DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Office of the Medicare Ombudsman

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Contents

List of Acronyms

Acronym	Term
CAO	Competitive Acquisition Ombudsman
CBP	Competitive Bidding Program
CCIIO	Center for Consumer Information and Insurance Oversight
CFC	Combined Federal Campaign
CM	Center for Medicare
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CSR	Customer Service Representative
CTM	Complaint Tracking Module
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMOA	Division of Medicare Ombudsman Assistance
DoD	Date-of-death/Date-of-discharge
DOE	Division of Ombudsman Exceptions
DORTA	Division of Ombudsman Research and Trends Analysis
EGWP	Employer Group Waiver Plan
ESRD	End-Stage Renal Disease
FFS	Fee-for-Service
FY	Fiscal Year
GHP	Group Health Plan
HDHP	High-Deductible Health Plan
HHS	U.S. Department of Health & Human Services
HSA	Health Savings Account
IRMAA	Income-Related Monthly Adjustment Amount
IRS	Internal Revenue Service
IVR	Interactive Voice Response
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAISTRO	Medicare Administrative Issue Tracker and Reporting of Operations (System)

Acronym	Term
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMCO	Medicare-Medicaid Coordination Office
MSA	Medical Savings Account
MSN	Medicare Summary Notice
NF	Nursing Facility
NUBC	National Uniform Billing Committee
OA	Office of the Administrator
OC	Office of Communications
OFM	Office of Financial Management
OIS	Office of Information Services
OMHA	Office of Medicare Hearings and Appeals
OMO	Office of the Medicare Ombudsman
QMB	Qualified Medicare Beneficiary
RDS	Retiree Drug Subsidy
RO	Regional Office
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Insurance

Message from the Medicare Beneficiary Ombudsman

It is my pleasure to present the Office of the Medicare Ombudsman's (OMO's) 2012 annual report to Congress and to the Secretary of the U.S. Department of Health & Human Services. This report describes the OMO's 2012 activities, systemic issues currently affecting Medicare beneficiaries, and the OMO's recommendations for addressing these issues. Since the OMO's inception 8 years ago, the type of work it does and its approach to fulfilling its mission have evolved as the OMO draws on lessons learned and adapts to the changing needs of Medicare beneficiaries. For example, the completion of comprehensive studies, which include detailed analyses of beneficiary issues and actionable recommendations, is now one of the OMO's core activities.

Today, Medicare beneficiaries have access to a variety of sources to answer their questions and address their concerns. Some of these sources have seen a decline in the number of inquiries, which suggests that the quality of information provided and beneficiaries' access to this information may have improved. For example, the number of calls to 1-800-MEDICARE was lower in fiscal year (FY) 2012 than in FY 2011, continuing the decline that started in FY 2007. In addition, the number of complaints related to Part C and Part D, as captured in Medicare data systems, has declined each year since FY 2007.

These declines in inquiries and complaints likely reflect several factors. First, CMS has become a more beneficiary-focused agency that places greater emphasis on anticipating beneficiaries' needs and concerns and on providing strong oversight of health plans and other contracted entities. Second, the advocates and other professionals who interact directly with beneficiaries and work with the OMO have improved not only how they communicate with beneficiaries but also how they convey beneficiaries' concerns to CMS staff, which helps solve problems more efficiently. Third, beneficiaries, their family members, and their caregivers are better able to access information because of Web-based resources. Fourth, CMS has improved program operations and oversight of the Part D program. Finally, the OMO continues to make strides in improving the beneficiary experience with Medicare as it leads the collaborative process of identifying beneficiary issues, researching them, and recommending solutions to CMS Leadership.   These positive developments have enabled the OMO to increase its focus on identifying the root causes of new, complex issues; tracking these issues; and, in many cases, guiding CMS components' implementation of the recommendations made by the OMO and presented in prior reports to Congress.

In addition to advocating for Medicare beneficiaries in 2012, I had the opportunity to advocate on behalf of many worthy nonprofit organizations as chairperson of the CMS Combined Federal Campaign (CFC). The CFC provides an opportunity for federal employees across the country to support thousands of organizations in their local communities, across the nation, and around the world. The CMS Central Office (CO) raised $435,511 through the campaign in 2012. It

is indeed a privilege to lead the effort to showcase the special work of these organizations as well as the generosity of our federal workforce.

I am also privileged to work with hundreds of talented, hard-working individuals within the OMO and at its partner organizations, including other CMS CO components, Regional Offices, State Health Insurance Assistance Programs, and advocacy organizations. Every day, these dedicated individuals are actively engaged in making Medicare work better in ways big and small. On behalf of the 50 million beneficiaries whose lives are improved through their continual efforts, I thank them.

Daniel J. Schreiner
Medicare Beneficiary Ombudsman

The Office of the Medicare Ombudsman provides direct assistance to beneficiaries with their inquiries, complaints, grievances, and appeals.

Mission, Vision, and Organization

MISSION

The Office of the Medicare Ombudsman (OMO) provides direct assistance to beneficiaries with their inquiries, complaints, grievances, and appeals. The OMO serves as a voice for beneficiaries by evaluating policies and procedures, identifying systemic issues, making recommendations to Congress and the Secretary of the U.S. Department of Health & Human Services, and working with partners to implement improvements to Medicare.

VISION

The OMO ensures that Medicare beneficiaries have access to the health care and coverage to which they are entitled. When issues arise, information and assistance are available for timely and appropriate resolution.

ORGANIZATION

The OMO is located within the Centers for Medicare & Medicaid Services (CMS) Office of Public Engagement and has direct access to the CMS Administrator to raise beneficiary issues and concerns. To handle its range of activities, the OMO is organized into three divisions: the Division of Ombudsman Exceptions (DOE), the Division of Medicare Ombudsman Assistance (DMOA), and the Division of Ombudsman Research and Trends Analysis. Both DOE and DMOA directly assist beneficiaries through casework. The Competitive Acquisition Ombudsman, also within the OMO, responds to inquiries and complaints from individuals and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) relating to the application of the Medicare DMEPOS Competitive Bidding Program. The activities of each of the OMO's divisions are discussed in more detail in this report.

Office of the Administrator

Office of Public Engagement

Office of the Medicare Ombudsman

Daniel J. Schreiner

Medicare Beneficiary Ombudsman

Competitive Acquisition Ombudsman

Tangita Daramola
Ombudsman

- Responds to suppliers' and beneficiaries' inquries and complaints about the Medicare DMEPOS Competitive Bidding Program

- Assists in identifying potential systemic issues

- Submits a seperate annual report to Congress

Division of Research and Trends Analysis

- Performs trending and analysis of Medicare inquiry, complaint, and appeals data

- Assesses, tracks, and facilitates resolutions to systemic Medicare issues that affect Medicare beneficiaries

Division of Medicare Ombudsman Assistance

- Manages and responds to beneficiary inquiries and complaints sent to the CMS Central Office and to the Medicare Beneficiary Ombudsman

- Reports trends in these inquiries and complaints

- Develops resources for case workers (e.g., standard language documents and training materials)

Division of Ombudsman Exceptions

- Works primarily with beneficiary systems focusing on the integrity of data for Medicare Parts A and B

- Resolves data discrepancies related to control problem identification and correction of Medicare enrollment, direct billing, third-party, Medicare Advantage, and Medicare Part D data and transaction exceptions

The beneficiary experience is evolving, and the Office of the Medicare Ombudsman, as the primary advocate for Medicare beneficiaries, is researching a variety of new and improved mechanisms to serve beneficiaries' needs better.

Executive Summary

Medicare serves more than 50 million beneficiaries through a variety of coverage options, including traditional Medicare, Medicare-contracted health plans, and prescription drug plans. The features of these programs and plans and the information provided about them to beneficiaries must evolve as beneficiaries' needs evolve.

The Medicare population has recently undergone significant changes: the aging of the baby boomer generation has led to an increase in the number of beneficiaries who have divergent demographic profiles because of changing socioeconomic factors. Today, many adults are continuing to work beyond age 65 and may choose to continue receiving employer-based health insurance benefits while also enrolling in Medicare. Participating in multiple programs requires beneficiaries to consider their available options carefully so that they can maximize their benefits and avoid penalties. Additionally, an increasing number of older Americans are becoming eligible for both Medicare *and* Medicaid, a health benefit program administered under a federal-state partnership for low-income persons who meet certain criteria. Becoming eligible for both programs can create complex issues for beneficiaries as the programs often offer different benefits and services that may not be well coordinated.

Thus, the beneficiary experience is evolving, and the Office of the Medicare Ombudsman (OMO), as the primary advocate for Medicare beneficiaries, is researching a variety of new and improved mechanisms to better serve beneficiaries' needs. In doing so, the OMO has used its position and relationships, both within and outside the Centers for Medicare & Medicaid Services (CMS), to protect the best interests of Medicare beneficiaries. This report describes the OMO's fiscal year (FY) 2012 activities and informs Congress and the Secretary of the U.S. Department of Health & Human Services (HHS) of the OMO's efforts and its recommendations for improving beneficiaries' experiences with Medicare.

KEY ACCOMPLISHMENTS

The key accomplishments of the OMO in 2012 are highlighted in figure 1 and include the following:

Direct service to beneficiaries: The OMO's total casework volume for FY 2012 was 26,400 cases. Of these, the OMO provided direct assistance with more than 13,500 contacts from beneficiaries, their caregivers, advocates, and congressional offices. The remaining cases were handled by CMS Regional Offices (ROs).

