support, people with Medicare and others involved in the Medicare Program seek answers to questions, information regarding the quality of various health plans, information on other general topics, and request supplementary information through publications that are available in print, audio, and Braille formats (as well as in languages other than English).

CMS consistently promotes 1-800-MEDICARE as the primary contact option for people with Medicare to receive information and assistance. The total operation has eight call centers throughout the country, at which approximately 3,000 CSRs are on-hand to respond to the anticipated high call volume periods during the year. CMS reports indicate that 20,167,308 calls were made to 1-800-MEDICARE in 2004, 28,173,893 in 2005, 37,480,603 in 2006, and 30,016,143 in 2007. As noted in Figure 3 below, from 2004 through 2007, there was an increasing trend in calls placed to 1-800-MEDICARE for various reasons which may include an increase in the number of new retirees (e.g., the

"Baby-Boomer" generation), the consolidation and transition of the Fee-for-Service calls, and a notable spike in 2006 due to the implementation of Part D Prescription Drug Benefit.

FIGURE 3: TOTAL YEARLY CALLS TO 1-800-MEDICARE (2004-2007)



(Source: National Medicare Education and Planning Committee Presentation – January 2008).

CMS reports indicate that the average monthly wait time was over seven minutes in 2007, primarily due to budgetary restrictions. Nonetheless, CMS reports indicate a favorable rate of customer satisfaction with 1-800-MEDICARE. However, representatives from the OBIS have explained that there would have been wait times during this time period both significantly above and below the seven minute average, and as expected there were a significant number of hang ups during periods with longer wait times.

In September of 2007, the Department of Health & Human Services' Office of Inspector General (OIG) published a report titled "1-800-MEDICARE: Caller Satisfaction and Experiences." That report published the outcomes of OIG's research, which was conducted with a random sample of callers over a one-week period (January 22 through 26, 2007) to assess their satisfaction and experiences with 1-800-MEDICARE customer service (*Source: OIG Report #OEI-07-06-00530_ 1-800-MEDICARE: Caller Satisfaction and Experiences*). The three specific areas of assessed customer satisfaction included:

- Caller satisfaction with the customer service he or she received;
- Whether the caller believed his or her questions were answered; and

- Whether the caller received all of the information he or she needed.

The OIG compared the outcomes of the 2007 research with the outcomes of a similar OIG report released in August of 2005, which provided findings from an assessment that was conducted during a lower call volume period. Considering this, the 2007 OIG report indicated a decrease in caller satisfaction, increased dissatisfaction with wait times, and roughly the same percentage of persons reporting negative opinions or difficulty with accessing the IVR system.

The OBIS provides several key reasons for those levels of service, with the primary reason being funding constraints:

- The OBIS indicates that budget constraints resulted in call centers maintaining an eight-minute average speed of answer; and

- The consolidation and transition of the Fee-for-Service calls was not complete during the time of the OIG study, which was a driver for beneficiary dissatisfaction.

CMS has taken several measures to address some of the service and resource issues (*Source: National Medicare Education and Planning Committee Presentation – January 2008*). These include:

- 1-800-MEDICARE initially was funded to meet an eight-minute average speed of answer; through operational improvements and efficiencies, CMS reduced the wait times and maximized use of 1-800-MEDICARE contractor staff; using advanced technologies and improved processes, significant reductions in average speed-of-answer have been realized; and

- CMS implemented process improvements to forecast call volume better, and to monitor CSR behavior and shift calls and staffing, as appropriate, to manage wait times; the implementation of technologies and process improvements changed 1-800-MEDICARE, and positively affected customer service and callers' experiences.

These improvements allowed for the reduction of caller wait times for the 2008 fall annual enrollment period. Resultant savings have been used to provide for a lower average speed-of-answer each month. Due to operational efficiencies, wait times during the last several months of 2008 were relatively low, with an average speed of

answer of approximately two minutes. Because the speed of answer has been lowered considerably during this time, 1-800-MEDICARE rarely utilized the call back process. CMS also implemented quality improvement techniques within 1-800-MEDICARE's current budgetary allotment. For example, the primary call center contractor provides various forms of coaching and feedback to CSRs to enhance their performance, and CMS contracts with a separate contractor to provide independent quality monitoring activities, which includes a review of CSR scripts and training materials.

The OBIS also has worked closely with several organizations, including the SHIPs, to identify and address their concerns. As a result, CMS learned that the SHIPs had some misconceptions and misunderstandings about 1-800-MEDICARE; therefore, it developed and disseminated a document that outlines what 1-800-MEDICARE CSRs can and cannot do. The document helped the SHIPs and other entities to understand better some of the responsibilities and functions of 1-800-MEDICARE, and redirected the SHIPs to entities (such as the Medicare Prescription Drug and Health Plans) that best can assist based on the issue. In addition, the OBIS implemented a special, toll-free number as a result of the direct work between the OEA, the OBIS, and the SHIP organizations. This number gives the SHIPs direct access to the appropriate CSRs based on their inquiry, which saves time and improves service to the SHIPs and to the beneficiaries they are assisting.

Finally, the OBIS has benchmarked and worked with many organizations to develop and implement the current business model. The OBIS' staffing and business models allow CMS to be fluid and agile to the constant fluctuations and challenges in the Program, as well as to call volume spikes. Using contractor staff allows for mass hiring and reductions based on call volume and cyclical activities. In addition, poor performers or employees with behavioral issues are removed with little effort or drawn out hierarchical review processes. A non-outsource environment would significantly increase the overall cost to the Program, as well as double the size of CMS; in addition, the loss of those jobs would impact negatively areas of the country in which CMS call centers are located. Continuous improvement efforts include:

- Each CSR receives one hour of refresher training a week and is monitored and scored four times per month for quality assurance;

- 1-800-MEDICARE has identified system and process changes to reduce calls and improve call handling, and monitors to adjust CSR shifts to match call arrival patterns;

- The call center releases alerts and performs updates to the systems used by CSRs to inform them of critical or new issues and information;

- Although rarely necessary, the call center initiates a call back process when wait times go above a predefined threshold, 20 minutes on average, and call backs generally are made within 48 hours;

- 1-800-MEDICARE has developed a list that describes which activities CSRs can and cannot perform; these have been shared with the SHIPs, CMS partners, and the CMS Regional Office caseworker staff to ensure that appropriate calls are made to 1-800-MEDICARE and other Agencies and organizations, such as SSA and the Medicare prescription drug and health plans, depending upon the nature or reason for the call; and

- 1-800-MEDICARE is looking into ways in which it can create more targeted messaging based on the specific caller profile (e.g., targeted menus for beneficiaries who are not in Original Medicare and menus for beneficiaries with prescription drug plans).

In addition to CMS' initiatives to enhance 1-800-MEDICARE outcomes, the OIG report made additional recommendations for CMS to consider, including:

- Reassess the level of resources directed toward improving the question answering capabilities of the IVR, or consider directing more resources toward supporting more CSRs to answer questions;

- Ensure that callers receive all needed information; many callers fail to receive complete information through 1-800-MEDICARE; according to the OIG, CMS could consider ways in which to ensure that callers' questions are answered during their first call; and

- Seek ways in which to reduce wait times for callers; redirecting resources from the IVR's question-answering capabilities and ensuring that calls are answered fully may reduce the need for callers to make multiple calls and shorten wait times.

The OMO acknowledges the efforts by CMS to take those steps necessary to address key performance concerns, and further acknowledges the various recommendations made by independent evaluations of its current operations. After evaluating these

reports and recommendations the Medicare Ombudsman concludes that the core issues associated with 1-800-MEDICARE are three fold:

- Increased complexity of a continually-changing Medicare environment and Program;

- A relatively high demand on 1-800-MEDICARE from a growing consumer population; and

- An operational model–*People*, *Process,* and *Technology*–that is constrained by fixed resources.

The Medicare Ombudsman concurs with the recommendations from the OIG, and acknowledges the efforts and activities in which CMS has engaged. Many of the problems that have been noted in past years have been addressed. Nonetheless, the OMO believes that CMS should continue to assess 1-800-MEDICARE operations to evaluate and define additional efficiencies and any necessary improvements to the services provided by the toll-free helpline, and define the requisite monetary resources to support any desired changes.

Issue Review: Use of the Social Security Number as the Basis for the Medicare Number

The issue of "privacy" and the potential for identity theft is widely known across the country. Data from the U.S. Department of Justice Bureau of Justice Statistics, which is provided in the special report entitled "Identity Theft, 2005," indicates that, during 2005, approximately 1.1 million households (not just Medicare beneficiaries) discovered misuse of personal information, including Social Security numbers (SSN). The subject of identity theft, privacy of personal information, and related topics are also a notable concern within the Medicare community. The Medicare Ombudsman has received complaints directly from people with Medicare regarding this issue over the past several years. During 2007, 1-800-MEDICARE received 79,792 calls regarding the general topic of fraud, which includes identity theft concerns. During 2008, there were 135,986 calls logged with 1-800-MEDICARE on the topic of fraud.

Central to the issue of privacy and potential opportunities for identity theft is the structure and widespread use of the Medicare Program's Health Insurance Claim Number (HICN). A HICN currently is assigned to every person with Medicare by the Social Security Administration (SSA) or the Railroad Retirement Board (RRB), as has been the sole practice since Medicare's inception. In general, an individual's SSN is utilized in the creation of his or her HICN number. Exceptions include the use of RRB

number or the use of a qualifying spouse's or parent's SSN. The HICN, including the SSN or other identifying number, is currently displayed on Medicare cards and the provider Remittance Advice (health insurance claim processing form). During the time of this report, over 44 million Medicare recipients have a Medicare card.

According to CMS data, in 2007, over 12 million people with Medicare were between the ages of 75 and 84, which means that they may have used this number to receive healthcare services for more than 10 years. This broad and frequent use of the HICN over time presents countless opportunities for unintended access to and use of this sensitive personal identifier. However, according to CMS findings, as of late 2008, there was no quantifiable data to support the notion that the use of the SSN as the basis for the HICN, and its display on the Medicare card, directly contributes to identity theft. CMS has taken the following steps to mitigate the risk of fraud and abuse activities that could stem from any misuse of the Medicare card:

- Prohibited Part C and Part D Plans from using the SSN or HICN as an identifier for approximately 5.7 million enrolled persons with Medicare;

- Removed the HICN from reimbursement checks (October 2005);

- Established policies and procedures for CMS contractors and employees around the disclosure of data to protect the confidentiality of people with Medicare, as outlined under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996;

- Educated people with Medicare on preventive measures of protection through a section in the "Medicare & You" handbook, and provided phone numbers to call if beneficiaries feel that they have been a victim of fraud and abuse;

- Reviewed documents and work processes that do not have a business reason for displaying the SSN or HICN;

- Removed, by 2008, the 9-digit SSN/HICN on the Medicare Summary Notice, which beneficiaries receive by mail to explain what services providers billed for, and replaced it with the last 4-digits of the SSN/HICN; and

- Beginning in January 2009, all beneficiary correspondence from Medicare's Qualified Independent Contractors no longer contain the 9-digit SSN/HICN; only the truncated 4-digit SSN/HICN appears in the appeal decision letters.

As previously stated, CMS receives inquiries and complaints expressing concerns about identity theft, and the existing structure and widespread usage of the HICN presents a significant potential for identity theft. In response to public interest and proposed legislation, CMS and SSA formed a joint Agency workgroup to formulate approaches and costs with regard to a possible change to the current Medicare Health Insurance Claim Number. Findings from an assessment conducted by the workgroup indicate that extensive additional resources would be required to execute such a complex transition without affecting existing critical operations and major initiatives, and that a transition would take at least six years to implement, with costs in excess of $500 to $870 million, depending upon the options chosen. These costs do not account for costs to State Medicaid Agencies, the costs to RRB, and the business costs of Medicare providers.

Given CMS' activities over the past few years and its planned future activities, this is an issue that the OMO will continue to monitor, as needed.

Medicare Fee-for-Service Contracting Reform

In addition to the provisions mentioned earlier in this report, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required reform and restructuring of the Medicare Fee-for-Service contracting structure. This reform (referred to as "Medicare contracting reform"), was intended to improve Medicare's administration of Part A and Part B services, including services to beneficiaries and healthcare providers. Under this mandate, Medicare would replace its current claims payment contractors—fiscal intermediaries (FI) and carriers—with new contract entities: Medicare Administrative Contractors (MAC) by 2011.

The process of transitioning to the MACs is underway. Prior to the initiation of contracting reform, CMS relied on a network of contractors to process nearly 1 billion Medicare claims each year from over 1 million healthcare providers. In addition to processing claims, the contractors enrolled healthcare providers in the Medicare program and educated them on Medicare billing requirements, handling claims appeals, and answering beneficiary and provider inquiries. These contractors included 25 FIs, which processed claims for Medicare Part A and Part B for facilities, including hospitals and skilled nursing facilities. There also were 18 carriers that processed FFS claims for Medicare Part B, in particular for physician, laboratory, and other services. In addition, four fiscal intermediaries served as regional home health intermediaries (RHHI), concentrating on home health and hospice claims exclusively. Finally, four

carriers served as durable medical equipment regional carriers (DMERC), focusing exclusively on claims for durable medical equipment, prosthetics, orthotics, and supplies. Medicare beneficiaries and those working on their behalf could contact these contractors directly to receive information and assistance regarding their Part A and Part B claims.

Counselors from State Health Insurance Assistance Programs (SHIP) and some CMS beneficiary services staff that handle Part A and Part B beneficiary inquiries and complaints have expressed difficulty in assisting beneficiaries with some Fee-for-Service issues because they are unable to contact the MACs directly as they have been able to contact the Medicare Fee-for-Service Fiscal Intermediaries and Carriers in past years. As a part of contracting reform, CMS established a single point of contact for the information needs of Medicare beneficiaries and providers of healthcare services. Providers use the MACs as their primary point-of-contact for conducting all claims-related business and obtaining information on behalf of their patients. The MACs are not required to have a dedicated customer-service inquiry staff to respond to beneficiary inquiries. The single point of contact for beneficiaries now is the 1-800-MEDICARE Beneficiary Contact Center, which will take them through a customer-service network that makes use of standard and advanced customer service tools and techniques, such as interactive voice response (IVR) systems.

Customer service representatives from 1-800-MEDICARE access and provide assistance with beneficiary and claims-specific information, and follow processes for referring pre-determined types of complex inquiries to the MACs. CMS Regional Office and OMO beneficiary services staffs also follow this same process for referring complex inquiries to the MACs. Upon receipt of these inquiries, the MACs have up to 45 days to resolve them. CMS reports indicate that the MACs generally are meeting this requirement, and that a relatively small percentage of complex inquiries are transferred to the MACs. However, for this small percentage, the process for handling beneficiary issues that are transferred to the MAC sometimes affects the ability to provide timely customer service to Medicare beneficiaries or those who work on their behalf. When a complex inquiry is submitted to a MAC with no means of direct contact, there is limited ability for those outside of CMS to follow up with the MAC to discuss and determine the status of the issue, or for those who are working to assist beneficiaries to facilitate the resolution of the issue.

Although Medicare contracting reform is necessary to improve Medicare's administration of Part A and Part B services and reduce administrative costs, CMS should consider means to enable more direct communication with MACs regarding complex issues so beneficiaries and those that work on their behalf can obtain the status

and facilitate the resolution of their issues in a timely manner. CMS also should ensure that expectations regarding the timeframe for resolving or responding to these complex inquiries clearly are communicated to beneficiaries and those working on their behalf.

This is another issue that the OMO will continue to monitor, as needed.

Issue Review: Medicare Ambulance and Wheelchair Coverage

During 2008, as a part of the issue-management process, the OMO found that Medicare beneficiaries were making complaints regarding coverage of ambulance services and durable medical equipment (DME), specifically the wheelchair benefit, because they were confused about the coverage policies. After researching the issues and the coverage policies, the OMO determined that tip sheets were the best and most practical means to address this issue. The OMO worked with Agency partners to provide language for the 2009 "Medicare & You" handbook regarding Medicare's coverage of ambulance services and wheelchair policies, and created tip sheets to make the coverage policies clearer to beneficiaries. The tip sheets for these topics are available to beneficiaries on www.medicare.gov:

- Medicare and Ambulance Coverage
  http://www.medicare.gov/Publications/Pubs/pdf/11398.pdf

- Medicare's Wheelchair and Scooter Benefit
  http://www.medicare.gov/Publications/Pubs/pdf/11046.pdf

In 2008, the OMO focused on continuous improvement opportunities for its issue-management process. It refined the ways in which new issues are surfaced, and ensured that the appropriate stakeholders were present to discuss issues and increase the effectiveness of meetings.

Medicare Administrative Issue Tracker and Reporting of Operations System

The CMS Consortium for Financial Management and Fee-for-Service Operations (CFMFFSO) is responsible for managing CMS casework and inquiries related to various aspects of Original Medicare (Part A and Part B). These types of inquiries number in the tens of thousands annually across the Medicare Program and CMS' 10 Regional Offices. The OMO and CMS Leadership believed that inquiry and complaint tracking for Medicare Part A and Part B ideally should be managed and supported in much the same way as it is for Part C and Part D.

There are various internal and external entities responsible for Fee-for-Service (FFS) operations within CMS, but no singular system existed for managing and tracking FFS inquiries and complaints that CMS received from people with Medicare and FFS providers. Although each CMS Regional Office has developed its own system to track and manage inquiries and complaints, these systems are inconsistent, and do not utilize standardized operational processes and procedures to guide how inquiries and complaints are handled and reported. During 2007, a FFS casework workgroup was established to address these issues, and to accomplish the goals of identifying and developing a system and ensure standardization of FFS inquiry and complaint management within CMS. Members of this group included three CMS Associate Regional Administrators within the CFMFFSO and a lead from the OMO.