Casework response time: On average, the Division of the Medicare Ombudsman Assistance (DMOA) responded to 99.5 percent of inquiries within 30 business days in 2012. This response rate marks a 6.5 percent increase above the 2010 rate of 93 percent.

National Casework Calls and caseworker training: In January 2012, the OMO conducted a national caseworker training needs assessment survey to develop a robust training program related to topics identified by RO and Central Office (CO) caseworkers. The OMO conducted 10 training sessions in FY 2012 via National Casework Calls, classroom sessions, and webinars, covering a variety of topics that reflected the needs of caseworkers, as expressed in the survey.

Comprehensive studies: Continuing its efforts to conduct in-depth research on complex issues affecting Medicare beneficiaries, the OMO completed three comprehensive studies in 2012 and began working with CMS components to make changes based on the findings from these studies.

FIGURE 1. MAJOR ACCOMPLISHMENTS IN FY 2012
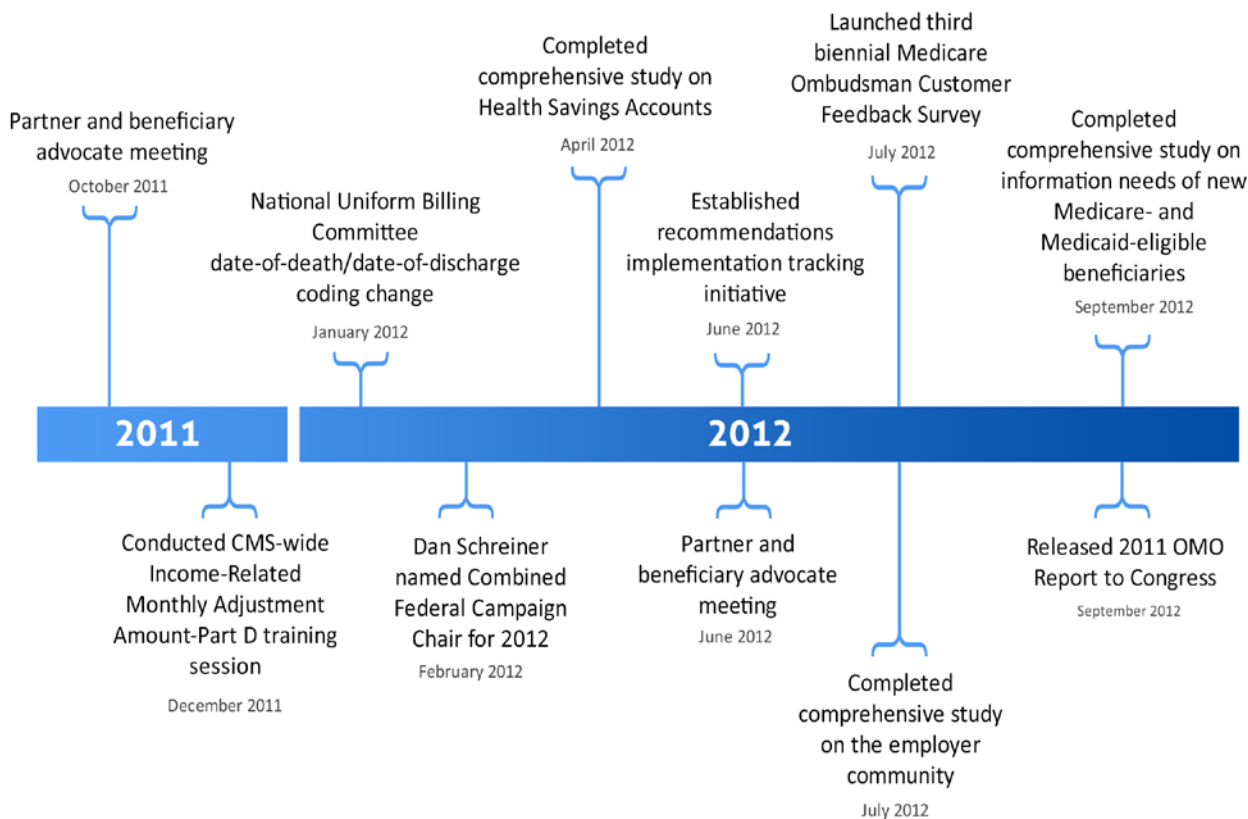
AREAS FOR IMPROVING BENEFICIARIES' EXPERIENCES WITH MEDICARE

In this 2012 Report to Congress, the OMO details three comprehensive studies, described below, that resulted in specific recommendations to CMS for improving Medicare.

HEALTH SAVINGS ACCOUNTS AND IMPLICATIONS FOR MEDICARE ENROLLMENT

Health Savings Accounts (HSAs), established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, are accounts that individuals can use to pay for qualified medical expenses, such as insurance deductibles, copayments, or services not covered by insurance. To be eligible to contribute tax-free income to an HSA, an individual must be enrolled in a high-deductible health plan (HDHP) and not be enrolled in Medicare.

Individuals who become eligible for Medicare due to age and who receive health coverage under an HSA–HDHP because they are active workers or spouses of active workers may face complicated decisions. For example, if they do not qualify for the low-income subsidy and do not enroll in Part D prescription drug coverage when they first become eligible for Medicare but then later decide to enroll, they may incur a late enrollment penalty for as long as they are enrolled in the Medicare drug plan. The penalty would apply unless two requirements are met: (1) they had been covered under a plan offering "creditable prescription drug coverage"—coverage that is at least as good as the standard Part D coverage, and (2) they did not have a break in such coverage for 63 days or more. However, high deductible plans are at greater risk of not meeting the creditable coverage requirement.

The comprehensive study found that, although the legislation governing HSAs–HDHPs and their interaction with Medicare is generally clear, active workers do not fully understand the effect of that interaction on their enrollment decisions. The creditable coverage requirement is a source of particular confusion, as the main informational resources on HSAs available to beneficiaries do not address this topic. The comprehensive study identified several recommendations, summarized below, for improving the informational resources for active workers and for ensuring that active workers are made aware of the new resources:

- Develop a new HSA fact sheet with input from the Internal Revenue Service (IRS) and reference it in other information sources to aid beneficiaries in understanding the nuances of their enrollment decisions, including the creditable coverage requirement for Part D.
- Train customer service representatives (CSRs) at CMS, request that the IRS and the Social Security Administration train their CSRs to promote the new HSA fact sheet, and educate them on the importance of the creditable coverage requirement.
- Coordinate with the IRS to include Medicare-relevant information in the IRS's HSA-related publication (969) and Web page.
- Provide information on HSAs–HDHPs in resources about enrollment decisions to employers.

MEDICARE INFORMATION NEEDS OF THE EMPLOYER COMMUNITY

Employers are becoming an increasingly important information resource for individuals who are eligible for or already enrolled in Medicare. These Medicare-eligible employees and retirees may have questions on such topics as eligibility, coverage options, premium payments, and coordination of benefits. However, previous OMO studies suggested that Medicare-related resources available to employers may be difficult to locate or incomplete. Additionally, employers themselves may not be aware of their own responsibilities relating to business interactions with Medicare, such as reporting related to coordination of

benefits. The comprehensive study found that, although many informational sources are available to employers, no single site consolidates the relevant resources.

Another finding was that employers require more resources and information about four major areas: Medicare enrollment, coordination of benefits, employer-provided Medicare-related coverage (e.g., employer group waiver plans), and account-based health arrangements (e.g., HSAs). In addition, employers are less familiar with the considerations associated with people who become eligible for Medicare because they have disabilities or end-stage renal disease than they are with the considerations associated with aging into Medicare.

The following specific recommendations are included in the study:

- Develop an Employer Community Portal on the CMS or Medicare Web site.
- Develop new informational resources and augment current sources to fill information gaps.
- Use multiple methods for reaching out to employers and making them aware of these resources.

INFORMATION NEEDS FOR NEW MEDICARE-MEDICAID ENROLLEES

Individuals who are already enrolled in Medicare and then become eligible for Medicaid or vice versa often need assistance with understanding the eligibility requirements and services associated with each program. In 2012, the OMO and the Medicare-Medicaid Coordination Office worked collaboratively to study how to improve information that is made available to new Medicare-Medicaid enrollees.

The comprehensive study highlights the fact that the pathways that lead individuals to Medicare-Medicaid enrollment, the individuals' characteristics, and the level of state Medicaid involvement combine to create a complex situation for these enrollees. Because of this high level of complexity, several information strategies

and mechanisms that are customized to the specific characteristics of these beneficiaries are needed. The study provides recommendations for assisting enrollees, professionals who work with these enrollees, and program administrators.

For new Medicare-Medicaid enrollees:

- Create a series of brief, targeted informational "Welcome Kits" based on the beneficiary's eligibility category and benefits.
- Create "one-pagers" focused on specific topics relevant to Medicare-Medicaid enrollees.
- Develop a Web page within Medicare.gov devoted to these enrollees.

For professionals who assist these enrollees:

- Develop a query process that health professionals and providers can use to obtain information on whether a Medicare beneficiary is also eligible for Medicaid.
- Develop informational resources, such as fact sheets, to educate them about the interaction of Medicare and Medicaid benefits/coverage.
- Develop technical assistance presentations that can be used by professionals in group settings with Medicare-Medicaid enrollees.