The CMS FFS casework workgroup was tasked with developing and implementing the FFS casework and customer service inquiry and complaint management system, as well as standard operational procedures and processes for the handling of Medicare beneficiary and provider inquiries and complaints received by CMS. This system, the Medicare Administrative Issue Tracker and Reporting of Operations system (MAISTRO), would serve to collect and maintain information on FFS casework that comes directly to and is handled by CMS staff. Current CMS customer support systems may evolve, or others may be developed, to accommodate the management and tracking of all inquiries and complaints received by CMS, but MAISTRO provides an interim solution until an enterprise-wide customer support solution that combines the tracking of Medicare Parts A, B, C, and D inquiries and complaints can be implemented.

Following efforts to gather requirements, develop the system, test the system, and deploy the system, MAISTRO was implemented in December 2008. An OMO staff member, in conjunction with the CFMFFSO, plays a key role in its post-implementation management and maintenance. This involves working closely with technical staff to ensure the continuity of system operations, identifying new system requirements, overseeing scheduled releases to satisfy those requirements, coordinating future system testing, and overseeing any necessary emergency fixes to the system.

MAISTRO provides a mechanism for CMS' Central and Regional Offices to capture, track, manage, trend, and report data on inquiries, complaints, and issues related to FFS. The system also enables consistency with tracking, resolving, and reporting FFS inquiries, complaints, and issues such that trends can be identified and systemic issues can be managed appropriately across the CMS offices. To this end, the CFMFFSO and the OMO established a FFS casework call within CMS, which is facilitated by the OMO. Both MAISTRO and this call provide the OMO with valuable tools to collect and

validate issues related to Part A and Part B of the Medicare Program; this information feeds into the OMO's issue-management process.

Complaints Tracking Module Weekly Summary Reporting

The OMO is one of several CMS components that utilizes CMS' Complaints Tracking Module (CTM), a tool that is used to collect data and serve as an indicator of trends in Part C and Part D issues. The primary source of these Part C and Part D complaints is data logged by 1-800-MEDICARE, the national Medicare call center operation. The CTM, a repository of Part C and Part D complaints received by CMS nationwide, is a vital tool for tracking and trending these types of complaints. Prior to its implementation, there was no central mechanism to track and trend complaints related to Part C and Part D of the Medicare Program. The CTM provides numerous functions that enable CMS to gain more timely insight into precise areas in which issues are impacting people with Medicare. These functions include classifying complaints into specific categories, assigning responsibility for resolution to specific CMS Regional Office or Central Office personnel, and reporting in a variety of capabilities.

The OMO and several other CMS components use the CTM to identify and analyze the issues that are driving the complaints. The OMO also uses CTM data and information to support its issue-management efforts and produces a weekly report that summarizes Part C and Part D complaint trends, highlights the top issues that involve or impact casework, and serves as a means to communicate this information broadly. This summary report is reviewed and discussed during recurrent meetings in which CMS Leadership and management are present. Perhaps more importantly, this weekly report helps facilitate an open dialogue between CMS Central and Regional Offices to validate the underlying causes for complaints, and to discuss recommendations for changes to policy, process, technology, and solutions, where possible.

Beneficiary Contact Trend Reporting

Another means to identify and understand issues that impact people with Medicare is to analyze and understand how they contact CMS and other entities about the Medicare Program. As discussed in the 2005-2006 Medicare Ombudsman Report to Congress, the OMO researched and documented CMS' beneficiary-assistance framework, through which people with Medicare could contact CMS to make inquiries and file complaints, grievances, and/or appeals.

Through this exercise, the OMO realized a need to consolidate this data and information for the purposes of identifying trends and possibly highlighting potential areas of concern. This, in turn, led to the design and initial development of the Medicare Ombudsman Data System (MODS). MODS was intended to be used by the OMO as a data system that would receive and manage aggregate beneficiary inquiry, complaint, grievance, and appeal data from various CMS data sources and serve as a tool for the OMO in the trending, analysis, and reporting of this data. The design and development of MODS involved the complex integration of data from multiple, disparate data sources. Ultimately, several factors led to the termination of the effort to develop MODS, including delays in bringing the source-data owners and experts into the requirements validation process, data-access issues due to the privacy and sensitivity of the data, recurrent apprehensions and draw-backs regarding the use and reporting of the data, and resource limitations. Due to the cumulative delays, unforeseen complexities, and resource limitations, decisions were made over time to significantly de-scope the project. As previously indicated, the end result was the termination of efforts to develop and implement MODS; however, the need to aggregate and trend data on beneficiary contacts to CMS remained.

In mid-2007, the OMO began development of the Beneficiary Contact Trend (BCT) report to meet the underlying needs for MODS. As the issues associated with each trend are determined to be prominent systemic issues, or are indicative of known issues, they are reported to CMS Leadership. The BCT Report provides the OMO with a baseline view of the volume and reasons for various types of contacts to the Medicare Program from sources from which data is readily available. Figure 4 identifies the BCT Report's seven CMS data sources:

FIGURE 4: CMS DATA SOURCES FOR INFORMATION COLLECTED IN THE BCT REPORT

CMS Data Sources*	CMS System	Information Collected
1-800-MEDICARE	National Data Warehouse (NDW)	• Total call volume for 1-800-MEDICARE; • Top 10 reasons and associated volumes for contact (e.g., "script hits").
State Health Insurance Assistance Programs (SHIP)	National Performance Report (NPR) System	• SHIP Contact volume; • Reasons for contact (e.g., "topics discussed").
Division of Medicare Ombudsman Assistance (DMOA)	Strategic Work Information Folder Transfer (SWIFT)	• Volume of contacts handled by the OMO; • Reasons for contact to OMO or CMS Central Office.
Components That Log CTM Complaints • 1-800-MEDICARE • CMS Regional and Central Offices	Complaint Tracking Module (CTM)	• Part D and Part C complaint volumes; • Volumes of 15 primary complaint categories for Part D beneficiary complaints; • Volumes of 6 primary complaint categories for Part C beneficiary complaints.
Fiscal Intermediaries, Carriers, and Medicare Administrative Contractors (MAC)	Contractor Management Information System (CMIS)	• Volume of Level 1 appeals (Part A and Part B appeals only); • Volume of inquiries (Part A and Part B).
Qualified Independent Contractors (QIC)	Medicare Appeals System (MAS) – Part A and Part B	• Total volume of Level 2 Part A and Part B appeals; • Volumes by type of Part A and Part B appeals.
Qualified Independent Contractors (QIC)	Medicare Appeals System (MAS) – Parts C and D	• Total volume of Level 2 Part C and Part D appeals; • Volumes by type of Part C and Part D appeal.

**Note:* *With the exception of the CTM, all of the listed CMS Data Sources log and resolve complaints.*

The OMO recognizes that these sources do not represent the full spectrum of entities to which people with Medicare turn when they have inquiries or complaints, or want to file appeals. Certainly, Part C health plans and Part D prescription drug plans are key resources for beneficiaries in need of such support; however, data from all of these entities is not readily available. Moreover, for the data that is available, there are important caveats, including:

- Contacts from a single beneficiary to more than one of the sources are counted by both sources because they reflect the volume (and workload) experienced by each source; this could include referrals from one entity to another;

- Medicare Part C and Part D plans report limited information about beneficiary contacts; for example, inquiries, complaints, and grievances made directly to the

plans are not reported to CMS; inquiries made to the SHIPs may be under-reported (e.g., SHIP reporting is inconsistent state-to-state);

- Each of the seven data systems uses substantially different classification systems to report information about the reason for the contact; some report the types of contacts, and not the specific topic or reason; some systems allow only one reason to be recorded, while others allow multiple reasons to describe a single contact; and

- CMS operational decisions, such as the transitioning of beneficiary call responsibility from Fee-for-Service claims administration contractors to the 1-800-MEDICARE helpline and initiating a broader collection of Part C complaint data during the year, account for some of the data changes.

These caveats are important to understand when interpreting data; however, none of them is surprising given the fact that these systems, along with the work plans for the entities that enter data into them, are framed around business needs for other operating purposes. In general, the systems measure workloads, such as the number of contacts, and not necessarily the reasons for the contacts. However, as new beneficiary service systems come online (e.g., the CTM), the data-collection and reporting functionality usually includes comprehensive categorization of the reasons for contacting Medicare, providing CMS and the OMO increased insight into the beneficiary experience.

In summary, the Medicare Ombudsman's effort to identify and tap existing data sources provides valuable information on contacts made to entities that handle Medicare related issues and concerns. Despite the shortcomings in precision and depth of the data, the BCT report provides a general view of the volume of beneficiary-related contacts to the Medicare Program and a broad perspective of their reasons for doing so.

In 2007, the sources included in the BCT report handled a total of over 34 million beneficiary-related contacts. In 2008, the sources included in the BCT report handled a total of more than 29 million beneficiary-related contacts. Figure 5 provides annual totals for all sources captured in the BCT in 2007 and 2008:

FIGURE 5: TOTAL NUMBER OF CONTACTS CAPTURED IN THE REPORT FOR 2007 AND 2008 PER CMS DATA SOURCE

Source	2007 Total Contacts	2008 Total Contacts
1-800-MEDICARE National Data Warehouse (NDW)	30,016,143	26,472,044
SHIP National Performance Report (NPR)	2,145,612	2,728,061
DMOA Reports	37,853	27,253
Complaint Tracking Module (CTM)	354,464	271,731
Contractor Management Information System (CMIS) – *Beneficiary Inquiries*	1,559,093	273,573*
Medicare Appeals System (MAS)	439,348	Not available**
Total	**34,552,513**	**29,772,662***

**Note:* *Many of Medicare Fee-for-Service inquiries that were previously reported in CMIS now are handled by the 1-800 MEDICARE Beneficiary Contact Center (BCC) and are captured in the NDW totals for 2007 and 2008. The significant decrease in CMIS inquiries from 2007 to 2008 reflects the further transition of this workload to the BCC over that time period.*

***Note:* *Appeals data for 2008 was unavailable at the time of this report.*

In general, the overall number of contacts from 2007 to 2008 decreased as a result of fewer inquiries and complaints about Medicare Part C and Part D issues, which is evident in the drop in contacts through the Complaint Tracking Module (CTM) and calls to 1-800-MEDICARE. The Contractor Management Information System (CMIS) contacts also reflect a significant decrease from 2007 to 2008 because the bulk of those contacts were captured by 1-800-MEDICARE. The reason for this is explained further beginning on page 58 of this report.

The following sections provide information on the contacts and, where possible, the reasons for those contacts for each data source included in the BCT report.

1-800-MEDICARE

As noted earlier in this report, CMS implemented this nationwide toll-free telephone help line in 1999 to provide a means for beneficiaries, their caregivers, and other members of the public to call and obtain information about the Medicare Program and its benefits, and to receive related assistance. The help line operates 24 hours a day, seven days a week, and is operated by a contractor. Calls are answered first by an automated system and, if requested, then routed to a Customer Service Representative (CSR) for more specific inquiries about Medicare benefits and assistance. Data on call volume and the reasons for contact are reported by the National Data Warehouse, and include total call volume by call type—Interactive Voice Response (IVR) system and calls handled by CSRs. Data on the reasons for contact are extrapolated from "script

hits," which reflect the number of times a given script is accessed by CSRs. CSRs are required to access the correct script prior to providing information, even if they know the answer to the question being asked. Internal controls are in place to measure CSR adherence to the protocol.

The real time help provided to callers through 1-800-MEDICARE requires significant expertise on the part of CSRs. Some calls are more complex than others; therefore, the program responds to calls on the following four levels:

- IVR—automated system with multiple menus that allow callers to order publications, access some information related to submitted claims, or receive general information on Medicare;

- Tier 1 CSR—persons trained to respond to general- and/or claims-related inquiries and log complaints; and

- Tier 2 CSR—persons with advanced training to respond to more complex inquires; there are some scripts that only can be accessed by Tier 2 CSRs.

- Advanced Resolution Center CSRs – a small number of highly trained CSRs who receive referral calls from 1-800 MEDICARE CSRs that require research on inquiries that do not have a scripted response. The CSRs research the issue and return a call within 48 hours.

The 1-800-MEDICARE helpline responded to over 30 million calls during 2007, and more than 26 million calls during 2008. Figure 6 provides an overview of the way calls to 1-800-MEDICARE were completed:

FIGURE 6: CALLS TO 1-800-MEDICARE HANDLED BY THE IVR AND CUSTOMER SERVICE REPRESENTATIVES (CSR) IN 2007 AND 2008

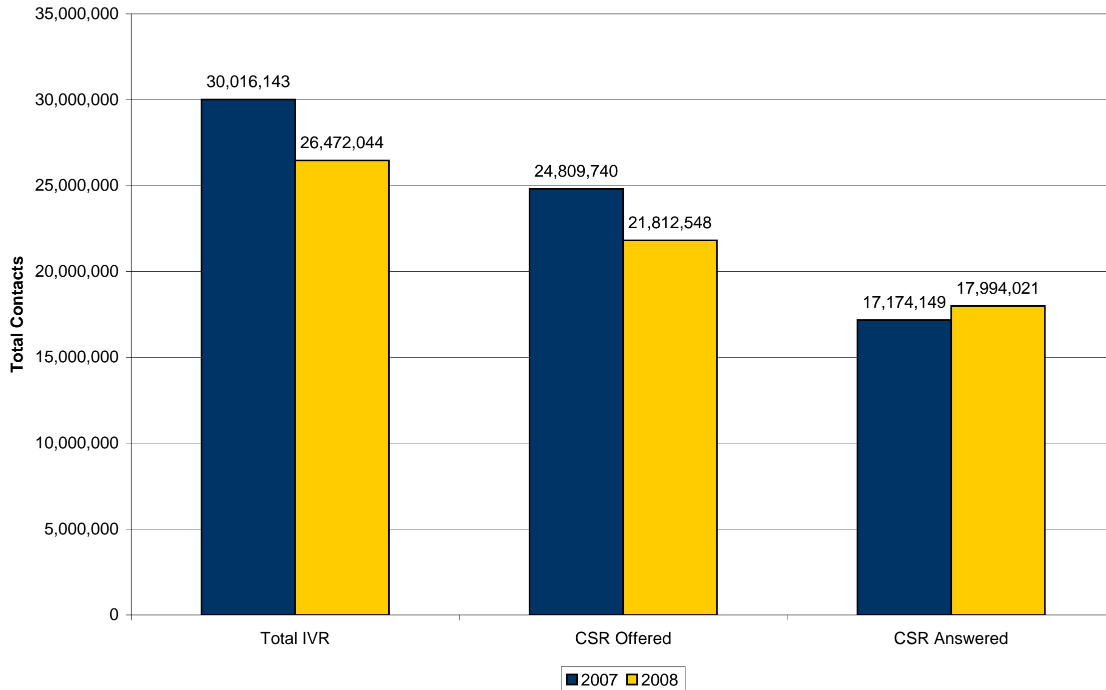
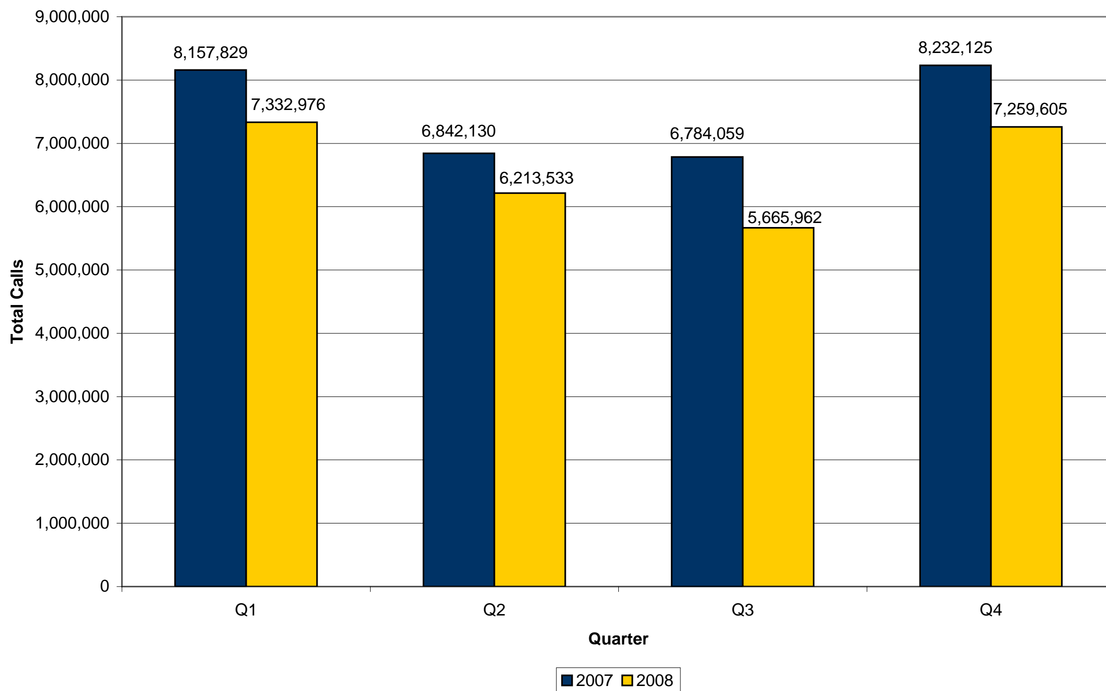


Figure 7 below displays the volume of calls to 1-800-MEDICARE per quarter for calendar years 2007 and 2008. As Figure 7 explains, the pattern of calls changed in similar fashions during both years, with higher volumes in the first and last quarters of the year. The higher volume of calls to 1-800-MEDICARE that occurred during the first quarter of 2007 and 2008, the months of January through March, corresponds to the Medicare annual enrollment period that took place in the last months of 2006 and 2007 (November 15 through December 31) and the Medicare Advantage open enrollment period that occurred during January 1 through March 31 of 2007 and 2008.