For program administrators:

- Assess the feasibility of developing Medicare Summary Notices tailored to the information needs of Medicare-Medicaid enrollees who are eligible to have their Medicare cost-sharing liability covered by Medicaid.
- Provide timely initiation of Medicaid buy-in for Medicare Part B premiums and assess the feasibility of giving advance notice to Medicaid agencies regarding current disabled Medicaid beneficiaries receiving Supplemental Security Income and Social Security Disability Insurance who are near the end of their 24-month waiting period for Medicare eligibility.

Seventy-six million baby boomers are poised to change the way older Americans live, much in the same way that they redefined societal norms as they came of age in the late 1960s and 1970s.

Changing Characteristics of the Elderly and Medicare: Implications for the OMO's Mission

SECTION HIGHLIGHTS

- The Medicare beneficiary population is expected to grow rapidly in the next 20 years as the baby boomer generation ages.

- Compared to previous generations of new enrollees, today's new Medicare beneficiaries are more likely to enroll in Medicare while also receiving primary health care benefits through an employer or other private or public sources.

- Enhancing communication with individuals approaching Medicare eligibility will help smooth beneficiaries' transitions into Medicare and between Medicare and other programs.

INTRODUCTION

The Medicare population increased by nearly two million enrollees between 2011 and 2012, and is expected to continue to grow rapidly in the next 2 decades, primarily because of the aging baby boomer generation.[1] Seventy-six million baby boomers are poised to change the way older Americans live, much in the same way that they redefined societal norms as they came of age in the late 1960s and 1970s.[2]

Compared to their parents and grandparents, baby boomers are more highly educated, likely to have dual-income households, and lead active lifestyles.[3] However, they are also less healthy than their parents. In a recent study using data from a national health survey, researchers compared health status indicators of baby boomers to those of the previous generation at the same age and found that baby boomers have higher rates of hypertension, hypercholesterolemia, diabetes, and obesity than the previous generation.[4]

Boomers started enrolling in Medicare in 2011, when the oldest of the generation turned 65. By 2040, nearly 80 million boomers will qualify for Medicare, compared to today's total enrollment of 50.7 million.[5] Figure 2 illustrates the increase in Medicare enrollees.

Along with the expected increase in Medicare enrollment attributable to the baby boomers, economic conditions and social factors will continue to affect Medicare enrollment in the coming years. Many adults are continuing to work beyond age 65 for a variety of reasons. Some of them lost a portion of their retirement savings during the stock market declines of the past decade and are working longer to stabilize their financial futures. Others may have had children later in life and are still supporting them. Some may be working longer due to the increase in the Social Security eligibility age, while others may choose to work longer because they enjoy doing so. Whatever the reason, older working Americans may choose to continue receiving some employer-based health insurance benefits while enrolled in Medicare, a choice that requires beneficiaries to consider the available options carefully to ensure that they maximize their benefits and avoid penalties.

Medicare enrollment may also be affected by an increasing number of enrollees who become eligible for both Medicare *and* Medicaid. As Medicaid enrollees enter Medicare or as Medicare beneficiaries enter Medicaid, they will need to navigate two complex programs and understand their differing benefits. With limited financial resources and often with significant health issues, these enrollees may struggle to navigate the complexities of being new Medicare-Medicaid enrollees.

In 2012, the Office of the Medicare Ombudsman (OMO) undertook three comprehensive studies focused on the issues and needs of Medicare beneficiaries, with a particular focus on transition periods related to becoming eligible for Medicare and interactions of Medicare with other types of coverage.

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[1] Baby boomers are defined as those who were born between 1946 and 1964. Dohm, A. (2000, July). Gauging the Labor Force Effects of Retiring Baby-Boomers. *Monthly Labor Review*: 17–24.

[2] Greenblatt, A. (2007, October 17). Aging Baby Boomers: Will the "Youth Generation" Redefine Old Age? *CQ Researcher, 17*: 865–888.
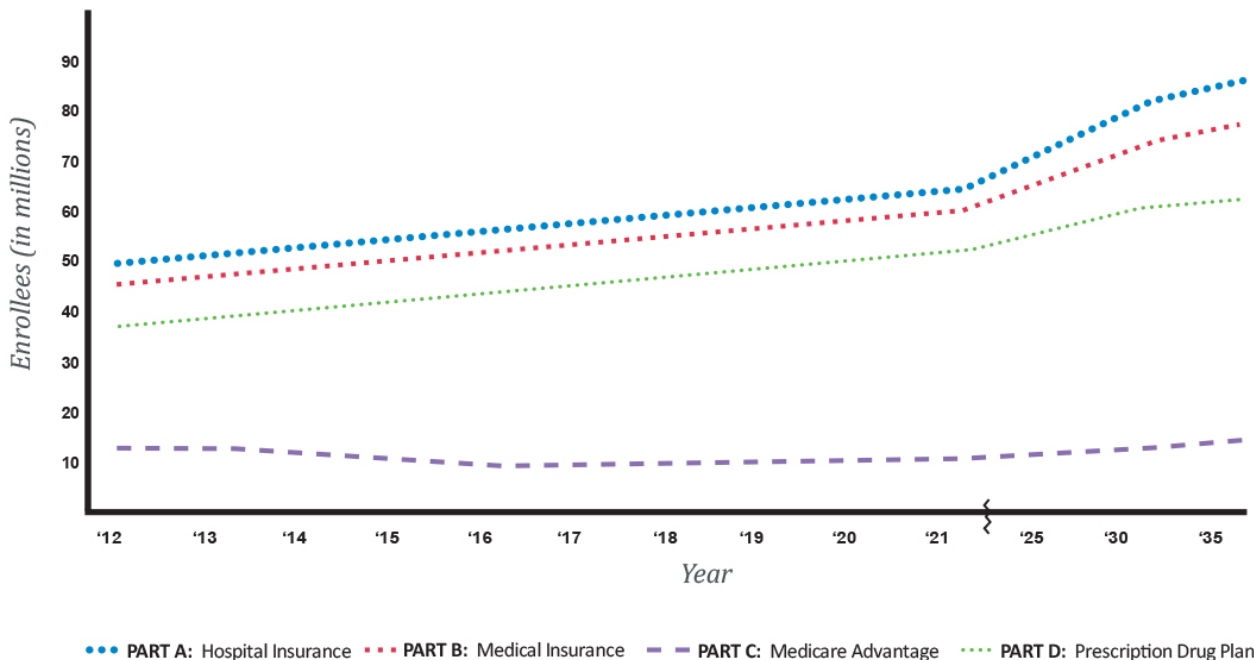
[3] Ibid.

[4] King, D.E., Matheson, E., Chirina, S., Shankar, A., and Broman-Fulks, J. (2013). The Status of Baby Boomers' Health in the United States: The Healthiest Generation? *JAMA Intern Med: 173*(5):385–386.

[5] U.S. Department of Health and Human Services' Centers for Medicare & Medicaid Services Office of Information Products and Data Analysis. (2012, June). CMS Pub. No. 03504.

FIGURE 2. CURRENT AND PROJECTED NUMBER OF MEDICARE ENROLLEES, BY PART

••• **PART A:** Hospital Insurance ••• **PART B:** Medical Insurance — — **PART C:** Medicare Advantage ····· **PART D:** Prescription Drug Plan

SOURCE: *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Centers for Medicare & Medicaid Services
NOTE: Beneficiaries in Part C are also generally considered to be in Part A and Part B.

Summarized later in this section and described in more detail in the Issues and Recommendations Regarding Beneficiary Concerns section of this report, these studies include a focus on the decisions that older working Americans face as they enroll in Medicare and the information needs of individuals enrolled in both Medicare and Medicaid, providing specific recommendations to smooth these transitions.

To provide a context for the OMO's work, this section describes the Medicare coverage options available to beneficiaries today. Following the coverage descriptions is a depiction of the changing demographic profile of the Medicare beneficiary population, a summary of the findings of the three comprehensive studies, and a discussion of the implications of that changing profile for Medicare.

MEDICARE COVERAGE OPTIONS

As the nation's largest, fully funded health benefits program serving approximately 50.7 million beneficiaries, Medicare plays a vital role in providing health care services not only to individuals who are 65 years and older but also to individuals who are under age 65 and have disabilities or end-stage renal disease.

Medicare offers multiple coverage options to meet the varied needs of its beneficiaries. Most people ages 65 or older are eligible for Part A for hospital insurance and may choose to enroll in Part B for medical insurance or Part C (Medicare Advantage [MA] Plans) for both hospital and medical insurance. Since 2006, beneficiaries have also had the option of receiving prescription drug coverage through Part D, either

through a private Prescription Drug Plan or through an MA Plan that includes prescription drug coverage. Parts C and D coverage are provided through private insurance companies that contract with Medicare.

Currently, the bulk of Medicare beneficiaries are enrolled in traditional Medicare (Parts A and B), while Part C (MA Plans) accounts for about 26 percent of the Medicare population, or 13.5 million beneficiaries.[6] Enrollment in Part C has increased substantially in recent years but is expected to decline after 2013, both in number and as a percentage of total beneficiaries.[7] If the availability of Part C plans becomes more limited in 2014, beneficiaries currently enrolled in a Part C plan may have to switch to a different Part C plan or to traditional Medicare. The OMO will monitor these changes and the inquiries that might result from them to help beneficiaries through this transition.