Later in the year, during the time of the Medicare annual enrollment period for joining or changing Medicare prescription drug plans and Medicare Advantage Plans, the volume of calls increased from 6.7 million during the third quarter to 8.2 million in the fourth quarter of 2007, and from 5.6 million during the third quarter to 7.2 during the fourth quarter of 2008. Additional data shows that the percent of calls requiring more complex assistance (e.g., those handled by Tier 2 CSRs) rose from 3.9% in the third quarter to 8.1% in the fourth quarter in 2007.

FIGURE 7: CALLS TO 1-800-MEDICARE PER QUARTER IN 2007 AND 2008



The CSRs that handle calls to 1-800-MEDICARE use numerous information scripts when they provide assistance to callers. This means that a CSR possibly could log multiple reasons for each call. Figures 8A and 8B below provide the top 10 reasons people contacted 1-800-MEDICARE during 2007 and 2008 (e.g., the 10 scripts accessed most often by CSRs), and the corresponding percentage of these script hits within the top 10 reasons for calls.

In 2007, the most common topics handled by CSRs were related to enrollment/disenrollment periods for drug coverage, complaints about drug coverage, questions or concerns regarding Medicare costs and premiums, and Medicare secondary-payer questions or concerns. It is interesting to note, however, that calls related to the medicare.gov tools almost doubled from the second and third quarters to the fourth (about 8% to 16%), during the open enrollment period for Part D. This correlates to the increased CMS promotion and higher public usage of the web tools during this period.

FIGURE 8A: TOP 10 REASONS FOR CONTACTS TO 1-800-MEDICARE DURING 2007

Reason	Script Hits	Percent of Top 10 Reasons for Hits
Enrollment/Disenrollment Periods Drug Coverage and Medicare Advantage	928,864	24%
Drug Coverage Complaints	433,513	11%
Medicare Costs and Premiums	416,966	11%
MSP Medicare Secondary Payer	400,492	10%
Medicare.gov Tools	349,581	9%
Durable Medical Equipment (DME) Covered/Non-Covered	309,050	8%
Part B Covered/Non-Covered Services	304,482	8%
Preventive Services Overview	262,981	7%
How Medicare Advantage Plans Work	228,437	6%
Drug Coverage LIS Extra Help Apply	215,173	6%
Totals	**3,849,539**	**100%**

From 2007 to 2008, the volume of script hits for Part B Covered/Non-Covered Services increased dramatically. This is likely due to the fact that a number of standalone scripts regarding this and related topics were merged into a consolidated script in 2008, and this script was notably enhanced in 2008. Also, script hits for MSP Medicare Secondary Payer inquiries also had a notable 53% increase in 2008, but the reason for this increase is not apparent.

FIGURE 8B: TOP 10 REASONS FOR CONTACTS TO 1-800-MEDICARE DURING 2008

Reason	Script Hits	Percent of Top 10 Reasons for Hits
Part B Covered/Non-Covered Services	1,153,027	19%
Enrollment Disenrollment Periods Drug Coverage and Medicare Advantage	950,163	16%
MSP Medicare Secondary Payer	749,518	13%
Durable Medical Equipment (DME) Covered/Non-Covered	665,211	11%
Medicare Costs and Premiums	597,282	10%
Medicare.gov Tools	433,800	7%
Drug Coverage Extra Help LIS	350,801	6%
Preventive Services Overview	344,905	6%
How Medicare Advantage Plans Work	339,413	6%
Part A Covered/Non-Covered Services	336,149	6%
Totals	**5,920,269**	**100%**

In addition, the script hits for the topic of Durable Medical Equipment (DME) Covered/Non-Covered more than doubled during 2008, which is most likely attributable to Medicare's launching of a campaign on durable medical equipment across 10 states (DMEPOS). Medicare changed requirements for contractors, asking them to reapply to be certified to offer DME in certain states; in addition, some changes in coverage were to take place. Finally, the number of script hits for Drug Coverage complaints decreased significantly from 2007 to 2008, and does not appear in the top 10. This likely is attributable to enhanced training of the CSRs on what constitutes a complaint and the appropriate categorization of Part D inquiries vs. complaints, as well as a general overall decrease in such complaints during 2008.

State Health Insurance Assistance Programs (SHIP)

SHIP grants are funded by CMS in all 50 states, as well as in the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. The SHIPs provide local, one on one counseling and assistance, either in-person or over the telephone, to people who are eligible for or enrolled in Medicare. Most of these benefits counseling sessions are handled by volunteer staff members who receive extensive, ongoing training. These SHIP Counselors complete client-contact forms for each benefits-counseling session; information from these forms regarding the nature of the counseling sessions is submitted to CMS through National Performance Report data. Counselors can record multiple topics discussed during each contact; however, counselors are not required to list each reason for the counseling session if there are multiple issues. This can skew the true number of individual topics discussed to some degree.

SHIP staff and volunteers recorded more than 2.1 million beneficiary related contacts for 2007, or about 30 contacts for each 1,000 beneficiaries. Additional data shows that contact volumes increased through 2007, with totals in the last quarter of the year about 59% higher than those in the first quarter of the year. This increase took place during the fall of 2007, as Medicare health plan open enrollment was taking place.

In 2008, SHIP staff and volunteers recorded close to 2.2 million beneficiary-related contacts. Figure 9A provides the counts for each of the Top 10 topics coded by the SHIPs and the percentage of all topics discussed and top 10 topics discussed in 2007:

FIGURE 9A: TOP 10 REASONS FOR 2007 NATIONAL-LEVEL CONTACTS TO SHIPS – INDIVIDUAL BENEFICIARY CONTACTS

Reason	No. of Contacts	Percent of All Contacts	Percent of the Top 10 Reasons for Contacts
Part D: Plan Eligibility, Benefit Comps.	487,305	18%	18%
Part D: Enrollment and Application Assist.	242,154	9%	9%
Part D: Low Income Assistance - Eligibility, Benefit Comparisons	226,897	8%	8%
Part A/B: Enrollment, Eligibility, Benefits	224,650	8%	8%
Plans: Enrollment, Disenrollment, Eligibility, Comparisons	191,134	7%	7%
Medigap: Enrollment, Eligibility, Comps.	180,476	7%	7%
Other: Other*	174,426	6%	6%
Medicaid: QMB - SLMB - QI	159,901	6%	6%
Part D: State Pharmacy Assistance Prog.	147,574	5%	5%
Medicaid: Other Medicaid	133,469	5%	5%
All Other Categories	560,075	21%	n/a
Totals	**2,728,061**	**100%**	

Note: *The category "Other: Other" represents reasons for visits where no pre-determined visit category or subcategory was available for the SHIP counselors to select.*

Topics regarding Medicare Part D accounted for nearly 40% of all topics discussed with the SHIPs during 2007, with the most frequent Part D-related topics involving questions about plan eligibility and benefit comparison (18%), enrollment and application assistance (8%), and Federal assistance for beneficiaries with low incomes (7%).

SHIP contacts regarding the topic of Medicare Parts A and B enrollment, eligibility and benefits accounted for 8% of all contacts, and the topic of Medicare health and prescription drug plan enrollment, disenrollment, eligibility and plan comparisons accounted for 7% of all contacts. Topics related to Medicaid accounted for about 11%. The remaining types of topics discussed each occurred less frequently and are grouped together as "All Other Categories" in Figure 9A. The top 10 categories and percentage of each were relatively stable throughout 2007.

Figure 9B provides the counts for each of the Top 10 topics coded by the SHIPs and the percentage of all topics discussed and top 10 topics discussed in 2008:

FIGURE 9B: TOP 10 REASONS FOR 2008 NATIONAL LEVEL CONTACTS TO SHIPS – INDIVIDUAL BENEFICIARY CONTACTS

Reason	No. of Contacts	Percent of All Contacts	Percent of the Top 10 Reasons for Contacts
Part D: Plan Eligibility, Benefit Comps.	384,491	18%	18%
Part D: Enrollment and Application Assist.	172,333	8%	8%
Part A/B: Enrollment, Eligibility, Benefits	168,029	8%	8%
Part D: Low Income Assistance - Eligibility, Benefit Comparisons	154,546	7%	7%
Plans: Enrollment, Disenrollment, Eligibility, Comparisons	150,857	7%	7%
Medigap: Enrollment, Eligibility, Comps.	143,871	7%	7%
Other: Other*	130,593	6%	6%
Medicaid: QMB - SLMB - QI	119,082	6%	6%
Part D: State Pharmacy Assistance Prog.	118,384	6%	6%
Medicaid: Other Medicaid	116,078	5%	5%
All Other Categories	487,348	23%	n/a
Totals	**2,145,612**	**100%**	

****Note:*** *The category "Other: Other" represents reasons for visits where no pre-determined visit category or subcategory was available for the SHIP counselors to select.*

Topics regarding Part D accounted for nearly 40% of all topics discussed with the SHIPs again during 2008. The total combined volume of the Part D-related topics increased from 2007 to 2008, which likely is attributable to intensified promotion and outreach on one-on-one counseling services to pick and resolve issues with Part D plans. Several of the other categories of topics discussed had notable increases in volume during 2008 as well. During 2008, the SHIPs received increased funding to conduct community-based programs targeted at reaching more beneficiaries who are unable to access other sources of information such as the CMS online tools at www.medicare.gov. The SHIPs continued their outreach and assistance to Medicare beneficiaries and their caregivers, as well as to beneficiaries with limited incomes who were likely eligible for the extra help with prescription drug costs. Some of this resulted in an increase in the volume of contacts with beneficiaries and assistance provided by the SHIPs. In addition, efforts to improve the reporting of SHIP contacts may have contributed to the increase.

Division of Medicare Ombudsman Assistance

The Division of Ombudsman Casework & Trends Management (DOCTM) was renamed to become the Division of Medicare Ombudsman Assistance (DMOA) during 2008 as the result of reorganization. The DMOA remains housed within the OMO, and receives and processes beneficiary complaints and inquiries submitted to CMS' Central Office as

well as those directed to the Medicare Ombudsman. For more information about the DMOA, see page 71.

Over the course of 2007, this staff received and processed over 36,000 inquiries and complaints from or on behalf of people with Medicare. In 2008, the staff received and processed over 27,000 inquiries and complaints. Processing these inquiries included analyzing, categorizing, triaging to CMS Regional Offices and other government entities, and ensuring the timely response to those contacts directed to CMS Central Office for a response either in writing, by telephone, or by email. The OMO directly handled over 22,000 of those inquiries and complaints received in 2007, and handled over 16,000 of the inquiries and complaints received in 2008, which included investigating, taking corrective action when needed, and providing a verbal or written response as appropriate. Topics included all aspects of CMS programs and many are considered complex in nature.

Figure 10A provides a breakdown of all categories of inquiries and complaints received by DMOA in 2007:

FIGURE 10A: BENEFICIARY CONTACT DATA FOR 2007 - REASONS FOR CONTACTS RECEIVED BY THE OMO

Reason	Contacts	Percent of All Contacts
Part D	11,277	30%
Part B Premiums	9,593	25%
Medicare Coverage	3,853	10%
Medicare Eligibility/Enrollment	2,453	6%
Claims Inquiries/Complaints	2,388	6%
Medicare Managed Care	1,526	4%
Medicare Secondary Payer	869	2%
Miscellaneous/Other	5,894	17%
Totals	**37,853**	**100%**

Additional data, not shown here, indicates concerns about Part D were more frequent at the start of the year, due to the fact that DMOA received a significant number of complex enrollment/disenrollment and premium-related questions and concerns during that time. These typically trend upward following health plan changes that people with Medicare make during annual enrollment periods. During 2008, CMS experienced a correspondence management system failure, and therefore shifted to a new system. With that came some revisions and additions to the categorization of reasons for

contact. For example, 2008 contacts for "premiums" consist of Part B and Part D related complaints in one category; in addition, the category of "disenrollment/enrollment/withdrawal" consists of contacts that were categorized as "Part D" in 2007 and before.

Figure 10B provides a breakdown of all categories of inquiries and complaints received by the DMOA in 2008:

FIGURE 10B: BENEFICIARY CONTACT DATA FOR 2008 - REASONS FOR CONTACTS RECEIVED BY THE OMO

Reason	Contacts	Percent of All Contacts
Premiums	6,883	25%
Medicare Coverage	3,484	13%
Medicare Eligibility/Enrollment	2,599	9%
Disenrollment/Enrollment/Withdrawal	1,726	6%
Claims Inquiries/Complaints	1,379	5%
Medicare Advantage	1,234	4%
Medicare Secondary Payer	1,167	4%
Inquiries Not Medicare/Medicaid Specific	738	3%
Coinsurance/Deductible/Pricing	464	2%
Quality of Care	288	1%
Other	7,291	27%
Totals	**27,253**	**100%**

There is a notable decrease in the total volume of inquiries and complaints received by the DMOA in 2008, which was partially due to CMS' addressing some of the issues that resulted in the "spike" of inquiries and complaints involving Medicare Part D and plan premium payments during 2006 and 2007.

Complaint Tracking Module

Developed in 1996, the Health Plan Management System (HPMS) Complaints Tracking Module (CTM) records Medicare Part D Prescription Drug Program and Part C Medicare Advantage program complaints that are received by CMS from beneficiaries and providers. It is CMS' central repository for complaints received from various sources, including, but not limited to, 1-800-MEDICARE and CMS' Regional Offices. All complaint casework documentation, intervention, and resolution notes are recorded in the CTM. CMS oversees the corresponding CMS health and prescription drug plan activities via random sampling of cases and monitoring of plan performance ratings.

Part C organizations, Part D sponsors, CMS Regional and Central Office staff, and the Medicare Drug Integrity Contractors (MEDIC) access the CTM to manage their respective complaint workloads and to document their actions in reviewing and resolving complaints. The Medicare health and prescription drug plans are accountable for the prompt resolution of complaints recorded in the Complaints Tracking Module (CTM). All complaints are assigned to a main category and a subcategory. The main categories include Access & Availability, Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information, Benefits/Access, Confidentiality/Privacy, Contractor/Partner Performance, Customer Service, Enrollment/Disenrollment, Exceptions/Appeals, Formulary, Grievances, Marketing, Medication Therapy Management, Payment/Claims, Pharmacies, Plan Administration, Pricing/Co-Insurance, Program Integrity Issues/Potential Fraud, Waste and Abuse, and Quality of Care/Clinical Issues.

CMS has made significant strides to improve the CTM's functionality. In 2007, the universal Health Insurance Claim Number (HICN) was implemented to assist in the proper identification of beneficiaries. CMS also added two new subcategories within the Pricing/Co-Insurance category to capture issues related to premium withholds and loss of Low Income Subsidy (LIS) eligibility because, previously, this information was collected inconsistently.

Later, in 2008, the CTM standard operating procedures (SOP) were revised to incorporate Part C plans and an updated list of CTM complaint categories and subcategories, with a high-level description of each were distributed to Part C plans and Part D plan sponsors in an effort to increase consistency of complaint category assignments.

In 2007, a total of 354,464 complaints were recorded in the CTM, in which the top two categories of complaints, enrollment/disenrollment and pricing/coinsurance, accounted for 87% of all complaints. During 2007, over 90% of the complaints in the CTM were recorded in the Part D module and the remaining complaints were recorded in the Medicare Advantage module. The significant disproportionate distribution of complaints is due to the fact that the responsibility for Part C organizations to use the CTM to access and resolve complaints was formalized in late July 2008. In addition, during this time complaints that related to both programs, such as enrollment complaints about a Medicare Advantage Prescription Drug Plan were classified as Part D complaints. This changed in October of 2008, when CTM enhancements were made to assign complaints to the Medicare Advantage or Part D program appropriately, based on the complaint category and the Medicare health plan or prescription drug plan identification data.

Figures 11A and 11B show the breakdown by category of all complaints entered into the CTM in 2007 and 2008, respectively.