THE CHANGING CHARACTERISTICS OF THE ELDERLY

The 2010 Census showed that the number of seniors—people ages 65 and older—has grown not only in size but also as a share of the total U.S. population. In 2010, older Americans represented 13 percent of the U.S. population, compared to 12.4 percent in 2000.[8] By 2050, the number of older Americans is projected to be double that of 2010, increasing to 88.5 million and representing 20.2 percent of the U.S. population.[9]

Increasingly, older Americans are staying in the workforce longer. For those 65 and older, the labor force participation rate is projected to almost double, from 11.8 percent in 1990 to 22.6 by 2020, as shown in figure 3.[10] Many socioeconomic factors, described above, are driving older Americans' decisions to continue working beyond the traditional retirement age.

> *Increasingly, older Americans are staying in the workforce longer.*

EMPLOYER-BASED HEALTH BENEFITS

Older Americans who are still working must decide whether to continue receiving coverage through their employers, to enroll in Medicare, or to use some combination of private health care and Medicare to meet their needs. Health Savings Accounts (HSAs) have become a particularly popular component of private health insurance policies. To be eligible to contribute tax-free income to an HSA, an individual must be enrolled in a high-deductible health plan (HDHP) and not be enrolled in Medicare. In January 2012, enrollment in HSAs increased to 13.5 million, the highest level since HSAs were introduced in 2004.[11]

The OMO completed two comprehensive studies in 2012 that address the complexities of the different coverage options available to older working Americans and retirees and provide recommendations for helping new beneficiaries make sound decisions.

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[6] 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. (2012, April). Retrieved October 10, 2012, from https://www.cms.gov/ReportsTrustFunds/downloads/tr2012.pdf.

[7] Ibid.

[8] The Older Population: 2010. 2010 Census Briefs. (2011, November). U.S. Census Bureau. Retrieved October 10, 2012, from http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf.

[9] Vincent, G. K. and Velkoff, V. A. (2010). *THE NEXT FOUR DECADES, the Older Population in the United States: 2010 to 2050*. Current Population Reports, P25-1138, U.S. Census Bureau, Washington, DC. Retrieved October 12, 2012, from http://www.census.gov/prod/2010pubs/p25-1138.pdf.

[10] Employment projections for civilian labor force. Bureau of Labor Statistics. Retrieved October 12, 2012, from http://www.bls.gov/emp/home.htm#labtables.

[11] January 2012 Census Shows 13.5 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs). (2012, May). America's Health Insurance Plans, Center for Policy and Research. Retrieved October 12, 2012, from http://www.ahip.org/AHIPResearch/.

FIGURE 3. LABOR FORCE PARTICIPATION, BY AGE GROUP

● ● ● **AGE:** 16-54   ▪ ▪ ▪ **AGE:** 55-64   ∙ ∙ ∙ ∙ **AGE:** 65-74   ▬ ▬ **AGE:** 75 and older
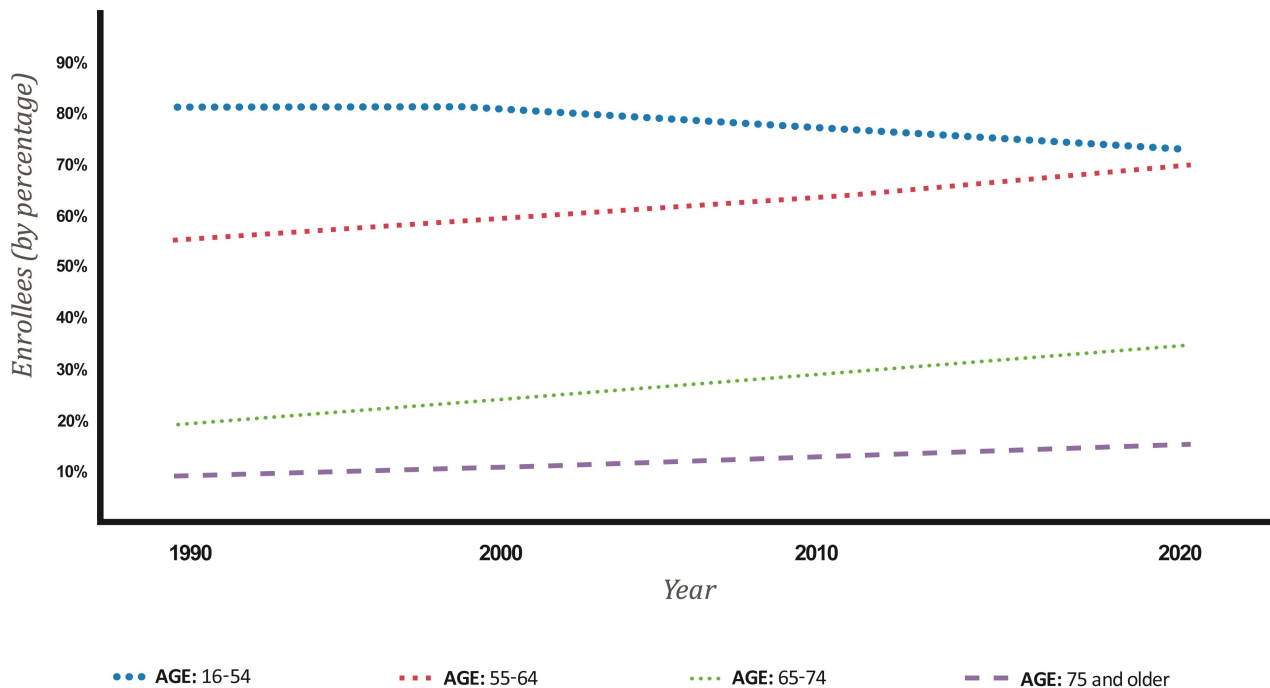
SOURCE: *Employment Projections Program*, U.S. Department of Labor, U.S. Bureau of Labor Statistics

The topic of the first study is the relationship between HSAs and the decision to enroll in Medicare. For individuals who are active workers or spouses of active workers, the decision to enroll in Medicare or receive health coverage under an HSA–HDHP is more complicated than decisions related to traditional employer-based insurance coverage.

Enrollees must consider many factors, such as the effect on tax burdens, creditable coverage requirements, and late enrollment penalties, because a person cannot be enrolled in Medicare while continuing to contribute to an HSA. The OMO examined the effect of HSAs on Medicare enrollment decisions for Part A, Part B, and Part D coverage and developed recommendations for educating newly eligible beneficiaries about the implications of their decisions.

In the second study, the OMO investigated ways in which employers can assist their active employees and retirees in determining how and when to enroll in Medicare. The study assessed Medicare-related resources that are currently available to employers and the informational needs of the employer community. It provides recommendations for how CMS can ensure that employers are aware of current and forthcoming resources available to them, their employees, and their retirees.

MEDICARE-MEDICAID ENROLLEES

Representing 19.7 percent of all Medicare beneficiaries, about 10.2 million individuals receive benefits from both Medicare and Medicaid.[12] Given their health

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[12] Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011 (2013, February). CMS Medicare-Medicaid

challenges and the complexities of navigating two entitlement programs that are not integrated, Medicare-Medicaid enrollees face unique challenges in accessing the health care they need.

Their health issues are often severe and complex, as they may have multiple chronic conditions accompanied by physical/cognitive disabilities and/or mental health issues. These individuals often become eligible for both programs after having endured significant health-related episodes or changes in their functional or cognitive status, which resulted in their needing long-term-care supports and services. Medicare-Medicaid enrollees are more likely to have a Medicare-qualifying disability: about 41.3 percent of Medicare-Medicaid enrollees have a disability, while about 12 percent of Medicare-only beneficiaries have a disability.[13] Although many are 65 or older, approximately 39 percent of Medicare-Medicaid beneficiaries are under age 65 and disabled, which is three times the rate among all other Medicare beneficiaries.[14]

Navigating informational resources and understanding the options offered by Medicare (a federally administered program) and Medicaid (a federal-state program) may come with a host of challenges, particularly for individuals with limited cognitive and physical functioning. The CMS Medicare-Medicaid Coordination Office (MMCO), created by the Affordable Care Act, exists to ensure that Medicare-Medicaid enrollees have full access to seamless, high-quality health care and to make the system as cost-effective as possible. The MMCO works with Medicaid and Medicare across federal agencies, states, and stakeholders to align and coordinate benefits between the two programs effectively and efficiently.

The OMO collaborated with MMCO on a comprehensive study to identify key changes and challenges experienced by individuals newly enrolled in both programs, to assess resources available to them, and to recommend improvements regarding informational resources that can assist individuals as they transition to enrollment in both programs. The improvements recommended in the study focus on informational resources for enrollees, their families, and program professionals who interact with beneficiaries. The study also recommends that program administrators assess the feasibility of developing processes that would draw on information from CMS systems regarding Medicare and Medicaid enrollment.

IMPLICATIONS FOR MEDICARE AND THE MISSION OF THE OMO

The large influx of enrollees into Medicare over the next 2 decades will likely affect CMS and the various other entities that assist in administering Medicare in two major ways. First, the large number of new beneficiaries will likely result in a higher volume of inquiries to the Medicare call center and to the many other entities that interact directly with beneficiaries.

Coordination Office. Retrieved March 21, 2013, from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf.

[13] Ibid.

[14] Jacobson, G., Neuman, T., and Damico, A. (2012). Issue Brief: Medicare's Role for Dual Eligible Beneficiaries (Report No. 8138-02).

Kaiser Family Foundation. Retrieved December 12, 2012, from http://www.kff.org/medicare/upload/8138-02.pdf.