FIGURE 11A: CTM DATA FOR 2007 - REASONS FOR BENEFICIARY PART C & PART D COMPLAINTS

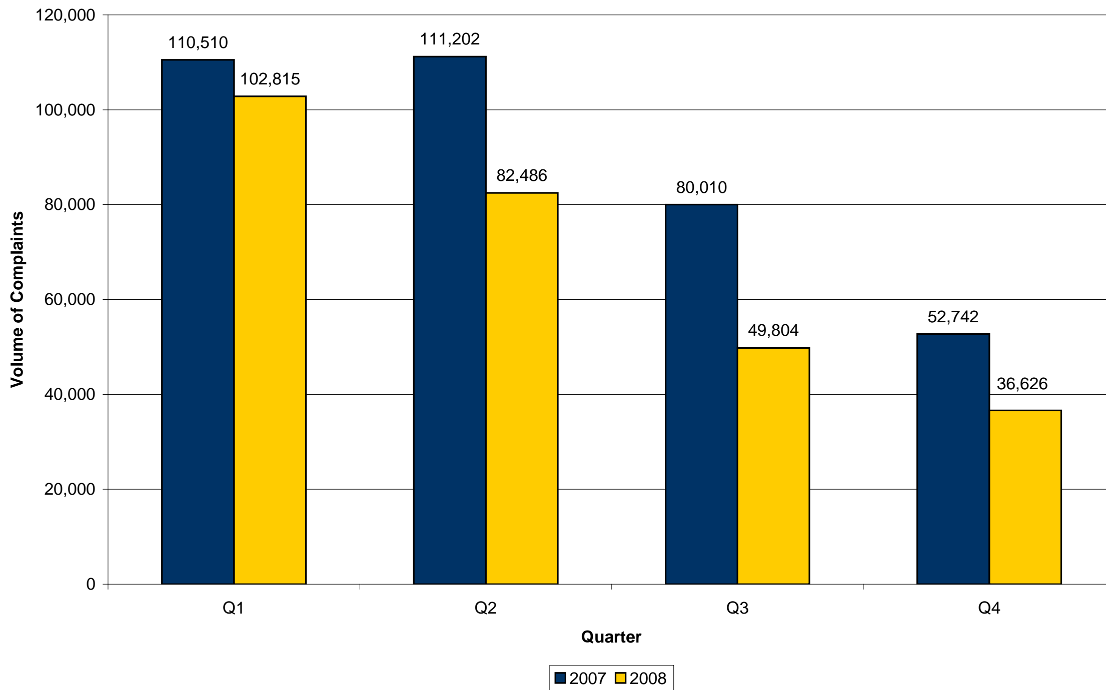
Reason	Contacts	Percent of All Contacts
Enrollment/Disenrollment	214,372	60%
Pricing/Coinsurance	96,485	27%
Customer Service	12,116	3%
Benefits/Access	11,094	3%
Grievances	4,786	1%
Formulary	4,596	1%
Program Integrity Issues/Potential Fraud, Waste, and Abuse	3,136	0.9%
Plan Administration	2,323	0.7%
Exceptions/Appeals	2,095	0.6%
Marketing	1,236	0.3%
All Others	2,225	0.6%
Totals	**354,464**	**100%**

FIGURE 11B: CTM DATA FOR 2008 - REASONS FOR BENEFICIARY PART C & PART D COMPLAINTS

Reason	Contacts	Percent of All Contacts
Enrollment/Disenrollment	169,826	61%
Pricing/Coinsurance	50,385	18%
Marketing	13,742	5%
Benefits/Access	12,753	5%
Customer Service	8,559	3%
Plan Administration	7,140	3%
Formulary	3,922	1%
Program Integrity Issues/Potential Fraud, Waste, and Abuse	3,473	1%
Exceptions/Appeals	1,979	0.7%
Grievances	1,570	0.6%
All Others	3,122	1%
Totals	**276,471**	**100%**

As Figure 12 shows below, the total number of complaints in the CTM system decreased notably from the first quarter of 2007 as compared to the last quarter, dropping from 110,510 in the first quarter to 52,742 in last quarter.

FIGURE 12: 2007 AND 2008 QUARTERLY VOLUME OF BENEFICIARY PART C AND PART D COMPLAINTS



Similarly, the total number of complaints in the CTM system decreased notably from the first quarter of 2008 as compared to the last quarter, dropping from 102,815 in the first quarter to 36,626 in last quarter. Additional data shows that a reduction in complaints about Part D drove this decline, decreasing from 108,000 in each of the first two quarters of 2007 to 46,490 in the last quarter of 2007. The same downward trend from Q1-Q4 is evident 2008.

This yearly trend of reduction in Part D complaints is partially attributed to CMS' correction of issues caused by numerous end-of-year plan changes and corresponding data discrepancies, CMS' efforts to address systems and payment processing issues during the year. The systems improvements and policy changes that have occurred since 2006 substantially have reduced systems problems, resulting in a decline in related complaints from 2007 through 2008. It also must be noted that, while the volume of total complaints decreased, the volume of plans and beneficiary enrollment in prescription drug and health plans increased over this two year period, further underscoring the positive impacts of CMS' enrollment assistance, systems

improvements, and casework efforts to reduce and resolve complaints. Figures 13A and 13B display the breakdown of Part D complaints in the CTM during 2007 and 2008:

FIGURE 13A: CTM DATA FOR 2007 – PRIMARY REASONS FOR BENEFICIARY PART D COMPLAINTS

Reason	Contacts	Percent of All Contacts
Enrollment/Disenrollment	166,049	52%
Pricing/Co-Insurance	102,965	32%
Benefits/Access	11,563	4%
Customer Service	10,968	3%
Marketing	7,473	2%
Grievances	4,754	2%
Formulary	4,142	1%
Program Integrity Issues/ Potential Fraud, Waste, Abuse	3,963	1%
Plan Administration	2,295	0.7%
Exceptions/ Appeals	2,162	0.7%
Contractor/Partner Performance	648	0.2%
Quality of Care/Clinical Issues	568	0.2%
Pharmacies	126	< 0.1%
Confidentiality/Privacy	48	< 0.1%
Medication Therapy Management (MTM)	37	< 0.1%
Implementation	25	< 0.1%
Totals	**317,786**	**100%**

As stated earlier, complaints regarding Part D tended to center around two issues: enrollment/disenrollment (52% of all Part D complaints in 2007; 61% of all Part D complaints in 2008) and pricing/coinsurance concerns (32% of all Part D complaints in 2007; 20% of all Part D complaints in 2008). The primary drivers for these complaints were numerous plan changes by Medicare beneficiaries during the enrollment period at the end of the year, and corresponding end-of-year data processing issues and discrepancies.

Since establishing Part D and its associated systems in 2006 on a relatively aggressive timeline, in collaboration with Social Security, CMS has made considerable progress in resolving virtually all of the systemic premium-withholding issues. This resulted in a remarkable reduction of complaints from early 2007 through 2008, particularly those complaints categorized as Pricing/Coinsurance.

FIGURE 13B: CTM DATA FOR 2008 – PRIMARY REASONS FOR BENEFICIARY PART D COMPLAINTS

Reason	Contacts	Percent of All Contacts
Enrollment/Disenrollment	150,424	61%
Pricing/Coinsurance	49,457	20%
Benefits/Access	12,281	5%
Marketing	10,589	4%
Plan Administration	6,779	3%
Customer Service	6,348	3%
Formulary	3,932	2%
Program Integrity Issues/ Potential Fraud, Waste, Abuse	3,338	1%
Exceptions/Appeals	1,809	0.7%
Grievances	1,480	0.6%
Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information	409	0.2%
Contractor/Partner Performance	335	0.1%
Quality of Care/Clinical Issues	176	< 0.1%
Pharmacies	102	< 0.1%
Confidential/Privacy	72	< 0.1%
Medication Therapy Management (MTM)	64	< 0.1%
Implementation	18	< 0.1%
Totals	**247,613**	**100%**

Similar to Part D complaints, concerns about enrollment/disenrollment also were the most frequent reason for complaints regarding the Medicare Advantage Plans. Complaints in this category accounted for about 90% of all CTM complaints logged for Part C during 2007.

From 2007 to 2008, the number of Part C customer service complaints doubled. In addition, complaints about marketing issues increased dramatically. This change largely is due to heightened public awareness of marketing issues. In addition, 1-800-MEDICARE CSRs and CMS caseworkers have become more adept at recognizing and appropriately categorizing marketing misrepresentation complaints. As system enhancements were made to the CTM, it was able to handle and categorize more appropriately the nature of the complaint.

Figures 14A and 14B below provide the breakdown of Part C complaints for 2007 and 2008:

FIGURE 14A: CTM DATA FOR 2007 – PRIMARY REASONS FOR BENEFICIARY PART C COMPLAINTS

Reason	Contacts	Percent of All Contacts
Enrollment/Disenrollment	32,755	87%
Marketing	2,700	7%
Customer Service	1,015	3%
Access and Availability	742	2%
Payment/Claims	235	0.6%
Program Integrity Issues/Potential Fraud, Waste, and Abuse	106	0.3%
Quality of Care/Clinical Issues	87	0.2%
Exceptions/Appeals	15	< 0.1%
Benefits/Access	13	< 0.1%
Plan Administration	2	< 0.1%
Totals	**37,670**	**100%**

FIGURE 14B: CTM DATA FOR 2008 – PRIMARY REASONS FOR BENEFICIARY PART C COMPLAINTS

Reason	Contacts	Percent of All Contacts
Enrollment/Disenrollment	19,712	67%
Marketing	3,162	11%
Customer Service	2,319	8%
Pricing/Co-Insurance	1,029	3%
Payment/Claims	951	3%
Access and Availability	896	3%
Benefits/Access	490	2%
Plan Administration	352	1%
Exceptions/Appeals	169	0.6%
Program Integrity Issues/Potential Fraud, Waste, and Abuse	148	0.5%
Quality of Care/Clinical Issues	123	0.4%
Grievances	95	0.3
Confidentiality/Privacy	3	< 0.1%
Contractor/Partner Performance	1	< 0.1%
Totals	**29,450**	**100%**

CMS' Regional Office and Central Office caseworkers, prescription drug and health plan Account Managers, and other CMS staff expended a significant amount of effort and resources to resolve these Medicare Part C and Part D complaints and to address the policy and operational issues related to these complaints. Their diligent work contributed to the reduction in the volume of complaints during 2007 and 2008.

Medicare Fee-For-Service Claims Administration

CMS maintains management systems to support the oversight and administration of its FFS operations. The Contractor Reporting of Operational Workload (CROWD) and the Contractor Management Information System (CMIS) are the Agency's systems through which most operational reporting is captured from the fiscal intermediaries, carriers, and Medicare Administrative Contractors that perform the range of functions related to FFS claims adjudication and payment, including claims processing, appeals, customer service, medical review, provider enrollment, and provider audit and reimbursement. CMS uses the data reported in the CROWD and CMIS systems to track claims administration contractor workload and productivity, and depends on other data sources as well as onsite reviews to assess performance.
Beginning in 2006 and ending in 2007, beneficiary-inquiry work was transitioned from Medicare Fee-for-Service claims administration contractors to the 1-800 MEDICARE Beneficiary Contact Center (BCC), which resulted in a notable drop in the volume of contacts. During 2007, Medicare's Fee-for-Service claims administration contractors handled over 1.5 million beneficiary inquiries, which include telephone and written inquiries. In 2008, Medicare's Fee-for-Service claims administration contractors handled fewer than 300,000 beneficiary inquiries. This huge decrease is due to the fact that a majority of the Fee-for-Service inquiry workload transitioned from the Medicare Administrative Contractors to the BCC. The majority of this activity involved Part B services.

Appeals

An appeal is the process by which a person with Medicare may challenge the decision by a Medicare contractor, or the decision by a Medicare prescription drug or health plan, not to provide and/or pay for an item or service that the person with Medicare believes should be covered or provided. CMS contracts with private insurance companies to perform many functions on behalf of the Medicare Program, including processing claims for Medicare payment and carrying out the first level of the Medicare claims appeals process. Although appeals are filed regarding services for which

beneficiaries have received or have been denied, the majority of appeals are filed by providers and suppliers.

The majority of the information the Medicare Ombudsman currently has access to on appeals comes from the Medicare Appeals System (MAS), which provides the number and type of Level 2 appeals (known as "reconsiderations") across the Medicare Program. The previously-mentioned CROWD system provides information on the number and type of Level 1 appeals (known as "redeterminations") for Part A and Part B. CMS does not have oversight of level 3 and 4 appeals, and cannot provide this data. A redetermination is an examination of a claim by the Medicare contractor or Medicare health plan personnel who are different from the personnel who made the initial claim determination (this is called reconsideration under Part D). There were approximately 2.5 million Level 1 appeals carried out during 2007 for Part A and Part B of the Medicare Program. At the time of this report, 2008 appeals data was not yet available. Figures 15A and 15B display the breakdown of the types of Level 1 appeals for Part A and Part B respectively during 2007:

FIGURE 15A: PART A LEVEL 1 APPEALS FOR 2007

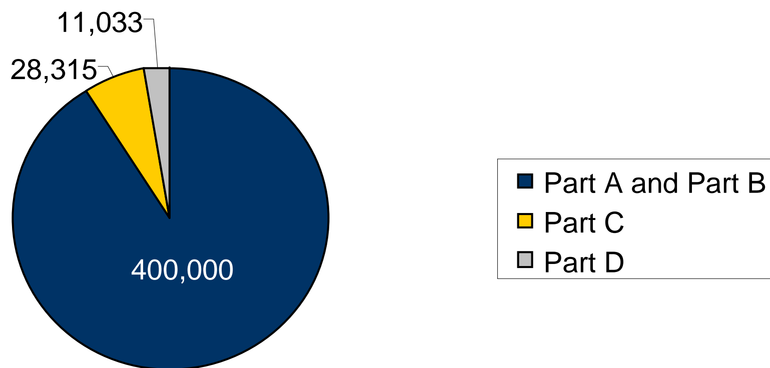
Appeal Category	Decided Claims	Percent of Total
Outpatient	160,528	67%
Other	34,574	14%
Inpatient	15,110	6%
Home Health	13,621	6%
Skilled Nursing Facility	7,884	3%
Ambulance	6,176	3%
Lab	2,428	1%
Totals	**240,321**	**100%**

FIGURE 15B: PART B LEVEL 1 APPEALS FOR 2007

Appeal Category	Decided Claims	Percent of Total
Physician	1,450,822	58%
Durable Medical Equipment	623,081	25%
Ambulance	218,869	9%
Other	134,090	5%
Lab	78,301	3%
Totals	**2,505,163**	**100%**

If a person with Medicare is dissatisfied with the redetermination decision (reconsideration under Part C), he or she may request reconsideration by a Qualified Independent Contractor (QIC) under Medicare Parts A, B and D or review by an Independent Review Entity (IRE) under Part C, which are considered Level 2 appeals. The QIC or the IRE are independent organizations that did not take part in the first level appeal decision. The Medicare Program handled a total of approximately 440,000 Level 2 appeals during 2007. As shown in Figure 16, over 90% of these involved Part A or Part B services, 6% were Part C appeals, and 3% were Part D appeals. This represents a rate of 3.27 reconsiderations per 1,000 Part C enrollees, and a rate of 0.45 reconsiderations per 1,000 Part D enrollees.

FIGURE 16: MEDICARE PROGRAM LEVEL 2 APPEALS FOR 2007



Over half of Part A Level 2 appeals involved services from outpatient services (26.3%), skilled nursing facilities (14.5%), and laboratory (10.9%). Additional data indicates that approximately 17% of Part A, 31% of Part B, and 25% of DME appeals result in favorable decisions, meaning appeals were successful and claims were paid. Figure 17 identifies the types of appeals and percentages accounted for by each type for Part A:

FIGURE 17: REASONS FOR TOP 10 PART A RECONSIDERATIONS FOR 2007

Appeal Category	Decided Claims	Percent of Total
Outpatient Services	9,925	26.3%
Skilled Nursing Facility	5,470	14.5%
Laboratory	4,125	10.9%
Home Health	3,167	8.4%
Other (Acute hospital, mental health)	2,253	6.0%
Hospice	2,206	5.8%
Drugs	2,184	5.8%
Hospital Inpatient	2,168	5.7%
Diagnostic Imaging	1,938	5.1%
Transportation	1,317	3.5%

Approximately 89% of Part B Level 2 appeals involved services from physician services, durable medical equipment, practitioner services, and those categorized as other (vision, exams, ambulatory surgical center, and preventive services). Figure 18 identifies the types of appeals and by each type for Part B:

FIGURE 18: REASONS FOR TOP 10 PART B RECONSIDERATION FOR 2007

Appeal Category	Decided Claims	Percent of Total
Physician Services	81,908	24.2%
Other (Vision, exams, ambulatory surgical center, preventive services)	80,130	23.7%
Durable Medical Equipment	77,061	22.8%
Practitioner Services	61,640	18.2%
Transportation	24,466	7.2%
Clinic/Lab/X-Ray	3,346	1.0%
Outpatient Services	1,630	0.5%
Medical Supplies	1,488	0.4%
Prosthetics/Orthotics	593	0.2%
Drugs	431	0.1%

Figure 19 identifies the types of appeals, the percentage accounted for by each type, and the number and relative percentage of overturns for Part C:

FIGURE 19: PART C LEVEL 2 APPEALS TYPES AND OVERTURN RATES FOR 2007

Appeal Type	Cases	Percent of Cases	Number Overturned	Percent Overturned*
Physician Services	6,946	24.5%	719	17.4%
Diagnostic Imaging	2,951	10.4%	406	24.4%
Hospital Inpatient	2,775	9.8%	397	26.0%
Non-MD Practitioner	2,614	9.2%	324	14.6%
Durable Medical Equip.	2,584	9.1%	212	10.5%
Out of Area	2,294	8.1%	238	19.1%
Skilled Nursing Facility	1,894	6.6%	568	34.6%
Transportation	1,618	5.7%	113	12.3%
Prosthetics/Supplies	1,096	3.8%	82	9.1%
Laboratory	1,083	3.8%	87	18.7%
Emergency	994	3.5%	161	27.6%
Drugs	887	3.1%	119	18.8%
Home Health	387	1.3%	77	33.6%
Other	192	0.7%	17	11.9%

** Withdrawn and dismissed appeals are removed from the calculation of % Overturned.*

The largest reason for Part C Level 2 appeals involved physician services (24.5%), followed by diagnostic imaging (10.4%), hospital inpatient (9.8%), non-MD practitioners (9.2%), and durable medical equipment (9.1%).

Figure 20 identifies the types of appeals and the percentage accounted for, by type, for Part D prescription drug benefit appeals:

FIGURE 20: PART D LEVEL 2 APPEALS TYPE AND REVERSAL RATES

Appeal Type	Reversal Rate*
Drug utilization management tool dispute	59%
Out-of-network pharmacy coverage	47%
Off-formulary exception requests	48%
Tiering exception request	26%
Cost-sharing dispute	25%
Non-Part D drug	28%

** Calculation of the reversal rate by appeal type excludes cases that were dismissed, withdrawn or remanded.*

Additional data, not shown here, indicates that most of the Part D Level 2 prescription drug benefit appeals were related to a drug not being covered under Part D (40%) or a dispute about a plan utilization management tool (38%).