These entities will need to be adequately staffed with well-trained representatives to handle the larger number of inquiries made by more informed beneficiaries.

Second, new enrollees are likely to be in the workforce and, as a result, will have other (private and public) sources of health care that they will continue to access even after enrolling in Medicare. Program professionals who interact directly with beneficiaries will need to be equipped with the knowledge and informational resources necessary to educate beneficiaries about the benefits to which they are entitled. Having highly trained program professionals and appropriate educational materials will help enrollees receive

seamless, high-quality care and avoid penalties for not having enrolled in Medicare at the right time.

As the Affordable Care Act is fully implemented, changes to existing care delivery options and the full implementation of new models of care delivery may create a need for new or improved educational materials for both beneficiaries and the professionals who interact with them. For example, the Medicare health and drug plans offered may change each year. This may result in questions and concerns from beneficiaries regarding enrollment options. Similarly, the growing number of Accountable Care Organizations—groups of health care providers who provide coordinated care to patients to improve quality of care—may raise questions for beneficiaries unfamiliar with this health care delivery option.

> The OMO carries out its mission by providing direct assistance to beneficiaries with their inquiries, grievances, and complaints.

How the OMO Manages Beneficiary Issues and Complaints

SECTION HIGHLIGHTS

The Office of the Medicare Ombudsman (OMO) participates in several core activities to manage and respond to beneficiary inquiries and complaints as well as to proactively identify beneficiary issues and solutions. In 2012, the OMO:

- Released three comprehensive studies on the following topics: the relationship between Health Savings Accounts and the Medicare enrollment decision, employers' Medicare-related information needs, and the informational needs of beneficiaries newly eligible for both Medicare and Medicaid.

- Began tracking all recommendations it made to the Centers for Medicare & Medicaid Services over its tenure and guiding agency components in implementing those recommendations determined to be feasible.

- Gained efficiencies in its core functions, which has allowed for an expansion of activities, such as recommendations implementation tracking.

- Strengthened its partnership with the Office of Medicare Hearings and Appeals to help identify emerging systemic issues facing Medicare.

INTRODUCTION

The Office of the Medicare Ombudsman (OMO) carries out its mission in part by providing direct assistance to beneficiaries with their inquiries, grievances, and complaints. Through collaboration with other Centers for Medicare & Medicaid Services (CMS) components, advocacy groups, and subject-matter experts, the OMO is able to identify and address systemic issues that affect Medicare beneficiaries. To enhance its ability to carry out its mission, the OMO has established a set of core activities, described in figure 4.

The OMO will build on these efforts during 2013, as it continually looks for ways to improve the overall beneficiary experience with Medicare. The following subsections provide a more detailed overview and specific examples of how the OMO assisted beneficiaries and their caregivers in 2012. Updates are also provided on the work of the Office of the Competitive Acquisition Ombudsman, which is located within the OMO.
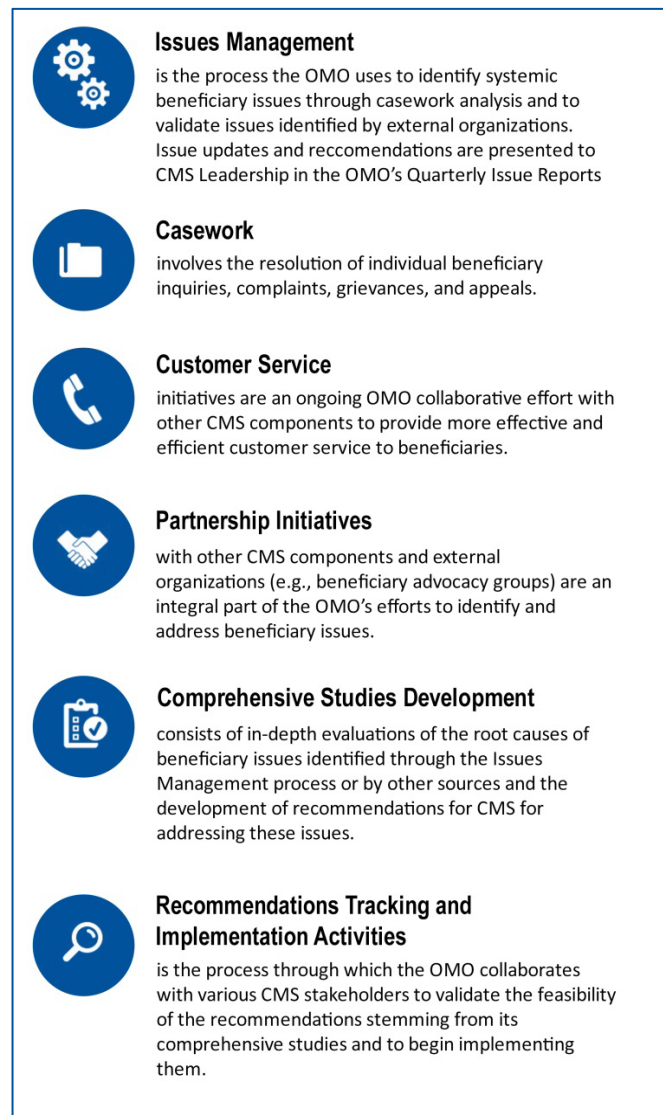
ISSUES MANAGEMENT

The OMO uses its Issues Management process to evaluate and address beneficiary issues that have been raised by its external partners or internally through the examination of inquiries and complaint (casework) trends. The process involves:

- Performing issues validation and tracking.
- Compiling research on beneficiary issues.
- Facilitating internal Issues Management meetings.
- Developing Quarterly Issues Reports.
- Issuing Beneficiary Contact Trend Reports, which summarize beneficiary inquiries, complaints, and appeals data from several CMS sources (see Appendix A).

To identify beneficiary issues, the OMO employs qualitative methods, such as investigating issues raised by beneficiary advocates, as well as quantitative methods, such as CMS data system analysis. For example, the OMO conducts environmental scans of news publications, advocacy groups, and Medicare-related blogs and Web sites. The OMO also analyzes data from CMS inquiry and complaint tracking systems to identify trends that might indicate systemic problems across the different parts of Medicare. Monthly Issues Management meetings give OMO leadership and analysts the opportunity to discuss newly identified concerns and to develop effective strategies for addressing them. For each issue, the lead analyst performs a root-cause analysis and, when necessary, solicits feedback from CMS subject-matter experts.

FIGURE 4. CORE ACTIVITY SUMMARY

Issues Management
is the process the OMO uses to identify systemic beneficiary issues through casework analysis and to validate issues identified by external organizations. Issue updates and reccomendations are presented to CMS Leadership in the OMO's Quarterly Issue Reports

Casework
involves the resolution of individual beneficiary inquiries, complaints, grievances, and appeals.

Customer Service
initiatives are an ongoing OMO collaborative effort with other CMS components to provide more effective and efficient customer service to beneficiaries.

Partnership Initiatives
with other CMS components and external organizations (e.g., beneficiary advocacy groups) are an integral part of the OMO's efforts to identify and address beneficiary issues.

Comprehensive Studies Development
consists of in-depth evaluations of the root causes of beneficiary issues identified through the Issues Management process or by other sources and the development of recommendations for CMS for addressing these issues.

Recommendations Tracking and Implementation Activities
is the process through which the OMO collaborates with various CMS stakeholders to validate the feasibility of the recommendations stemming from its comprehensive studies and to begin implementing them.

ESTABLISHING THE OFFICE OF THE MEDICARE OMBUDSMAN

Section 1808(c) of the Social Security Act, which was added by section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires the Secretary of the U.S. Department of Health & Human Services (HHS) to appoint a Medicare Beneficiary Ombudsman. In establishing the position and primary functions of the Medicare Beneficiary Ombudsman, Congress recognized the need for an entity that would serve as a resource for Medicare beneficiaries. In March 2005, the Centers for Medicare & Medicaid Services appointed Daniel J. Schreiner as the first Medicare Beneficiary Ombudsman, giving him the responsibility of establishing the Office of the Medicare Ombudsman (OMO) and fulfilling the provisions of section 1808(c).

Section 1808(c) requires the OMO to assist Medicare beneficiaries with their complaints, grievances, and requests for information as well as with problems arising from disenrollment from Medicare Advantage (MA) Plans. The OMO is required to provide assistance with the collection of relevant information for appealing decisions made by a fiscal intermediary, carriers, MA Plans, and the HHS Secretary; its assistance is also necessary for presenting information to beneficiaries concerning income-related premium adjustments. Although the MMA allows the OMO to identify issues and problems related to payment or coverage policies, the law prohibits the OMO from serving as an advocate for any increase in payments or new coverage of services.

The OMO must also work with health insurance counseling programs (e.g., State Health Insurance Assistance Programs), to the extent possible, to help provide information to beneficiaries regarding traditional Medicare (i.e., Parts A and B) and any changes to MA Plans. Lastly, the MMA requires the OMO to submit annual reports to Congress and to the HHS Secretary that describe its activities and provide recommendations for improving the administration of Medicare.

As the resolution process continues, implementation steps (e.g., developing new educational materials or revising the search function on Medicare.gov) are identified and reported during Issues Management meetings.

The issues that enter the Issues Management process are centrally tracked and documented, enabling a comprehensive view of the entire effort for each issue. The information is used to develop Quarterly Issues Reports, internal CMS documents that highlight data and trends, and provide a synopsis of the issues and of the OMO's actions and recommendations to CMS for each issue. The reports are presented to CMS Leadership, including the Office of the Administrator, and other stakeholders.
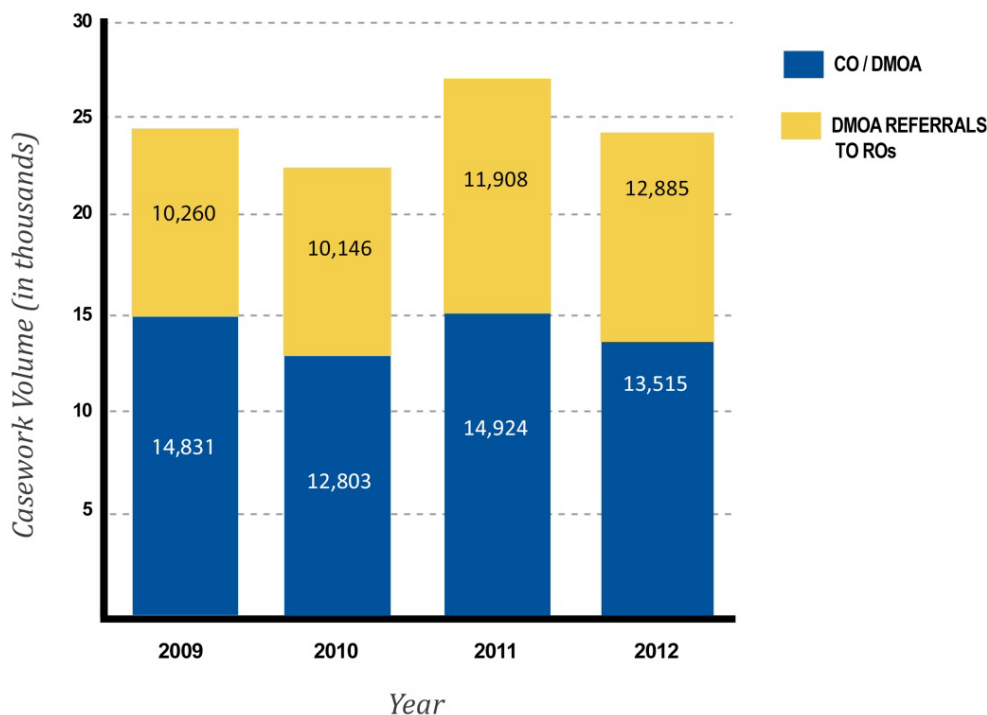
CASEWORK

Some beneficiaries need help both obtaining and understanding information about the benefits and services to which they are entitled. OMO caseworkers provide direct assistance to beneficiaries on an individual basis by triaging and responding to inquiries and complaints in writing, via e-mail, and over the phone. The OMO's Division of Medicare Ombudsman Assistance (DMOA) and Division of Ombudsman Exceptions (DOE) share responsibility for handling a large portion of inquiries and complaints received through the CMS Central Office (CO). In fiscal year (FY) 2012, 99.5 percent of the inquiries sent to OMO staff were handled in fewer than 30 days (the OMO's response time requirement), with an average response time of 11 days.

DMOA CASEWORK

DMOA received 26,400 inquiries in FY 2012, a decline of two percent from FY 2011. Casework staff directly responded to 13,515 inquiries from October 2011 through September 2012, a decline of 11 percent from FY 2011. The remaining 12,885 cases were referred to the Regional Offices (ROs). Figure 5 illustrates the volume of casework completed by DMOA and the number of cases referred to the ROs.

FIGURE 5. DMOA/RO CASEWORK VOLUME, FY 2009–2012

SOURCE: *OMO Casework Reports*

Figure 6 compares the top reasons for beneficiary contacts to DMOA in 2011 and 2012. In 2012, the top 10 reasons remained largely the same as in 2011. The highest number of contacts continued to be related to premiums, but several categories experienced declines in the number of contacts. Contacts related to coordination of benefits experienced the largest decrease, with 42 percent fewer inquiries in 2012 than 2011.

Contacts related to the low-income subsidy program decreased by 15 percent. These decreases could be partially due to improvements in beneficiary information, outreach, and education. In an effort to make information clearer and more readily available, CMS has made such improvements as adding clarifications to the Medicare handbook, *Medicare and You,* and launching a streamlined Web site.

DOE CASEWORK

DOE works primarily with beneficiary data systems to maintain the integrity of Medicare Parts A and B enrollment and premium payment data. DOE also manages and enables the resolution of data discrepancies related to:

- Medicare enrollment
- Direct premium billing[15]
- Third-party premium billing[16]
- MA and Part D data and transaction exceptions

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[15] Direct premium billing issues arise for beneficiaries who pay their Part A and/or their Part B premiums directly rather than through a Social Security check withholding.

[16] Third parties include states, private entities, local governments, and the Office of Personnel Management.

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FIGURE 6. COMPARISON OF FY 2011 AND FY 2012 BENEFICIARY CONTACTS TO DMOA

Reason for contact	Contacts, FY 2011	Contacts, FY 2012	Percent change from FY 2011 to FY 2012
Premiums	13,622	13,457	↓ -1%
Medicare eligibility/enrollment	1,880	1,706	↓ -9%
Medicare coverage	1,131	1,302	↑ 15%
Coordination of benefits	1,502	877	↓ -42%
Inquiries not Medicare/Medicaid specific	605	772	↑ 28%
Medicare Advantage	797	745	↓ -7%
Claims inquiries/complaints	530	502	↓ -5%
Low-income subsidy	586	496	↓ -15%
Disenrollment/enrollment/withdrawal	300	357	↑ 19%
Health insurance replacement cards	345	324	↓ -6%
Other	5,534	5,865	↑ 6%
Total	26,832	26,400	↓ -2%

Additionally, DOE tracks trends in beneficiary data systems and casework through weekly and monthly reporting of key issues. Of all the cases that DOE handled directly in 2012, it closed 33,292 direct-billing cases (96 percent of the direct billing caseload) and 35,477 third-party cases (99 percent of the third-party billing caseload).

CUSTOMER SERVICE FEEDBACK SURVEY

In 2012, the OMO conducted its third biennial Medicare Ombudsman Customer Service Feedback Survey to assess whether the OMO is meeting the needs of beneficiaries and advocates. The survey was sent to individuals who contacted the OMO for assistance. It contained four closed questions and one open-ended question that allowed the beneficiaries/representatives to make comments or suggest ways to improve service. The survey questions sought beneficiary perspectives on the timeliness, quality, clarity of responses, and beneficiaries' overall satisfaction with the assistance

they received. The rating scale ranged from one (strongly dissatisfied) to five (strongly satisfied).

Also in 2012, the OMO mailed 2,242 surveys written in both English and Spanish to beneficiaries. More than 40 percent of the surveys were sent to beneficiaries with premium-related issues. More than 1,340 responses were received, a response rate of 60 percent. The overall satisfaction rating recorded by the 2012 survey was 4.5 out of a possible 5.0 points, an increase of 0.5 points from 2009. The two highest-rated measures were clarity and quality, which each had an overall average score of 4.6. The lowest-rated measure was timeliness, which had an overall average score of 4.0.

Findings from the 2012 Customer Service Feedback Survey have assisted the OMO in identifying areas that could be improved to meet the service and information needs of beneficiaries better. To improve overall responsiveness for complex cases, the OMO is contacting beneficiaries, through an interim response letter or phone call, whose inquiries will require more

than 20 business days to resolve. This interim response will confirm that a beneficiary's inquiry was received and that the OMO is in the process of resolving the issue.

Furthermore, to reduce response times, analysts are sending beneficiaries e-mail responses (when applicable) and following up with a hard copy of the responses for future reference. In addition, the survey indicated that premiums continue to cause confusion for beneficiaries. The OMO is working to alleviate beneficiary confusion through a redesign of the Part B and Part D direct premium bills.

SERVICE

The OMO engages in and supports activities to improve customer service. In particular, the OMO promotes efforts to address beneficiary issues in a consistent manner through National Casework Calls, facilitation of caseworker training, standard language letters, and foreign language correspondence.

NATIONAL CASEWORK CALLS AND TRAINING PROGRAMS

The OMO facilitates National Casework Calls that include staff from the CMS CO and its ROs. These calls communicate changes in policies, regulations, or other important programs that may affect beneficiaries and their caregivers. The OMO also uses these calls to conduct training sessions to improve the quality of customer service in inquiry and complaint management.

In January 2012, the OMO conducted a national needs assessment survey administered to RO and CO caseworkers. The results of the survey were used to design a training plan related to topics identified by the caseworkers. Trainees also included representatives from other CMS components, including the Office of Public Engagement, the Center for Medicare (CM), and the Office of Financial Management (OFM).

The OMO conducted 10 training sessions in FY 2012 via National Casework Calls, classroom sessions, and webinars. CO and RO caseworkers participated in the training sessions to gain the knowledge and skills necessary to resolve beneficiary inquiries efficiently and effectively. The topics of these calls included the following:

- **Reinstatement for good cause following non-payment of income-related monthly adjustment amount for Part D (IRMAA-D).** As mandated by the Affordable Care Act, Part D enrollees with higher incomes are required to pay an additional IRMAA to help fund the Medicare Part D Trust Fund. If beneficiaries paying via direct bill do not pay their IRMAA-D on time, they will be disenrolled from their Part D plan and could incur reenrollment penalties. CMS provides an opportunity for individuals to be reinstated into their Medicare Part D plan in good cause situations. The OMO developed a casework protocol to train staff from the Kansas City RO to use the Direct Bill System to correct IRMAA-D beneficiary records meeting good cause requirements. The resulting casework-protocol training document was also used to conduct a CMS-wide training session for IRMAA-D and the Direct Bill System during the Part C/D National Casework Call.