Medicare Beneficiary Casework Management

In 2006, the OMO assumed responsibility for the CMS National Casework Call, and began to play a role in how casework was handled by the Agency. This function, in addition to affording the OMO the opportunity to serve people with Medicare directly, serves as a primary means for the OMO to understand the issues affecting people with Medicare as their inquiries and complaints are handled by CMS' 10 Regional Offices (RO) and the OMO in the CMS Central Office. In 2007, the OMO collaborated with the ROs and other groups within CMS to coordinate and implement improvements to CMS casework processes, and to identify and work to resolve operational and policy related Part D issues.

During 2008, the OMO carried out several key functions in support of CMS casework activities, including working to resolve the most complex complaints, sometimes in collaboration with its SSA liaison. In addition, the OMO delivered information, including processing schedules, known issues, tips, and reminders to caseworkers on a regular basis.

CMS National Casework Call

In 2006, the OMO began to lead the weekly National Casework Call with CMS Regional Offices and other CMS components who respond to individual beneficiary inquiries and concerns. The OMO facilitates the weekly interaction and collaboration to plan proactively for, anticipate, and address policy, process, and CMS systems issues that impact casework and people with Medicare in general. A primary focus of these calls in 2007 was to solicit ideas and recommendations for improvements to existing casework processes and procedures, and to develop and provide casework specific guidance to CMS caseworkers nationwide. During 2008, the calls moved to a bi-weekly schedule because there were fewer Medicare prescription drug and health plan issues and topics to address, and there was a need to alternate calls dedicated to Medicare Parts C and D with calls dedicated to Medicare Parts A and B.

One important outcome of the National Casework Call was the OMO's and the Regional Offices' joint efforts to develop, update, and maintain documented standard casework processes. The OMO works closely with the ROs to ensure that casework operations are performed consistently throughout the Agency in a way that maintains quality control of processes and resolutions.

In 2007, the OMO helped to facilitate the development of numerous SOPs covering a wide range of topics. One of the goals was to ensure that casework processes continue uninterrupted and that approved procedures are followed in compliance with CMS regulations and policies. A standard operating procedure (SOP) is a written set of instructions or guidance that caseworkers should follow to research, analyze, and resolve individual complaints from or regarding people with Medicare. Casework SOPs outline the CMS policies and specific job steps that help standardize casework processes nationwide. The SOPs also serve as training documents for teaching new caseworkers about the topic or process for which the SOP was written.

Also in 2007, the OMO became responsible for the CTM SOPs. In short, the enhancement of existing procedures and the continuous development of new SOPs enable CMS caseworkers to provide appropriate, timely, and effective responses to people with Medicare. These SOPs supplement the CMS Casework Management Protocol, the primary authoritative casework management authority and procedural document, which was developed and is maintained by CMS' Consortium of Medicare Health Plan Operations.

Another collaborative effort between the OMO and the ROs involved standardizing language for use in written CMS responses to inquiries and complaints from people with Medicare. Although standard language has been available and used by CMS Central and Regional Offices for a number of years, the OMO, in its casework facilitation role, discovered that the language often was outdated or, in many instances, non-existent. In addition, people with Medicare and some of the organizations that work closely with the OMO complained of inaccurate or conflicting information from several different Medicare sources. As a result, the OMO implemented a collaborative RO and Central Office effort to update existing standard language, develop new language where needed, and provide a user-friendly means for CMS caseworkers to access approved language.

The OMO recognized that language used in casework needed to be clear, precise, and consistent for a wide variety of Medicare related issues, problems, and inquiries. Standardized language is structured vocabulary that provides caseworkers with a consistent means of communication to people with Medicare. Standardized responses

to frequently asked questions ensure that when a caseworker responds to a beneficiary question or complaint, the reader understands the response and the appropriate response always is provided for the same or similar type of inquiry. In efforts to improve responses to people with Medicare, the OMO also implemented a process for the continuous modification of CMS standard beneficiary correspondence language and caseworker guidance procedures. During 2007, 82 standard language letters for use in responses to inquiries and complaints from people with Medicare were updated, and 62 new standard language letters were developed. A total of 152 new and/or updated standard language letters were developed in 2008.

Another important effort to improve and facilitate casework that resulted from the weekly National Casework Call was the development and maintenance of a single database to serve as a repository for information regarding various CMS and Social Security data reconciliation and cleanup efforts. Recognizing that these system changes often drive the resolution of casework, the OMO developed this database during 2007 for CMS caseworkers to review files transactions and conduct other research to resolve complaints that involve system updates or data file transactions. This database is updated on a regular, as-needed basis with new information.

HHS Portal

In its role to facilitate CMS casework, the OMO works to ensure that pertinent information is dispersed and available to all of those involved directly or indirectly with CMS casework. The use of the Department of Health & Human Services (HHS) Information Portal (the Portal) serves as a means for CMS Central and Regional Office casework leads to view and disseminate important information via a web-based content management tool.

The Portal provides a broad range of functions. Although it is accessible to all CMS employees, it is relatively new, and few areas in CMS have fully taken advantage of the portal's usefulness. The OMO utilizes the Portal in its support of casework as a tool for subscribers (Central and Regional Office casework analysts) to access updated policy and procedural documents, phone listings, standard language, and other key information essential to the management of Medicare casework. The use of the Portal allows the OMO to distribute casework-related information broadly and in a timely manner to facilitate the provision of assistance to people with Medicare. Rather than accessing numerous Intranet and Internet sites or relying on email distribution, the Portal provides a centralized access point for all casework resource materials that come from various sources of information. The OMO manages the Portal daily and controls

what caseworkers can view and download, while taking advantage of the existing security controls inherent to the Portal.

Training

To further improve service to people with Medicare within an ever-changing Program, the OMO realized the need for CMS caseworkers continually to enhance their knowledge of Medicare. As a result, the CMS caseworker training program was instituted by the OMO to provide training targeted specifically for those who handle CMS casework. Initially, the training coordinators solicited feedback from CMS caseworkers on the areas of training that they felt was needed to do their jobs effectively, and used this feedback to create a training schedule for 2007.

The OMO conducted several trainings during 2007 regarding various aspects of the Part D program and other topics. Subject matter for the trainings included the Low-Income Subsidy for Part D payments, open enrollment and special enrollment periods for Part C and Part D, and ongoing training for Central and Regional Office analysts for efficient responses to address the needs of people with Medicare and their advocates. By mid-November of 2007, a total of 21 local and national training sessions on various topics were facilitated by the OMO.

In 2008, the OMO continued to improve service to people with Medicare through its national training program. Every three months, training coordinators solicited feedback from CMS Caseworkers on the areas of training they felt was needed to do their jobs effectively. The training coordinators used this feedback, as well as information obtained about special Agency Initiatives (e.g., the Caregiver Assistance Program), to create a training schedule for 2008. The training sessions included such topics as best practices in customer service, privacy and confidentiality, CMS prescription drug and health plan marketing provisions, and several sessions on the use of CMS and Social Security data systems. The OMO facilitated a total of 18 local and national training sessions by the end of 2008.

All procedures and training materials were posted to the HHS Portal for all CMS caseworkers to access as job aids. Some of this information also was shared, as needed, with the CMS Office of Beneficiary Information Services, the CMS component responsible for ongoing updates and training for 1-800-MEDICARE Customer Service Representatives.

Providing Services to People with Medicare

Not only does the OMO engage in activities in the areas of partnership, issues management, and casework on a national level, it also has the opportunity to engage people with Medicare directly by providing them assistance with their individual concerns regarding their Medicare benefits.

Division of Medicare Ombudsman Assistance Casework

As discussed in the 2005-2006 Ombudsman Report to Congress, the Division of Ombudsman Casework & Trends Management (DOCTM) was an established division within CMS that moved to the OMO in 2006. Due to reorganization in 2008, its name changed to the Division of Medicare Ombudsman Assistance (DMOA).

The DMOA is the focal point for beneficiary inquiries and complaints that CMS' Central Office receives directly from people with Medicare, including high-level complex inquiries that have been directed from various sources. These sources include Congress, the Executive Office of the President, the Office of the Secretary of HHS, and the Office of the CMS Administrator. The DMOA also handles many inquiries from the general public, people with Medicare, and their caregivers and/or advocates, and also is responsible for monitoring trends in beneficiary inquiries and casework received by CMS' Central Office.

The DMOA's casework staff also serves as the focal point for urgent-need casework and individual, problematic Medicare situations directed to the Medicare Ombudsman. This consists of written, e-mail, and telephone inquiries or complaints that require expeditious resolution in order to prevent further potential hardship to individuals with Medicare.

The DMOA staff consists of highly skilled caseworkers who must quickly analyze and determine the best solution for each case, taking into account CMS policies and any organizational constraints. This often requires DMOA casework staff to liaison with other Federal, State, or Local Agencies, CMS administrative contractors, and other CMS staff members to bring resolution to specific cases. All cases are documented, tracked and reported to the OMO's senior management, who in turn ensures CMS Leadership is aware of any specific trends or individual cases that require their attention.

The DMOA caseworkers respond to inquiries from state Medicaid and Congressional Offices on behalf of people with Medicare, including Spanish and several other foreign

language inquiries. The DMOA focuses on the specific skills required to appropriately and effectively communicate with Medicare beneficiaries and those who are representing them. This includes reinforcing the techniques necessary for handling sensitive individual complaints. Active listening skills, acknowledgment of the issues, agreement on acceptable solutions, taking the appropriate actions, and following up to confirm the issues are resolved to each customer's satisfaction all are critical caseworker skills that the DMOA's management regularly reinforces. As a part of managing its workload, the DMOA staff produces various reports and tracks key workload information to provide weekly, monthly, and ad-hoc reports to OMO Leadership. The table below, Figure 21, describes some of the various workloads of the DMOA's casework staff:

FIGURE 21: DIVISION OF MEDICARE OMBUDSMAN ASSISTANCE WORKLOAD

Workload	Primary Function
Beneficiary Casework	Receives, analyzes, triages, and provides response to complex and non-complex inquiries and complaints that require a response from CMS.
Write-In Campaigns: Responding to High Volumes of Form Letter Inquiries or Complaints sent to CMS	Serves as the focal point for "write-in campaigns" (see the description of "write-in campaigns" immediately below Figure 21) for concerns received from people with Medicare, their representative Congressional offices, advocates, and caregivers on various topics associated with Medicare policy or operations.
Development and Maintenance of Standard Language	Serves as the focal point for developing and maintaining the standard language used to respond to the concerns of people with Medicare in order to promote uniformity and consistency in CMS caseworker communications.
National Caseworker Training Program	Conducts training and informational sessions to improve caseworker skills, and to provide useful resources for resolving casework.
Beneficiary Customer Service Survey	Administers a bi-annual survey to measure the opinions of beneficiaries and their representatives, regarding quality, timeliness, and clarity of responses and services received from the DMOA caseworkers.
Correspondence System Administration	Maintains the daily operations of the electronic correspondence tracking system used by the OMO.
Tracking & Reporting of OMO Casework	Produces OMO casework trends and workload tracking reports for OMO leadership.

The DMOA casework staff had many accomplishments during 2007 and 2008, including the processing of over 63,000 inquiries and complaints from or on behalf of people with Medicare, and directly handling and/or responding to approximately 22,000 and 16,000 of these during those respective years. This included receiving, analyzing, categorizing, triaging to CMS Regional Offices and other government entities, and responding to non-complex and complex written , telephone and email inquiries and complaints, as well as "write-in campaigns." The term "write-in campaigns" refers to numerous standardized letters sent to CMS en masse regarding a specific topic. Most often these

are signed form letters provided by an organization to its supporters, in efforts to mobilize these supporters to inquire, complain, or request information about a particular topic of concern regarding the Medicare Program. The OMO works with the appropriate CMS subject matter experts to develop language used for responding to these inquiries.

As discussed previously, in addition to the more routine inquiries and complaints, the casework staff also responds to numerous complex inquiries and complaints that are often resource intensive. This involves conducting detailed analysis, gathering pertinent information, and following up with multiple people or entities to resolve the issue. This more complex workload included handling several hundred "urgent-need" calls to CMS' Central Office each year, and resolving numerous complex inquiries and complaints that were sent directly to the attention of the Medicare Ombudsman.

Beneficiary Customer Service Feedback Survey

To ensure the DMOA's customer service and assistance to people with Medicare was effective in meeting the needs and expectations of people with Medicare, the DMOA developed a Beneficiary Customer Service Feedback Survey in 2004 to measure its performance. The goal of the survey was to measure and improve overall customer service by developing and testing a standardized questionnaire that could be used to collect and report reliable and meaningful information about the services that the DMOA provides. The survey assessed the opinions of both English and Spanish speaking people with Medicare, regarding the quality, timeliness and clarity of the written responses and services it provides. The DMOA began utilizing the survey in August 2004 and completed its first full round of surveys in August 2005. Out of the 2,872 surveys sent, 1,333 surveys were returned for an overall response rate of 46%. The overall final rating was 4.1 out of a scale of 5.0, with 5.0 representing total satisfaction with the services they received from the DMOA.

In June 2007, the DMOA began conducting a second customer satisfaction survey. At the close of the second survey in 2008, the OMO sent 1,146 surveys, of which 639 were returned, providing a response rate of 56%. The overall rating was 4.0, on a 1.0 to 5.0 scale, with 5.0 representing total satisfaction with the services they received from the DMOA.

Casework Collaboration

The OMO also played an important role in facilitating casework for other CMS components. To this end, the DMOA casework staff assisted CMS Regional Offices with over 2,000 difficult to resolve cases involving reconciliation of Part D premium withhold payments for people with Medicare in 2007. This involved researching the problems and offering guidance on fixing the problem, and/or consulting with Social Security on resolution of these cases. The DMOA caseworkers also collaborated with the CMS Office of Financial Management in 2007 to research and provide resolution for an additional workload of 2,700 cases that were directed to CMS as a result of problems surrounding processing for the 2006 Medicare Part D premium payments. The OMO engaged in similar efforts during 2008.

Outreach and Education

The DMOA casework staff was involved in several efforts to provide outreach and education to people with Medicare. One such effort was to facilitate the development of a CMS publication that would help people with Medicare better understand their rights in the appeals, grievances, and complaints processes for Parts A–D of the Medicare Program. The newly developed publication is entitled "How to File a Medicare Part A or Part B Appeal in the Original Medicare Plan" *(CMS Publication No. 11316).* In addition, the DMOA facilitated the enhancement of two existing publications, entitled "Medicare Prescription Drug Coverage: How to File a Grievance, Request a Coverage Determination, or File an Appeal" *(CMS Publication No. 11112)* and "Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal)" *(CMS Publication No. 11312)*. These publications can be found on the Ombudsman's webpage, available at www.medicare.gov.

To improve its responsiveness to more routine, informational requests, the DMOA designed and implemented a postcard response that notifies individuals on the status of their requests for publications and address changes. Other outreach efforts involved coordinating with staff from the CMS Office of External Affairs to provide face-to-face information and assistance to people with Medicare at various CMS partner conferences nationwide.

Division of Ombudsman Exceptions

To enhance the OMO's efforts to advocate for Medicare beneficiaries, the Division of Ombudsman Exceptions (DOE) became a part of the OMO during 2008. The DOE works primarily with beneficiary systems by focusing on the integrity of data for

Medicare Part A and Part B. In addition, the DOE manages, provides oversight for, and enables the resolution of data discrepancies related to the control, problem identification, and correction of Medicare enrollment, direct billing, third-party, Medicare Advantage, and Part D data and transaction exceptions.

The DOE works to prevent the loss of healthcare coverage for Medicare beneficiaries that are the result of data system exceptions that go undetected or unresolved in a timely manner. System exceptions occur when a data transaction goes undetected or fails a certain number of pre- programmed systems edits, resulting in the transaction not being processed. In addition to exceptions, the DOE analyzes and handles system alerts, which are data transactions that are processed, but are flagged for some reason for review and correction, if necessary. Additional functions of the DOE include:

- Managing and providing oversight and support for the collection of Medicare premiums for the direct-paying beneficiary population;

- Analyzing system exceptions to identify recurring issues and systems anomalies, and initiating corrective actions or recommendations for improvement; and

- Participating, from a user perspective, in the development of systems requirements for new systems and/or systems changes.

To accomplish its goals, the DOE collaborates with other organizations and partners to provide direct interaction with, and on behalf of, Medicare beneficiaries in order to process inquiries and exceptions. This includes working with caseworkers and analysts in the OMO's Division of Medicare Ombudsman Assistance. In this way, the DOE enhances the OMO's beneficiary service (casework) functions by enabling more direct and timely collaboration between and among caseworkers and the DOE's analysts. Issues arise from a variety of sources, including beneficiaries, state Medicaid offices, Congress, and the Social Security Administration.

A DOE-led collaborative team finalized a significant workload of approximately 800,000 alerts and exceptions during 2008. As a result of the DOE's efforts, thousands of duplicate alerts and exceptions were eliminated and automated processes replaced manual processes. Medicare beneficiaries will benefit from more efficient processing of their Medicare entitlement and premium billing transactions. Another of the DOE's top priorities during 2008 was working to resolve premium billing issues within two weeks. The DOE's analysts received more than 500 cases each week during 2008, yet averaged less than one week's processing time. The DOE's annual caseload includes more than 80,000 cases, which includes 1,500 telephone inquiries per year.