- **Medicare direct billing and premium collection.** The OMO developed a training module for national-state buy-in premium billing and a complete direct-bill-premium-

> *To reduce response times, analysts are sending beneficiaries e-mail responses (when applicable) and following up with a hard copy of the response for future reference.*

training package in collaboration with OFM. State buy-in programs assist low-income beneficiaries by allowing Medicaid to pay for Medicare premiums.

- **Third-party payer program/state buy-in.** For this training, a webinar was used, which allowed 187 people to participate, including staff from the ROs/CO, state Medicaid agencies, and the Railroad Retirement Board. "Third-party payer" refers to companies that bill Medicare on behalf of Medicare providers and suppliers.

Other call topics included coordination of benefits, the Consolidated Omnibus Budget Reconciliation Act, Medigap, Medicare fraud, and coverage determinations. Post-session evaluations showed that the webinar training format was well received, the training sessions increased CO and RO caseworkers' knowledge, and the training provided a venue for meeting agency subject-matter experts.

STANDARD LANGUAGE LETTERS

To help ensure that CMS caseworkers consistently and accurately answer beneficiary inquiries about various Medicare topics, the OMO has developed standard language letters. These letters use plain language principles and recommendations from the Medicare Tone of Voice Workgroup to ensure uniformity and the appropriate delivery of information.

In FY 2012, the OMO developed 34 new standard-language letters as changes in program information occurred, bringing the total number of standard language letters to 543. For example, a new letter was developed to respond to approximately 500 beneficiary requests for a variety of information about the $250 rebate checks mailed in 2010 and reissued in 2011 to beneficiaries who should have received the rebate but did not.

FOREIGN LANGUAGE CORRESPONDENCE

Along with providing consistent responses to beneficiary inquiries via standard language letters, the OMO also needs to ensure that it can respond to inquiries in a variety of languages. In FY 2012, the OMO handled 1,052 foreign language inquiries.

Correspondence in Spanish accounted for the greatest number of foreign language inquiries, with additional inquiries in Albanian, Chinese, French, Greek, Japanese, Russian, German, Hmong, Italian, and Vietnamese.

PARTNERSHIP INITIATIVES

A large part of the OMO's mission is to identify beneficiary issues that are systemic and to recommend potential solutions to those problems. To aid in this effort, the OMO strengthened its relationships not just within the agency but with advocacy groups and other stakeholders.

INTERNAL PARTNERSHIPS

Throughout the past several years, the OMO has focused on capacity building and collaboration with other components and offices within CMS. When necessary, the OMO facilitates efforts involving the competing interests of several CMS internal groups that are responsible for the business operations of the agency. Figure 7 provides some examples of internal collaboration efforts in FY 2012.

INTRA-AGENCY PARTNERSHIPS

In 2012, OMO staff continued collaborating with the Social Security Administration (SSA), the Railroad Retirement Board, the Office of Personnel Management,

the Administration for Community Living/Administration on Aging, the Small Business Administration, the U.S. Department of the Treasury, and the states.

The OMO continues to be involved in several cross-agency workgroups, such as the Enrollment Database and SSA/CMS Change Control Boards and the Systems Management Board, which manage all the major beneficiary systems. These workgroups develop best practices to provide accurate and timely responses to beneficiary inquiries and system problems in collaboration with CMS system/business owners.

In accordance with Section 923 of the Medicare Modernization Act, the OMO also works closely with

FIGURE 7. OMO'S INTERNAL CMS STRATEGIC RELATIONSHIPS

Partner	Strategic Relationship
Office of the Administrator (OA)	The Office of the Medicare Ombudsman (OMO) elevates systemic issues to OA and obtains OA's support in addressing these issues.
Regional Offices (ROs)	The OMO collaborates with ROs to identify and facilitate the resolution of systemic issues related to CMS processes and to develop standard casework procedures. The OMO also provides training to RO staff through national casework calls and training programs.
Center for Medicare (CM)	CM provides valuable insight into issues related to health plan operations, policies, and communications. CM collaborates with the OMO to assess and address issues regarding traditional Medicare (Parts A and B).
Office of Communications (OC)	The OMO collaborates with OC to facilitate updates to existing CMS publications and the development of new publications, as needed.
Office of Information Services (OIS)	The OMO engages with OIS components to identify changes to CMS data systems that may affect Medicare beneficiaries.
Office of Financial Management (OFM)	The OMO works with OFM to address payment, data, and policy issues, including Medicare secondary-payer and third-party liability policies and practices and coordination of benefits issues.
Center for Consumer Information and Insurance Oversight (CCIIO)	The OMO served on the CCIIO Exchange Complaints Process Workgroup in support of the implementation of the Affordable Care Act. The workgroup is establishing a process to handle the complaints and complex inquiries that are expected once the new provisions of the Affordable Care Act go into effect in 2013.
Medicare-Medicaid Coordination Office (MMCO)	The OMO collaborates with MMCO on issues affecting Medicare-Medicaid enrollees. In 2012, the OMO and MMCO collaborated on the Information Needs of New Medicare-Medicaid Enrollee comprehensive study.
Office of Medicare Hearings and Appeals (OMHA)	The OMO and OMHA work together to identify issues encountered by administrative law judges that the OMO can assist with by providing education and outreach materials.
Center for Medicare and Medicaid Innovation (CMS Innovation Center)	The OMO works with the CMS Innovation Center to identify the potential beneficiary implications of new initiatives, such as the Medicare-Medicaid Financial Alignment Demonstration and Pioneer Accountable Care Organizations.

State Health Insurance Assistance Programs (SHIPs), federally funded state programs that provide free health insurance counseling to beneficiaries by telephone and through face-to-face sessions. Specifically, the OMO collaborates with SHIPs to identify issues that affect Medicare beneficiaries. At the same time, the OMO seeks to understand the challenges SHIPs face when providing support to beneficiaries and their caregivers. As in previous years, the OMO attended the annual national SHIP Directors' Conference in 2012 and presented information about several topics, including the following:

- How the OMO provides information and assistance to Medicare beneficiaries.
- How CMS provides support and technical assistance to SHIPs.
- Current OMO initiatives, such as comprehensive studies.
- Plans and training for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Round Two Competitive Bidding.

ADVOCACY PARTNERS

In addition to working directly with thousands of Medicare beneficiaries each year, the OMO also works in partnership with advocacy organizations that help identify a variety of other important issues affecting Medicare enrollees. The OMO communicates with these external partners via Medicare Ombudsman partner and beneficiary advocate meetings and national conferences.

Medicare Ombudsman Partner and Beneficiary Advocate Meetings

The purpose of the Medicare Ombudsman partner and beneficiary advocate meetings is twofold: they serve as a forum for informing organizations about the OMO's efforts to address systemic beneficiary issues, and they allow the OMO to learn about the beneficiary concerns these organizations' constituents have about Medicare.

The OMO typically uses the first part of these meetings to discuss updates on issues raised during the previous meeting as well as the status of its comprehensive studies. The latter half of the meetings is reserved for the advocacy groups to raise new issues they have observed in their work with beneficiaries.

In 2012, the OMO held two partner and beneficiary advocate meetings, which were attended by representatives from the National Council on Aging, the Alzheimer's Association, Families USA, the Legal Aid Society of the District of Columbia, the Medicare Rights Center, Medicare Access for Patients Rx, Administration for Community Living/Administration on Aging, and various SHIP representatives. Key issues included concerns about the Medicare-Medicaid Financial Alignment Demonstration,[17] the 1-800-MEDICARE referral process, health risk assessments administered during the Annual Wellness Visit, balance billing outreach, and specialty drug tiers.

As appropriate, the OMO investigates the issues raised during these meetings, shares them at Issues Management meetings, and presents concerns to CMS leaders for evaluation and possible resolution. For example, the proposed Financial Alignment Demonstration has raised beneficiary concerns about the large scope of the demonstration, the impact of passive enrollment, and the need for additional support services. Consequently, the OMO met with staff from the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation to understand the implications of the demonstration better, so the OMO could address the concerns of partner and advocacy groups.

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[17] Beginning in January 2013, CMS will implement a 3-year, multistate demonstration authorized by the Affordable Care Act to test new service delivery and payment models for people dually eligible for Medicare and Medicaid. Retrieved November 30, 2012, from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

National Conferences

Through conference attendance, the OMO has the opportunity to learn firsthand which programmatic and systemic issues are affecting the Medicare population and to conduct provider, beneficiary, and caregiver outreach. In 2012, the OMO participated in five external partner conferences:

- National SHIP Directors' Conference
- American Health Lawyers Association Conference
- Medtrade Fall Conference
- American Society on Aging Conference
- The National Association of Community Health Center's Policy & Issues Forum

INDUSTRY PARTNERS

The OMO collaborates with industry partners when necessary. For example, when working on the comprehensive study of employers' Medicare information needs, the OMO interviewed large and small employers to gain an understanding of the impact Medicare may have on their employees and how they access Medicare-related information. Additionally, the OMO worked with many private premium payers on issues related to benefit entitlement and premium billing.