Each of the core activities of the OMO outlined in this section provided the Medicare Ombudsman and his staff with unique opportunities to assist people with Medicare, and to identify or be informed of various systemic issues that may affect people with Medicare. The OMO seeks out and works with other CMS components to address issues whose resolution will improve the Medicare Program as a whole. The following section discusses several of those issues in greater detail, and provides the Medicare Ombudsman recommendations for addressing those particular issues within the Medicare Program.

ISSUES AND RECOMMENDATIONS

The Office of the Medicare Ombudsman (OMO) serves as an advocate for Medicare beneficiaries, and focuses on the continuous improvement of the Medicare Program on behalf of people with Medicare. During 2007 and 2008, the OMO continued its efforts to identify and understand systemic issues that impact people with Medicare. As previously discussed, the OMO has collaborated with internal and external organizations to listen to, identify, and work to facilitate the resolution of issues. The Issues and Recommendations section of this report describes several key systemic issues and corresponding recommendations that the Medicare Ombudsman believes are important as CMS considers activities to improve the Medicare Program for people with Medicare.

Issue: Need to Implement Best Practices to Serve Medicare Beneficiaries Optimally

The Medicare Program provides a wide range of benefits that presents a broad choice of services for over 44 million Medicare beneficiaries. The size and complexity of the current customer service delivery model make the Program vulnerable to lapses in customer service. In addition, in 2007, the customer service landscape changed significantly due to the full transition of beneficiary inquiry customer service work from Fee-for-Service (FFS) claims administration contractors to 1-800-MEDICARE. Therefore, the OMO believes in the need for CMS to implement best practices in customer service to serve Medicare beneficiaries optimally.

CMS provides customer service through various means, including CMS caseworkers and other Federal staff, numerous Medicare contractors, and prescription drug and health plans. As the culture of the organization continues to shift to become customer focused, CMS may want to consider dedicating and fully integrating a customer service framework to focus solely on the needs of beneficiaries. The OMO further encourages the identification of best practices and implementation of those best practices that can be translated to the Medicare Program toward improved service for people with Medicare. Some of the factors that may result in lapses in service for Medicare beneficiaries include: multiple points of contact for assistance and resolutions for beneficiaries; no formal integration process for handling beneficiary issues; the use of disparate correspondence management tools; and the need for more comprehensive oversight of Medicare contractor and health plan customer service. Furthermore, the

Medicare Program has many working parts, and offers a variety of healthcare and prescription drug choices requiring special attention to the customer service needs of people with Medicare. The delivery mechanism is highly distributed, supported both by the public and commercial sectors, which presents a significant, ongoing challenge to the assurance of optimal support for people with Medicare relative to access to and quality of services. Given the Medicare Program's use of both Government and non-government staffs to provide customer service, and the breadth and depth of the Program's benefits, services, and populations served, this is a particularly-challenging issue.

In addition, currently there is no central oversight of customer service within CMS to create general standard practices across the Program. For example, when a component receives initial contacts from people with Medicare or those who are acting on their behalf, there should be, to the degree possible, "sole ownership" of the issue by that component. The component would serve to research and resolve an issue, communicate the status of the issue as needed, and communicate the resolution to the beneficiaries instead of referring them onward to other entities, unless absolutely necessary.

The OMO believes that services to people with Medicare would be improved by a dedicated customer service framework for the following reasons:

- A customer service framework could mitigate issues that result from the multiple points of contact that exist for people with Medicare regarding assistance and resolutions to their issues;

- The framework could address the current lack of consistent coordination and integration of customer-service functions, which sometimes hinder the efficiency in which the individual issues of Medicare beneficiaries are handled; and

- The customer service framework could resolve the need for improved CMS oversight of entities that provide Medicare customer service to improve awareness about the quality of service that people with Medicare receive from external entities that operate on behalf of Medicare.

The OMO is an integral part of the existing CMS customer-service structure and plays a role in assisting people with Medicare. Given this role the Medicare Beneficiary Ombudsman supports the establishment of a customer service lead or component within CMS. Such a lead or component would, amongst other related functions, set

performance expectations or standards across the various customer service segments of the Medicare Program, lead a CMS wide beneficiary-focused steering committee to focus on areas of concern and improvement for beneficiary services, and direct areas of assessment and resolution of customer service issues that impact Medicare beneficiaries. This lead or component would need to have adequate resources and CMS leadership support.

Multiple Points of Contact for People with Medicare

People with Medicare have an assortment of information sources—including www.medicare.gov, www.MyMedicare.gov, 1-800-MEDICARE, numerous Medicare health and prescription drug plans, various Medicare contractors, multiple components within CMS (including CMS' Central Office and 10 Regional Offices), State Health Insurance Assistance Programs, and numerous partner and/or advocacy organizations. Figure 5 on page 49 of this report provides the number of contacts handled by some of these components. Having so many options to contact for various purposes may be confusing for people with Medicare, making it difficult for them to select the right source for key information or required actions. Having multiple points of contact creates difficulty for CMS to ensure that customer service practices are adequate and that the delivery of information is consistent and accurate. It makes effective responses to the needs of people with Medicare more difficult in some instances because not all those who are contacted by people with Medicare have the most appropriate tools (e.g., systems) or knowledge to respond to all issues. Multiple points of contact make tracking issues across the Medicare Program more difficult because data are dissimilar between each beneficiary facing entity, as noted in the Beneficiary Contact Trend Reporting section of this report.

No Formal Integration Process

Although there is no designated central point for CMS customer service, several CMS components lead customer-service oversight for their respective areas of responsibility within the Medicare Program. Regional Offices generally are acknowledged as the leads for customer service, with support from other components. Staff and managers in CMS' Consortium of Medicare Health Plan Operations have clear expectations with regard to customer service, as they have established a casework management protocol for Part C and Part D casework. As a part of this protocol, complaint aging reports at the caseworker level are reviewed weekly. Similar efforts are undertaken by the Consortium for Financial Management and Fee-for-Service Operations for Fee-for-Service casework.

CMS plans to continue to invest in the necessary customer service training and tools to aid the Medicare Program's customer-service staff in resolving issues for people with Medicare.

Multiple Customer Service Correspondence Management Tools

CMS Regional Offices utilize a number of disparate correspondence management tools to document and track information when resolving inquiries and complaints from people with Medicare. This can mean that one particular CMS Regional Office or CMS' Central Office does not have direct access to another Regional Office's correspondence-management system to gather information for resolving a particular inquiry or complaint regarding a person with Medicare. This access could increase the resolution and response time in these instances and might reduce unintended duplications of efforts.

Development of a single tracking system that provides all CMS staff members who respond to beneficiary issues with access to information regarding beneficiary contacts for the same or similar issues would allow for comprehensive research and awareness in addressing a particular concern, and improve communications regarding these concerns. Such a system could enhance the efficiency of CMS' Central and Regional Offices in resolving inquiries and complaints and improve the overall timeliness of service to people with Medicare. It also could allow for more comprehensive tracking of individual inquiries and complaints.

CMS conducted a Joint Application Development session with key CMS personnel. The purpose of the session was to discuss the high-level system requirements needed to develop and integrate a secure, enterprise wide customer service system that will collect, track, and trend contacts and issues regarding all parts of the Medicare Program, making sure to maintain existing safeguards and practices for protecting the privacy of this information. A system that consistently is used by all sources could facilitate analysis, assist with the progression and resolution of individual inquiries and complaints, and improve the management of casework at CMS. However, CMS has not made a formal decision for implementation of what would be a multi-year effort, and the corresponding funding would need to be approved. In the interim, the Medicare Ombudsman supports the idea of requiring more comprehensive information/data from plans. The Medicare Ombudsman also supports the development of an enterprise-wide correspondence management system.

Need for Comprehensive Oversight of Medicare Contractor and Health Plan Customer Service

With the implementation of Part D (Medicare prescription drug coverage) and Medicare Fee-for-Service (FFS) contractor reform, changes were made to the scope and delivery of Medicare's customer service. CMS wants to ensure that people with Medicare are receiving the best service possible, whether dealing directly with CMS and its contractors, or through Medicare prescription drug and health plans. In addition, the CMS Office of Beneficiary Information Services maintains oversight responsibility for 1-800-MEDICARE, and the CMS Center for Drug and Health Plan Choice engages in numerous efforts to maintain Medicare prescription drug and health plan customer service oversight.

CMS has taken some actions with regard to reporting from Medicare prescription drug and health plans on the beneficiary complaints that the plans handle. The Complaint Tracking Module allows for tracking of status and resolution of beneficiary complaints. CMS also has established additional reporting requirements for Part C health plans, and has dedicated monitoring resources specifically to monitor Part C and D call center performance. These data are used in calculating overall plan ratings, which are then posted on the appropriate CMS plan finder to improve plan accountability and offer people with Medicare additional information to use in their decision making.

Although data is captured regarding several categories of grievances received by Part D plans, CMS does not receive data routinely indicating the reasons for and timeliness of response to inquiries and complaints that prescription drug and health plans receive directly from people with Medicare. Such data would be valuable information for the Medicare Beneficiary Ombudsman in understanding the nature of beneficiaries' Medicare related issues and concerns, and would provide a more comprehensive view of their Medicare experiences. In addition, regular reporting of this information by Medicare prescription drug and health plans and CMS contractors would provide valuable information on how the Medicare Program is performing in these areas. Such reporting would better enable CMS to comprehensively exam the level of customer service provided across the Medicare Program and identify any related issues or areas for improvement. However, CMS' current access to or collection of this information, for some parts of the Medicare Program, is either limited or infrequent.

Although customer service has always been a primary focus for CMS, it has become a more prevalent issue in recent years as beneficiary services have expanded and as the Agency increasingly transforms into a customer centric, consumer oriented organization. The Medicare population continues to grow, as do the challenges for the

Nation's healthcare system and economy. During the report period, the United States' economy contracted sharply, and this may result in additional challenges and stress on the nation's healthcare system. For these reasons, focusing on the consumer has never been more important. Although CMS has made great strides to transition from a claims-processing organization into a customer-facing service provider, some work remains to be done.

The Medicare Ombudsman recommends that CMS considers the following regarding the implementation of best practices in customer service:

- Establish a customer service lead and/or component and an enterprise wide correspondence management system for beneficiary correspondence.

- Enhance the overall customer service support that CMS provides currently to people with Medicare through the implementation of adaptable customer service best practices. By taking into account best practices exercised by customer service organizations outside of CMS, including representation both from the public and private sectors, CMS may identify activities and initiatives that will enhance the effectiveness and efficiency of the Agency's support for Medicare beneficiaries.

- Require more comprehensive reporting from health and prescription drug plans on the reasons for and timeliness of responses to beneficiary inquiries, complaints, and grievances that they receive and handle directly.

- Require adequate oversight of complex beneficiary inquiries and beneficiary sponsored Congressional inquiries that are directly received and processed by legacy Medicare Fee-for-Service contractors and MACs.

Issue: System Issues that Impact People with Medicare

The implementation of Part D (Medicare prescription drug coverage) was completed within notably aggressive timeframes. Inherent in this new and expansive aspect of the Medicare Program was the design, development, and implementation of the systems necessary to support program changes and services that were required by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The aggressive timeframes for the implementation of the drug benefit carried over to these systems and their eventual deployment.

When system development or system changes are required within considerably short timeframes contained in legislation, CMS understandably faces challenges and constraints in developing and implementing the associated systems and changes. One of the outcomes of these compressed timeframes was an increase in issues associated with system-related errors or problematic data exchanges. The Medicare Ombudsman notes the potential and realized impacts upon people with Medicare, the significant amount of CMS' resources expended on issue resolution, and the countless resources dedicated to implementing data corrections and providing beneficiary assistance. Because these issues can result in negative impacts on people with Medicare, the OMO advocates efforts to mitigate these impacts in order to serve Medicare beneficiaries optimally.

For example, one of the requirements for the benefit was to have Medicare drug plan premiums deducted from beneficiaries' Social Security payments. Because this was a new requirement at the time, CMS had to develop the necessary systems to support this new service. However, there were several issues associated with withholding Medicare Part C and Part D premiums from the Social Security benefits of people with Medicare. Some of these issues, for instance beneficiaries having too much or too little withheld from their Social Security payment, were consequences of the relatively complex operations required to provide this benefit. CMS' data systems and associated business processes require multiple, interdependent data and information exchanges, which involve four separate entities: the Medicare beneficiary, the health or prescription drug plan, CMS, and Social Security.

During 2006, issues with premium withholding affected over 109,000 people with Medicare, which comprised less than 2% of the total population that had at least one month of elected premium withholding for 2006. More specifically, over 38,000 people with Medicare were due a refund for over collected 2006 premium payments, and another approximately 59,000 people with Medicare were owed premiums for under

collected 2006 premium payments. During 2007, on-going issues with premium withholding affected approximately 115,000 people with Medicare, which again comprised approximately 2% of the total population that had at least one month of elected premium withholding for 2007. More specifically, approximately 20,000 people with Medicare were due a refund for over collected 2007 premium payments, and more than 94,000 people with Medicare owed premiums for under collected 2006 premium payments.

As a result, a number of meetings, discussions, and planning sessions between CMS components, and with Social Security, were held to address the issue. These efforts resulted in substantial reductions of these issues over time. However, a segment of this population was affected significantly by problems associated with the length of time their premiums were withheld, and with issues involving concurrent direct billing for their premiums. This particular issue consumed a significant amount of resources. However, given the nature of the premium withholding process, there likely always will be some people with Medicare who are affected by problems associated with premium withholding. As the broader systemic problems are addressed, these instances should decrease and should be managed and effectively resolved within a timely manner by CMS' casework efforts.

CMS continues to work to address issues that result from such problems. It allows time for systems testing, and established several operations boards and groups that involve those necessary to take part in system changes and testing. Since the implementation of the Part C and Part D systems, these efforts have been enhanced by the addition of a CMS component with this particular focus. CMS also has taken steps to ensure more timely and accurate transfer of data. For example, CMS, in collaboration with SSA, has made considerable progress in resolving the premium withholding issues that resulted from the aggressive timeline for establishing the Part D benefit and its associated systems in 2006. Therefore, while premium withholding was a significant issue in 2007, at the close of 2008, it largely had been resolved. In fact, GAO published a study in July 2008, GAO Study 08-816R, which made the following conclusion: "SSA and CMS have made considerable progress in working together to solve problems and reduce delays in processing premium withholding requests…" (p. 5).

Indeed, as of November 2008, only 900 cases of premium withholding imbalances from 2006 and 2007 remained to be resolved and were scheduled for resolution in January 2009. These cases have been identified and were set to be implemented after the 2008 open enrollment season concluded on December 31, 2008. Similarly, the number of beneficiary complaints received with respect to premium withholding has dropped

sharply since 2007. In July 2007, there were over 10,000 open beneficiary inquiries on the topic of beneficiary withholding. Open inquiries on this topic fell to about 500 by November 2008. Furthermore, CMS has developed a procedure to submit smaller amounts of data outside of the normal data processing cycle, allowing it to address high priority casework in a much shorter timeframe.

With regard to re-evaluating plan payment policies to avoid simultaneous plan billing and Social Security withholding, the concern was addressed in CMS' proposed rule issued in May 2008. The regulation would prohibit plans from direct billing any beneficiary who is signed up for premium withholding. Therefore, while there invariably will be individual problems with respect to premium withholding, CMS believes the systematic and widespread issues in this area have been addressed successfully and resolved appropriately in 2008.

Also in 2007, the CMS Center for Beneficiary Choices (now the Center for Drug and Health Plan Choice, as of June 2008) and Office of Information Services were instrumental in implementing additional enhancements to the primary enrollment and eligibility system, which allows caseworkers and plan managers to make some individual manual data corrections within the system. This type of enhancement is an effective way to resolve discrepancies and complaints received from people with Medicare in a timely and efficient manner.

However, despite CMS' best efforts to identify and mitigate system- and data-related problems experienced by people with Medicare, issues still will arise for some individuals. In these instances, the CMS caseworkers in CMS' Central Office and 10 Regional Offices will work to resolve these individual problems for people with Medicare. These caseworkers take actions to reduce the number of open complaints continually by resolving complaints as quickly as possible. This includes individually researching complex issues and submitting corrected data transactions to Social Security outside of the normal transaction processing schedule, as well as working closely with Medicare health and prescription drug plans to address issues within their control.

The OMO recognizes that CMS cannot foresee how every distinct aspect of system and data changes will or might impact people with Medicare. Allowing sufficient time to conduct full, end-to-end testing when developing or implementing system or data changes and ensuring the full involvement of the appropriate parties could reduce the number of person-hours necessary to analyze resultant system problems and manage the fallout from corresponding data clean-ups. In addition, involving from the onset

key CMS staff from various areas within CMS, such as the OMO, would allow for proactive cross-departmental communication to understand how people with Medicare may be impacted as a result of system development, implementation, and/or data clean-up, as needed.

The Medicare Ombudsman recommends the following regarding system issues that impact people with Medicare:

- Ensure that sufficient time is allowed for conducting end-to-end testing, including comprehensive end-user testing and shared-system testing (as applicable), when developing and implementing new systems or conducting system upgrades.

- Ensure the appropriate CMS staff members who are providing direct beneficiary services are involved in end-user testing of systems.

- Continue to improve the responsiveness and effectiveness of Part C and Part D support systems, involving key CMS IT staff, policy/operations subject matter experts, and beneficiary services staff members to decide on systems development, enhancements, or changes that will or may impact people with Medicare.

Issue: Medicare Advantage Marketing Abuses

During 2007, numerous people with Medicare, their advocates, and caregivers cited problems with what often are called “unscrupulous” practices used by some insurance agents who are authorized by healthcare organizations to promote and facilitate enrollment into these plans. The concerns included reports that people with Medicare have been pressured or coerced by insurance agents to sign up for plans without fully understanding the coverage and benefits, fraudulently enrolled into these plans without their knowledge or authorization, or provided misleading or incomplete information from agents or other plan representatives in efforts to persuade them to enroll in these plans. The OMO handled such complaints during 2007; while they represented less

than 1% of the total Part C and Part D complaints received by CMS, the ramifications of these types of complaints are significant.

Due to their structure and nature Medicare Private Fee-for-Service (PFFS) healthcare plans created some unique challenges in this area, and made up the bulk of marketing related complaints at the outset. Medicare Private Fee-for-Service plans are Medicare Advantage Plans (Part C) offered by private insurance companies. For those who are enrolled in these plans, Medicare pays a set amount of money each month to the private insurance company to provide healthcare coverage to people with Medicare on a Fee-for-Service arrangement. In June of 2007, CMS announced that, in response to concerns about marketing practices, seven healthcare sponsors had signed an agreement to voluntarily suspend the marketing of PFFS Plans. The healthcare sponsors included: United Healthcare, Humana, Wellcare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee.

This suspension for a given plan was to be lifted following CMS certification that the plan had the systems and management controls in place to meet all of the conditions specified in earlier guidance issued by CMS. Plans signed the agreement with the understanding that they would be actively monitored by CMS to ensure that they did not engage in marketing while this voluntary suspension was in place. Violators of this agreement were subject to several possible penalties, which included suspension of enrollment, suspension of payment for new enrollees, civil-monetary penalties, and termination of the plan's involvement in the Medicare Program. In September 2007, following CMS' marketing review and verification of the plans' compliance with marketing guidelines, these plans were approved by CMS to resume their marketing efforts.

When marketing began for the 2008 benefit year on October 1, 2007, all PFFS plans had to abide by standard marketing rules, which include the following:

- All brokers and agents selling the product must pass a written exam to demonstrate an understanding of Medicare PFFS policies and the products being marketed;

- Plans must telephone beneficiaries requesting enrollment in a PFFS Plan to confirm that they understand the terms and conditions of the plan;

- A provider-outreach and education program must be in place to ensure that providers are aware of PFFS Plans and their payment provisions and are encouraged by the plans to provide services to PFFS enrollees;

- Plans must include specific disclaimer language in key enrollee materials to ensure beneficiaries understand the unique aspects of PFFS; and

- Lists of planned marketing and sales events sponsored by the plan's brokers and agents must be provided to CMS so that CMS can monitor these events.

Sponsors that sell these PFFS Plan products are monitored actively through complaints received during calls to 1-800-MEDICARE and CMS' casework system, as well as improved CMS-oversight systems. CMS also developed partnerships with State Insurance Commissioners and others to obtain additional help in monitoring the marketing of these Medicare health plans. Some of the oversight activities include:

- Creation of a dedicated monitoring team and a comprehensive rapid response plan;

- Enrollment verifications of new PFFS Plan enrollees by CMS to ensure the enrollees understand the characteristics of a PFFS Plan and were not subject to inappropriate marketing activities;

- Increased "secret shopping," which is unannounced participation and monitoring of marketing practices and activities by CMS officials or representatives during PFFS marketing events;

- Random audits of PFFS agent training and test files;

- Thorough reviews of PFFS enrollment packages to verify all required disclaimers are included; and

- Coordination with state insurance departments to share information about agent and broker complaints and license suspensions.

CMS also has developed an outreach plan to educate people with Medicare, advocacy organizations, and other interested parties about the marketing guidelines and what actions they can take to avoid or handle potential violations.

In 2008, CMS actively worked to reduce the incidence of marketing abuse in both Medicare Advantage (MA) and Part D, which addressed marketing problems beyond just the PFFS plans. The Medicare Improvements for Patients and Providers Act (MIPAA) made several notable changes to the MA and Part D programs. CMS issued final and interim regulations in September to institute these MIPAA provisions, which included several marketing provisions intended to strengthen beneficiary protections. CMS also provided formal guidance to assist MA and Part D plans in implementing the marketing requirements that were specified in the new regulations. These rules are effective for the marketing season starting October 1, 2008, for plan year 2009. Additionally, CMS further refined the marketing requirements in November 2008 by releasing an additional regulation to clarify the compensation requirements that were established by the enactment of MIPAA. The purpose of this second interim final rule was to ensure that health insurance agents enrolled individuals in plans that met their health care needs rather than enrolling them based on financial incentives, with the intent of eliminating inappropriate moves of beneficiaries form plan to plan.

CMS currently works to ensure that beneficiaries receive comprehensive and accurate explanation of plan benefits and rules by requiring MA and Part D plan sponsors to disclose specific plan information annually. This includes the Annual Notice of Change/Evidence of Coverage (ANOC/EOC), a comprehensive or abridged formulary, and provider and pharmacy directories. Plans sponsors also include these materials on their websites. The ANOC/EOC, which must be sent to beneficiaries by October 31st of each year, provides information about year-to-year changes as well as comprehensive benefit information for the following year. CMS has also established and enhanced a comprehensive marketplace surveillance program. Specifically, the Agency has continued to monitor plan performance through its secret shopper activities, review and standardization of plan materials, review of plan websites to ensure that key benefit information has been accurately posted, collaboration with States, and other key oversight initiatives.

While the efforts that CMS has undertaken to address this issue are applauded, CMS may want to consider:

Enhancing efforts to ensure that marketing materials, including information provided on CMS and health plan websites, provide comprehensive and accurate explanations of benefits and rules, to include complete listings of covered and non-covered drugs and services. CMS can also continue to closely monitor the marketing practices of health-plan sponsors actively to protect people with Medicare from potential abuses, and sanction plans that violate these guidelines, when necessary.

Issue: Improving Medicare Communications to Target Populations

Due to numerous places and resources from which messages about the Medicare Program and its benefits are delivered to and received by people with Medicare, opportunities arise for the communication of conflicting and inaccurate information, sometimes resulting in confusion among people with Medicare and those who act on their behalf. Therefore, communication is an issue on which the OMO has focused since its inception. The OMO has noted a number of challenges associated with communicating effectively with CMS' diverse audiences, including, but not limited to, people with Medicare, their caregivers and families, others acting on their behalf, advocacy organizations, Federal Agencies, the SHIPs, and other public and private sector partners.
Compounding issues related to accurate and consistent messages about Medicare, and complexities around preferences for and places to which people with Medicare turn to receive information (e.g., www.medicare.gov, direct mail, 1-800-MEDICARE, the SHIPs, private insurers, etc.), there are some Medicare benefits about which relatively few beneficiaries currently are aware (e.g., the new "Welcome to Medicare Exam"). In addition, after accessing these information sources, some Medicare beneficiaries have difficulty understanding and finding the specific information for which they are looking. For example, the structure of the main website for the Medicare Program, www.medicare.gov, presents a challenge to some people with Medicare in obtaining the specific information they need because content is widespread and is not always easily accessible or available.

Traditionally, Americans age 65 and older have preferred traditional means of communication, which are primarily written, telephone, and in-person communication. After a review of existing research, the OMO has noted that the communications preferences regarding healthcare information of Baby Boomers (Americans between the ages of 44 to 61) and 'pre-Medicare beneficiaries' (including Americans between the ages of 50 to 64) is the Internet first, cell phones and land lines second, and in-person communication third (*Source: Citizens Service Levels Interagency Committee, MITRE GSA report 2008*). Today, there are more than 20.5 million Internet users aged 62 or older, representing more than 10% of all Internet users and 62% of the total 62+ year-old population (*Source: eMarketer – Baby Boomers & Silver Surfers; November 2007*). Those aged 44 to 64 represent 46.8% of all Americans who seek healthcare information online. These numbers are expected to climb year-after-year; in 2011, more than 82% of Baby Boomers are expected to use the Internet, representing more than 30% of all Internet users (*Source: Center for Studying Health System Change (HSC), "Striking Jump in Consumers Seeking Health Care Information," August 21, 2008*).

The Medicare Program's growing population of more than 44 million beneficiaries continues to turn to an increasing number of resources about the Program and its benefits. In order to determine which needs are greatest regarding communicating with target populations, CMS must prioritize its various audiences in a way that delivers the maximum exposure to the greatest number of Medicare beneficiaries. To accomplish this goal, CMS works with partners to collaborate to ensure that the right communications are targeted to specific audiences, which vary by language, region, culture, and preferences for receiving information. For example, efforts have begun to offer non-English language versions of the top 25 Medicare publications. Despite efforts such as this one, more should be done to ensure that people with Medicare receive accurate information that they can understand.

The Medicare Ombudsman recommends that CMS considers the following regarding CMS' communicating with Medicare's target populations:

- Explore ways in which to communicate earlier and more proactively with beneficiaries and their caregivers by broadening access to information in various languages and formats, and leveraging new media to direct information to Medicare beneficiaries and soon-to-be beneficiaries earlier.

- Work to enhance its current efforts to determine the unique communications needs and issues of disease specific and regional populations and pockets, as well as efforts to conduct performance gap analyses to discover the best method and the most effective opportunities to communicate with these segmented populations.

- Devote the necessary time and resources to examine thoroughly the ways in which other Federal Agencies (e.g., SSA) have enhanced their services through their websites (e.g., number of clicks to retrieve useful information) to meet the growing information needs and concerns of people with Medicare, who turn increasingly to the Internet to find answers to questions about Medicare's benefits and services.

- Augment the Agency's work to date through its relationships with partner organizations to drive information more regularly to beneficiaries and soon-to-be beneficiaries earlier and more often—and through multiple touch-points, including social media.

Issue: Coverage Issues that Result from Determinations and Beneficiary Understanding of Whether Services are Inpatient or Outpatient

Policies often are implemented by CMS with the intent to manage and administer the various benefits and services of the Medicare Program, and to enhance benefits and services to people with Medicare. However, these changes sometimes result in unintended consequences that can have negative impacts on Medicare beneficiaries' experiences and access to services. Coverage issues that result from provider determinations to provide a beneficiary outpatient services within the hospital setting vs. admitting the beneficiary as a hospital inpatient can result in unintended beneficiary issues such as not meeting Medicare qualifications for admission for and coverage of nursing home stays, being billed for "self-administered drugs", and, in some instances, beneficiary complaints of being billed for extended outpatient stays rather than inpatient stays. Because of the potential for negative impacts on people with Medicare, the OMO is concerned about this issue.

Use of Observation Services and the Effects it has on Beneficiaries

The OMO has become aware of increasing concerns with the practice of beneficiaries not being admitted as hospital inpatients, but being registered as hospital outpatients and provided with 'observation services' and other outpatient services. In general, hospital outpatient or observation services are intended to be of short duration, while inpatient hospital stays would typically last more than a day. Observation services are defined by Medicare as a set of specific, clinically appropriate hospital outpatient services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are generally supportive and ancillary to other major services furnished to hospital outpatients and are commonly ordered for patients who present to the emergency department and who then require a period of treatment or monitoring in order to make a decision about whether they need to be admitted to the hospital or can be released from the hospital. The beneficiary is registered on a hospital's or critical access hospital's (CAH) records as an outpatient and receives services directly from the hospital or CAH.

Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Hospitals may bill for patients who are directly referred to the hospital for outpatient services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation services, so that a hospital clinic or emergency department visit is not required. In the majority of cases, the decision whether to release a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. Only in rare and exceptional cases would reasonable and necessary outpatient services span more than 48 hours. Like other services furnished to hospital outpatient, observation services are billed and paid under Part B. If a beneficiary was admitted to the hospital as an inpatient following hospital outpatient services, including observation services, payment for the pre-admission outpatient services may be bundled into the payment for the inpatient stay, which would be paid under Part A.

A very small percentage of hospital outpatient claims (for Part B payment) include observation services extending longer than 48 hours. CMS data at the time of this report indicates that approximately 5 percent of the hospital outpatient claims for observation services are for outpatient encounters lasting more than 48 hours. Although there is no national policy where Medicare would deny payment for outpatient encounters, including observation services, lasting more than 48 hours, individual Medicare contractors have their own policies about subjecting cases to medical review. Some of these contractors review certain claims for observation services extending for more than 48 hours. Medicare beneficiaries and their advocates have expressed that they believe they incur undue additional out of pocket costs when they receive observation services over an extended period of time rather than being admitted. Advocates have indicated that they have cases where beneficiaries are being billed significant amounts when they remain in a hospital outpatient setting notably longer than 48 hours, and that they believe this trend is increasing.

As CMS works continuously to improve the Medicare beneficiary experience, it is crucial that potential problems are identified and addressed prior to implementing or changing policies. CMS should proactively and consistently consider the potential for underlying problems that may result from changes in existing policies, or after the implementation of new policies, which may result in circumstances that negatively impact people with Medicare. As these potential problems are identified, every effort should be made to mitigate the negative impacts on people with Medicare and to the Medicare Program.

Meeting Qualifications for Covered Skilled Nursing Facility Admissions

In some instances, beneficiaries have received observation services in hospital outpatient settings for more than 48 hours, and subsequently were admitted to a skilled nursing facility (SNF) by their healthcare providers. When these beneficiaries were admitted to SNFs following these prolonged outpatient encounters, they were deemed ineligible for coverage for the SNF admission because they did not meet the Medicare program's 3-day inpatient hospital stay requirement. The Social Security Act requires that a beneficiary must be an inpatient at a hospital for a medically necessary stay of at least three consecutive calendar days in order for Medicare to cover a SNF stay. The three consecutive days do not include time spent receiving hospital outpatient services such as observation services or emergency department services prior to (or in lieu of) an inpatient admission to the hospital.

In the majority of cases, the decision whether to release a patient from the hospital following resolution of the reason for observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. However, there are instances where beneficiaries receive hospital outpatient services for more than two days, with some reports of observation services spanning longer period of time. When this occurs and a beneficiary needs to be transferred to a SNF, the beneficiary is negatively impacted because he or she does not meet the three consecutive day inpatient qualifier for SNF coverage.

Beneficiaries Billed for Self-Administered Drugs

In January of 2008, the OMO learned of an issue regarding hospital outpatient care and self-administered drugs that are provided to Medicare beneficiaries in outpatient settings, which primarily involved beneficiaries who are treated for extended periods of time in with observation services. One indicator of an issue was a notable number of calls to 1-800-MEDICARE regarding Medicare beneficiaries receiving bills, some considered excessive, for drugs during hospital outpatient encounters.

Medicare Part A covers drugs provided during care as a hospital inpatient. A drug which is integral to the performance of a treatment or procedure and provided along with a physician's service in the hospital outpatient setting, on the other hand, may be covered by Medicare Part B. Medicare Part B generally covers care that Medicare beneficiaries receive in hospital outpatient settings, such as an emergency room or pain treatment setting; however, Part B covers only drugs that are required for the hospital outpatient services that the beneficiary is receiving at the time. In simple terms, self administered drugs (SADs) can be described as prescription or over the counter drugs that one takes regularly and would normally take on one's own if not receiving

treatment in a medical care setting. CMS regulations state that SADs are "covered if integral to the outpatient services being provided" under Part B. Examples of situations where SADs provided in outpatient settings that may not meet this coverage criterion include a patient who receives outpatient chemotherapy treatment and develops a headache that is treated with a pain reliever that they take by mouth, or a patient who is being monitored and treated in an outpatient observation unit for high blood pressure and has to take a routine dose of medicine for their diabetes.

If a beneficiary is enrolled in a Medicare Part D prescription drug plan (PDP) their SADs may be covered. Because most hospital pharmacies do not participate in Medicare Part D and are not a part of the Medicare drug plans' pharmacy network, beneficiaries may have to pay out-of-pocket for such drugs and submit a claim to their Medicare drug plan for an out-of-network reimbursement. However, under Medicare Part D, coverage of SADs provided in these outpatient settings is limited. If the drugs are covered by the plan, the beneficiary has to pay the difference between what the hospital charges and what the drug plan pays, and the plan is required only to reimburse the amount that the beneficiary would have paid at a network pharmacy. In addition, some beneficiaries who bring their own medications to the outpatient settings to avoid the cost cannot take them, because although Medicare does not prohibit hospitals from giving them, typical hospital standards are not to accept these medications because the hospitals must accept liability for them.

Hospitals are not required to notify beneficiaries of non-coverage of SADs provided in hospital outpatient settings because the law prohibits coverage of these drugs by Medicare Part B. Understandably, many of the beneficiaries that face this situation are under the impression that they are being treated in the hospital and, therefore, the drugs they receive are covered as a part of their care. The impact to beneficiaries is that when they receive SADs that are not covered by Part B while in hospital outpatient settings, they may receive unexpected bills from the hospital for those drugs. As a result, some beneficiaries are paying, sometimes, significant amounts for self-administered drugs including their routine prescription drugs during these outpatient stays.
Complaints and other feedback received indicate that those who receive bills for such drugs often perceive them as unwarranted and excessive.

During the review of this issue, the OMO learned that a couple of components within CMS were looking into this issue, and that a tip sheet was being developed to educate beneficiaries on the subject. Some clarifications of policy were necessary, and the OMO participated in and facilitated several discussions to obtain the necessary clarifications.

The fact sheet on self-administered drugs was completed and posted on www.medicare.gov in December 2008. This fact sheet can be viewed at the following web link:

http://www.medicare.gov/publications/pubs/pdf/11333.pdf

Condition Code 44

In some instances, a physician may order a beneficiary to be admitted as an inpatient, but upon reviewing the case later, the hospital's utilization review committee (URC) may determine that services being furnished do not meet the hospital's admission criteria for an inpatient level of care. When this scenario occurs, hospitals can use Condition Code 44 (CC44) to change the inpatient admission to outpatient; however, when using CC44 the following conditions must be met:

- The change in patient status from inpatient to outpatient must be made prior to discharge or release, while the beneficiary is still a patient of the hospital;
- The hospital must not have submitted a claim to Medicare for the inpatient admission;
- A physician must concur with the URC's decision; and
- The physician's concurrence with the URC's decision must be documented in the patient's medical record.

When a hospital changes a beneficiary's status from inpatient to outpatient the services rendered are billed as an outpatient episode of care. When a URC committee decides that an admission or continued stay is not medically necessary, written notification must be given, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient no later than two days after the determination. Regardless, some beneficiaries are surprised when they receive a hospital bill for Medicare non-covered charges incurred during their hospital stay.

CMS data indicates that the frequency of claims with CC44 is relatively low, occurring with a small percentage of inpatient admissions. However, this issue is nonetheless important because the use of CC44 can have a domino effect and may create financial hardship for a beneficiary. If a beneficiary is admitted to a hospital as an inpatient, he or she is responsible only for their Medicare Part A deductible. However, when a beneficiary receives only outpatient services, the beneficiary is not only responsible for paying their approximately 20% coinsurance for covered Medicare Part B services, but the beneficiary is also responsible for paying for any applicable SADs and SNF charges.

Medicare Notifications

Under the Medicare program, both Medicare beneficiaries and providers have certain rights and protections related to financial liability. Usually, these rights and protections are communicated through policy manuals, and several fact and/or tip sheets, which may overwhelm beneficiaries, especially if they do not know what type of outpatient services they may receive. Beneficiaries are also informed of their rights and protections, related to financial liability, through Medicare notices given by providers. These notices include the Fee-for-Service (FFS) Advance Beneficiary Notice (ABN) and the Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN).

The FFS ABN is a notice given to beneficiaries, in Original Medicare, to convey that Medicare is not likely to provide coverage, in a specific case, and the beneficiary may be financially liable for the charges. The FFS ABN is not an official denial of coverage by Medicare. Entities that provide the FFS ABN include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B. The FFS ABN must be verbally reviewed with the beneficiary or his or her representative and any questions raised during the review must be answered before it is signed. In addition, the FFS ABN must be delivered far enough in advance to ensure the beneficiary or representative has time to consider the options and make an informed choice. However, FFS ABNs are not permitted in emergency situations. The FFS ABN gives beneficiaries the following three choices regarding the items or services in question:

1. To receive the service, have the provider bill Medicare for the service, pay for the service if Medicare does not pay, and retain the right to appeal;
2. To receive the service, request that Medicare is not billed, pay for the service, and forfeit the right to appeal; or
3. To not receive the service and forfeit the right to an appeal.

Providers cam also voluntarily issue the FFS ABN to beneficiaries or their representatives to alert them, in advance, that Medicare does not cover certain items and services because the items or services do not meet the definition of a benefit or because the items or services are specifically excluded by law.

SNFs are required to issue a SNFABN to beneficiaries for extended care items and/or services that are initiated, reduced or terminated and Medicare is not expected to pay. The SNFABN must be given to the beneficiary or his or her authorized representative prior to the delivery of non-covered items or services. Currently, providers can also voluntarily provide beneficiaries with a Notice of Exclusions from Medicare Benefits (NEMB) SNF, which alerts Medicare beneficiaries, in advance, that

Medicare does not cover certain extended care items and/or services because the items or services do not meet the definition of a Medicare benefit or because the law specifically excludes the items or services. While the NEMB SNF includes '*No qualifying three-day inpatient hospital stay'* as a reason Medicare will not pay for a beneficiary's SNF services, there is no statute that requires SNFs to give notice to beneficiaries who do not meet the three-day requirement.

Through discussions with Medicare beneficiary advocacy organizations, the OMO learned that some hospitals do not comply with Medicare policy and are not furnishing ABNs to hospital outpatients when applicable. Some hospitals furnish applicable ABNs to beneficiaries, but do not clearly identify and explain the ABN to the beneficiary, the items in question are not itemized on the ABN and the beneficiary is not requested to sign the ABN as required. In addition, issues sometimes arise for beneficiaries because they usually do not know or clearly understand what services or items do not meet the definition of observation care or what services or items are not otherwise covered under Medicare Part B prior to having the services or items rendered to them. When these situations occur, beneficiaries are uninformed and often are unaware of their admission status and coverage of their hospital and/or SNF stays, which results in their receiving bills for items and services without prior knowledge of potential liability. As previously indicated, beneficiaries are often surprised to receive a bill for such services or items.

The Medicare Ombudsman recommends that CMS considers the following regarding coverage issues that may result from determinations of inpatient vs. outpatient services:

- Enhance beneficiary outreach and educational information to inform beneficiaries about the three-day inpatient qualifier for SNF coverage and the importance of knowing their status.

- Enhance beneficiary outreach and educational information to inform beneficiaries that :
    - Some drugs received in outpatient settings are classified as Self-Administered Drugs (SADS) and are not covered by Medicare Part B, and that
    - SADs may have limited Part D coverage.

- Consider means to address the underlying SAD drug policy issue, such as requiring Medicare Part A participating hospitals to participate in Part D.

- Broaden education and outreach efforts to inform beneficiaries of their Medicare rights and protections, which includes:
    - Receiving written notification that their inpatient stay has been changed to outpatient; and
    - Appealing denials of Medicare coverage in applicable situations.

- Enhance beneficiary outreach and educational materials to ensure beneficiaries are aware of the ABN and its purpose.

SUMMARY OF THE MEDICARE OMBUDSMAN'S RECOMMENDATIONS

Recommendations for the Need to Implement Best Practices to Serve Medicare Beneficiaries Optimally

CMS actively pursues and implements, when appropriate, best practices in order to serve Medicare beneficiaries optimally. Its efforts to enhance the customer service support for people with Medicare take into account best practices exercised by customer service organizations in the public and private sectors. In addition, the Agency should carefully consider establishing a customer service lead and/or component and an enterprise-wide correspondence management system for beneficiary correspondence. Additional insights into customer service may also be achieved by requiring more comprehensive reporting from health and prescription drug plans on the reasons for and timeliness of responses to beneficiary inquiries, complaints, and grievances that they receive and handle directly. CMS should also require adequate oversight of complex beneficiary inquiries and beneficiary sponsored Congressional inquiries that are directly received and processed by legacy Medicare Fee-for-Service contractors and Medicare Administrative Contractors.

Recommendations for System Issues that Impact People with Medicare

One of the outcomes of the compressed timeframes in which CMS and the Medicare Program must accomplish specific objectives is an increase in issues associated with system-related errors or problematic data exchanges. While the OMO recognizes that CMS cannot foresee how every aspect of system and data changes will impact people with Medicare, it recommends that CMS should take appropriate measures to the degree possible to ensure that sufficient time is provided to conduct end-to-end testing when developing or implementing system or data changes, and that there is full involvement of the appropriate end-users and other stakeholders. By doing so, CMS can reduce the number of person-hours necessary to analyze resultant system problems, and manage better the fallout from corresponding data clean-ups. By involving key CMS staff from various Offices, proactive and cross-departmental communication can

identify ways in which people with Medicare may be impacted as a result of a system implementation, change and/or data clean-up. Furthermore, CMS should consider ways to continue improving the responsiveness and effectiveness of Part C and Part D support systems, involve key CMS IT staff and policy/operations subject matter experts, and engage beneficiary-services staff members to decide on systems development, enhancements, or changes that may impact people with Medicare.

Recommendations for Medicare Advantage Marketing Abuses

A primary issue for the Medicare Program during 2007 was the occurrences of deceptive practices regarding the marketing of Medicare Private Fee-for-Service plans. CMS has undertaken several efforts to address these issues. In effort to continue to address this issue CMS should continue to actively monitor and enhance the monitoring of marketing practices of healthcare sponsors to protect people with Medicare from potential abuses, and consider aggressively sanctioning plans that violate these guidelines, when necessary.

Recommendations for Improving Medicare Communications to Target Populations

In an effort to ensure continuous improvement in communicating with its target audiences and various populations, CMS should consider ways in which to communicate earlier and more proactively with beneficiaries by broadening language access and leveraging new media to reach Medicare beneficiaries and soon-to-be beneficiaries earlier. In addition, CMS could determine the unique communications needs and issues of disease specific and other groups of beneficiaries. To accomplish these goals, CMS can conduct analyses to discover the best method and the most effective opportunities to communicate with targeted populations. By leveraging its relationships with partner organizations, CMS can drive information to beneficiaries and soon-to-be beneficiaries earlier, more often, and through multiple touch points.

Recommendations for Coverage Issues that Result from Determinations of and Beneficiary Understanding of Whether Services are Inpatient or Outpatient

Policy determinations and application sometimes result in unintended consequences that can have negative impacts on Medicare beneficiaries' experiences and access to services. Coverage issues that result from provider determinations to provide a beneficiary outpatient services within the hospital setting vs. admitting the beneficiary as a hospital inpatient can result in unintended beneficiary issues such as not meeting Medicare qualifications for admission for and coverage of nursing home stays, being billed for "self-administered drugs", and, in some instances, beneficiary complaints of being billed for extended outpatient stays rather than inpatient stays. Because of the potential for negative impacts on people with Medicare CMS should enhance beneficiary outreach and educational information to ensure that beneficiaries are well informed about the qualifications for SNF coverage, Medicare's coverage of self-administered drugs, and the associated appeal rights and protections. CMS should also consider means to address the underlying self-administered drug policy issue, such as requiring Medicare Part A participating hospitals to participate in Part D.

CMS' EFFORTS THAT ADDRESSED THE MEDICARE OMBUDSMAN'S RECOMMENDATIONS FROM THE 2005–2006 REPORT TO CONGRESS

The Office of the Medicare Ombudsman (OMO), CMS' dedicated Office to serve as an advocate for people with Medicare, presented several general recommendations for improvements to the Medicare Program in the OMO Report to Congress for calendar years 2005 and 2006. The following section summarizes CMS' efforts that have served, either directly or indirectly, to address these recommendations since the recommendations were formulated by the OMO.

RECOMMENDATION: "Bring together a cross-functional team at the outset of any new program, process, or benefit to determine its effects on people with Medicare and develop risk-mitigation plans, as needed"

CMS' Efforts:

Around the time that this recommendation was formulated in 2005, or sometime afterwards, CMS brought together several cross-component, cross-functional groups to address the impacts of programmatic changes on people with Medicare, such as the:

- **MA/PD Operations Board —** Where policy, operations, and associated issues regarding the Medicare Modernization Act are discussed, coordinated, and handled by key CMS Leadership and subject matter experts.

- **CMS Communications Council —** Where strategies, planning, methods, and the status/timeline for CMS' external communications are discussed and coordinated by key CMS Leadership and subject matter experts.

- **CMS National Casework Teleconference —** Where caseworkers and subject matter experts from the CMS' Central and Regional Offices provide and/or obtain casework-specific guidance regarding policy, operational issues, and relative updates that impact inquiries and complaints involving people with Medicare in a weekly teleconference.

- **CMS Casework Leadership Team Meetings —** Where Agency Senior Leadership responsible for beneficiary customer assistance focused on the identification, discussion, and resolution of issues that impact Medicare beneficiaries' access to services in bi-weekly meetings.

- **CMS Casework Escalation Meetings —** Where the Casework Leadership Team and the CMS Chief Operating Officer meet bi-weekly to escalate systemic issues that impact Medicare beneficiaries' access to services.

RECOMMENDATION: "Create a consistent and standard method for all Medicare entities to report beneficiary inquiries, complaints, and issues"

CMS' Efforts:

CMS Leadership does understand the need for /benefit of an enterprise-wide solution to centralize and standardize the collection, trending, and response to inquiries, complaints, and issues from people with Medicare. In mid-2007, CMS conducted a Joint Application Design session, with key CMS personnel, to begin to capture the high-level business and functionality requirements for an enterprise-wide casework system that will collect, track, and trend issues on all parts of the Medicare Program from all sources. Such a system will facilitate analysis, assist with progression and resolution of individual inquiries and complaints, and improve the management of casework at CMS. However, CMS has not made a formal decision, and this is a multiple year effort that would require adequate funding to implement. In the interim, until full implementation of an enterprise-wide system takes place, CMS does have a means to track complaints and issues regarding Medicare Part C and Medicare Part D (called "MA and Part D Complaint Tracking Module" – CTM) of the Medicare Program, and is working to develop a similar mechanism (called "Medicare Administrative Issues Tracking and Reporting of Operations system" – MAISTRO) to track Part A and Part B issues within the Medicare Program.

RECOMMENDATION: "Strengthen the communication within CMS to be proactive in detailing beneficiary impacts and enhance resolution of issues impacting people with Medicare"

CMS' Efforts:

The Medicare Ombudsman made this recommendation in 2005, after the Medicare Part D benefit was introduced, making proactive discussions within CMS necessary. This included the establishment of a National Casework Call, on which beneficiary casework issues are discussed and areas requiring the establishment or changes to policy are identified. Other additional forums were put in place to foster cross-component collaboration, including the Medicare Modernization Act Operations Center, the establishment of the Complaint Tracking Module Technical Team, and the Regional Office/Central Office Account Management Call. CMS also has plans to establish a Beneficiary Steering Committee to this regard.

RECOMMENDATION: "Prepare for significant Program change by educating people with Medicare and their advocates about where to obtain assistance. Ensure the entities assigned to provide assistance have appropriate and adequate information and resources to provide quality service to people with Medicare"

CMS' Efforts:

Since the implementation of the Medicare Part D benefit and subsequent to this recommendation, CMS has worked in an unprecedented fashion with stakeholders (e.g., Social Security, advocates, State Health Insurance Assistance Programs, pharmacies, congressional offices, etc.) to ensure that CMS' constituencies are aware of CMS' policies and how to secure assistance with the issues they face. There have been many successes in this area and, while there is still more that can be done in this regard, the foundation for many constructive relationships has been set. Examples of such efforts include the CMS Mobile Office Tour events and various Open Door Forums that provide information on and resources regarding major programmatic changes to stakeholders who work closely with people with Medicare. CMS also has undertaken efforts to improve its websites, as well as the information that is available from 1-800-MEDICARE.

Moreover, in establishing the Office of External Affairs (OEA), the Agency has taken steps to centralize and improve upon its efforts to educate people with Medicare and those who act on their behalf on the various means to obtain necessary assistance. Specific examples of this include:

- **Communication Campaigns —** An all-out external communications push led by the OEA to educate individuals about where to go for assistance. A variety of materials are developed for each campaign, including publications, advertising, and drop-in articles.

- **Publication Development —** Clear, readable, and user-friendly publications developed by the OEA for people with Medicare, providing consumers with consistent, up-to-date information about benefits and services, upcoming Program developments, and current healthcare issues. Each of these products, informed by the latest beneficiary research, includes referrals to resources to which consumers can go for additional information on any given topic. Flagship products include the "Medicare & You" handbook, the "Your Medicare Benefits"publication, and a host of constantly-updated consumer fact sheets and partner tip sheets. In all of CMS' communications materials, beneficiaries and those acting on their behalf are directed to resources including CMS websites, 1-800-MEDICARE, and local community resources, including the SHIPs, for help with and information on topics such as the low-income subsidy, Medicare prescription drug coverage, www.MyMedicare.gov, and general Medicare information.

- **Intergovernmental Partnership —** Regular conference calls, maintenance of websites, and electronically disseminated information via listservs provided by the OEA to audiences with a specific focus on state issues (e.g., State Medicaid Directors, budget officers, or State Legislators) to assist people with Medicare, stakeholders, and constituents with issues related to Medicare, Medicaid, and State Children's Health Insurance Program.

- **Outreach and Education Coordination —** Coordination and advertising of local and community events at which counselors are available to assist people with Medicare and their advocates directly. The OEA maintains regular communications with the Aging Network, key advocacy and provider partners, and others to equip them with accurate and user-friendly information and the tools and training needed to assist people with Medicare, throughout the year, on a variety of Medicare- and Medicaid-related topics, including the Annual

Enrollment Season. This includes sponsoring regular partner forums with CMS experts to discuss Medicare Part D issues, including preparation for new Benefit Periods, to ensure that people with Medicare experience smooth transitions to their new plans and have access to the medications that they need.

- **Satellite, Cable, and Webcast Public Programming –** Video productions developed by the OEA for training and public information on a wide range of Medicare-related topics, including issues impacting Native American tribal communities, caregivers of Medicare and Medicaid beneficiaries, Medicare's preventive services benefits, open enrollment periods for Medicare, and many others that are initiated by CMS. These broadcasts are shared with people with Medicare and the healthcare industry via satellite communications, local public-service and Government-cable stations, and webcasts throughout the country.

CMS recognizes, more than ever, that beneficiary-education and outreach efforts are essential for the success of the Medicare Program. In addition to the activities above, the OMO has developed a section on www.medicare.gov to provide people with Medicare with a central location at which they can obtain beneficiary-focused information related to obtaining assistance with inquiries, complaints, grievances, and appeals across the Medicare Program. The OMO has worked with CMS' subject matter experts to develop informational material where none existed, and to improve existing information so that people with Medicare easily can understand these topics.

Finally, the OMO developed a SHIP technical assistance program (SHIP TAP) to provide the SHIPs with sensitivity and awareness training appropriate for SHIP volunteers, and a partnership-development strategy toolkit to assist SHIP counselors in reaching and serving more effectively people with Medicare with disabilities.