COMPREHENSIVE STUDIES DEVELOPMENT

In 2012, the OMO completed three comprehensive studies, bringing the total number of comprehensive studies to 11 since this effort was initiated in 2009. The OMO began conducting these studies to assist in identifying the root causes of beneficiary issues and to develop specific, actionable recommendations for addressing them.

Initially, issues selected as the subjects of comprehensive studies emerged from the Issues Management process. More recently, new issues have been identified from the comprehensive studies

themselves. The following are the most recent study topics, described in detail in the Issues and Recommendations Regarding Beneficiary Concerns section of this report:

- Health Savings Accounts and how to inform Medicare-eligible individuals about their coverage choices.
- The Medicare-related information needs of the employer community.
- Information needs of new Medicare-Medicaid enrollees.

Using the findings from the research in these areas as a guide, the OMO has been able to develop specific, actionable short- and long-term recommendations that can be implemented quickly and effectively. The OMO presents each study to CMS Leadership.

Figure 8 provides a time line for the 11 studies the OMO has completed, information on the methods used to conduct the studies, and an illustration of how some studies have led to others.

To gain a better understanding of beneficiary issues involving appeals, the OMO reached out to the Office of Medicare Hearings and Appeals. Discussions included issues encountered by Administrative Law Judges that the OMO may provide assistance with by working within the agency to enhance education and outreach to beneficiaries. As a result of these discussions, the OMO will be conducting two comprehensive studies in FY 2013.

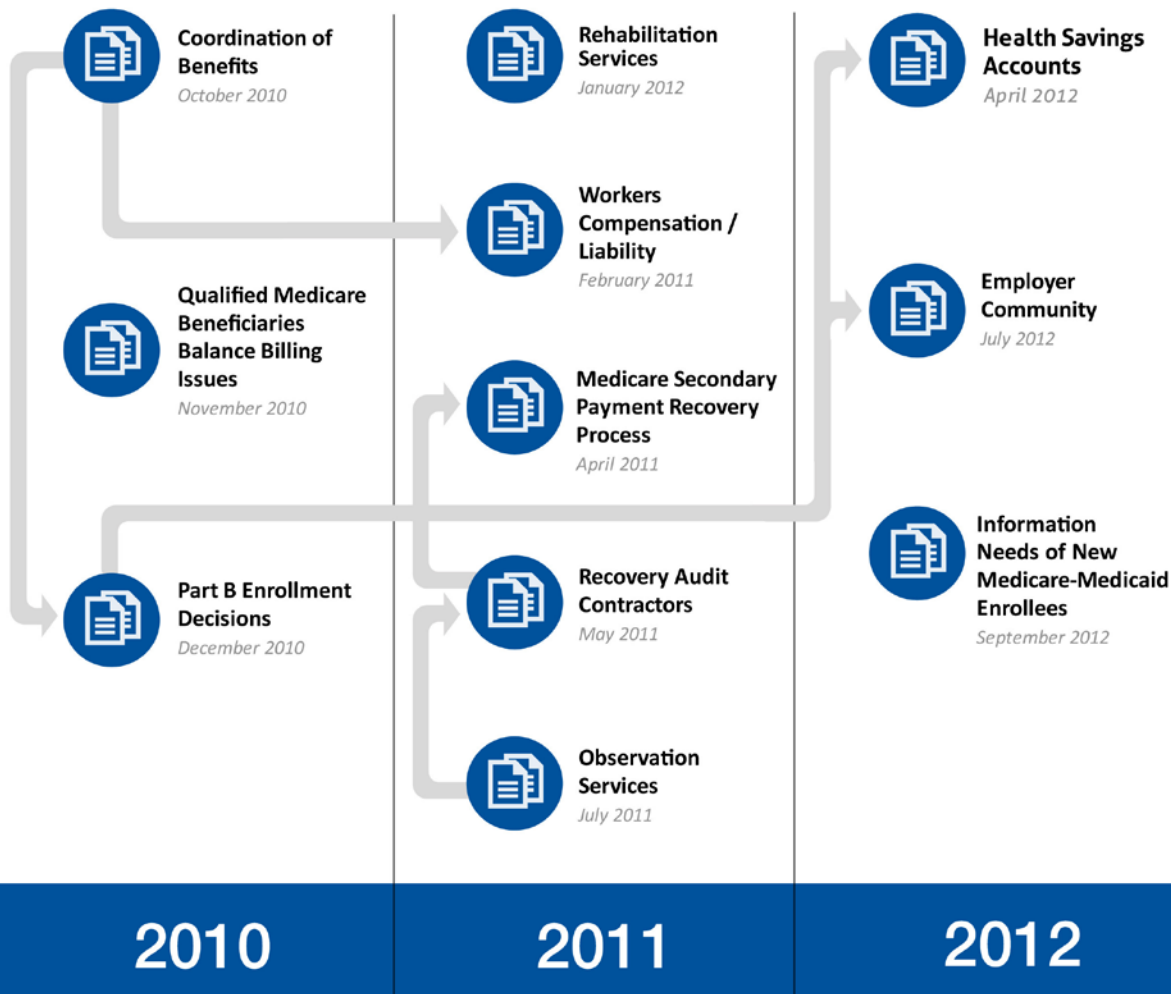**FIGURE 8. COMPREHENSIVE STUDY METHODOLOGY AND DEVELOPMENT**

STUDY METHODOLOGY

The overarching methodology for each comprehensive study includes the following elements:

- Environmental scans of pertinent legislation, Medicare regulations, policy background materials, and both CMS websites and other external relevant websites.
- A review of available communication and education materials for beneficiaries and other target audiences.
- Evaluation and gap analysis of available resources.

- Interviews with stakeholders, such as CMS subject-matter experts, beneficiary advocacy groups, CMS contractors and providers, and commercial organizations.
- Analysis of CMS data or data from external sources.
- Synthesis of findings and development of recommendations.

STUDY DEVELOPMENT

This graphic represents the progression of studies since 2010. In many cases, the initial research and/or findings of studies led to new studies. The grey arrows illustrate relationships between studies. The dates indicate when studies were completed. Studies may have been released to the agency after completion.

Coordination of Benefits
October 2010

Qualified Medicare Beneficiaries Balance Billing Issues
November 2010

Part B Enrollment Decisions
December 2010

Rehabilitation Services
January 2012

Workers Compensation / Liability
February 2011

Medicare Secondary Payment Recovery Process
April 2011

Recovery Audit Contractors
May 2011

Observation Services
July 2011

Health Savings Accounts
April 2012

Employer Community
July 2012

Information Needs of New Medicare-Medicaid Enrollees
September 2012

2010 **2011** **2012**

The first study will examine beneficiary use of and financial liability for ambulance services. Beneficiaries may believe that certain denied ambulance services were reasonable and necessary and thus eligible for the Social Security Act's beneficiary liability protections. However these denials are, in fact, "technical denials" and thus not eligible for these beneficiary protections.

The second study will explore possible enhancements to the OMO's role in the Medicare beneficiary appeals process, particularly in light of its statutory responsibility to assist beneficiaries with appeals. After engaging with Office of Medicare Hearings and Appeals subject-matter experts, the OMO study team will conduct outreach to other groups who likely have experience assisting beneficiaries with Medicare appeals, including SHIPs, beneficiary advocacy organizations, CMS ROs, and OMO case workers.

Additionally, in 2013, the OMO will examine the customer service practices of Medicare Parts C and D plans and identify and review CMS requirements and related beneficiary feedback.

FACILITATION AND TRACKING OF RECOMMENDATIONS IMPLEMENTATION

With the development of comprehensive studies, the OMO has been able to make more specific and better informed recommendations to CMS. In 2012, the OMO also began facilitating and tracking the implementation of its recommendations. OMO staff compiled and organized nearly 150 recommendations that had been developed over the last 6 years and presented to the agency in annual reports to Congress, interagency

CASE EXAMPLE: IMPROVING THE PARTS B AND D DIRECT BILL

The Office of the Medicare Ombudsman's (OMO's) facilitation of the redesign of CMS-Form 500 is one example of its efforts to implement recommendations. CMS-Form 500 is sent to beneficiaries who are directly billed for their Medicare Part A and/or Part B premiums and beneficiaries who are billed for the Income-Related Medicare Adjustment Amount (IRMAA) for their Medicare Part B and Part D premiums. Beneficiaries who receive CMS-Form 500 often have difficulty understanding how the premium amount due is calculated, especially when previous amounts due have been carried forward. The current form lacks a detailed breakdown of previous billing cycles of applied payments (i.e., credits), which sometimes leads beneficiaries to believe that CMS or the Social Security Administration (SSA) has made a mistake in calculating the premium amount due. The OMO conducted a Part D IRMAA outreach effort to contact beneficiaries in danger of disenrollment due to nonpayment of Part D IRMAA premiums.

In collaboration with CMS Regional Office staff, the OMO analyzed CMS-Form 500 and reviewed the number of direct bills issued to gain a better understanding of the number of beneficiaries who may experience issues. To reduce beneficiaries' confusion about the premium bill and significantly lower disenrollment caused by a failure to pay Part D-IRMAA, the OMO recommended that CMS redesign the form so that it would provide a more detailed breakdown of the amount due and would be written in plain language.

Not only is CMS-Form 500 confusing for beneficiaries, but responding to beneficiary questions about the premium bill creates a considerable resource burden and cost for CMS. A cost-benefit analysis comparing the benefits of leaving the bill as is to the costs of committing resources to improve the bill was presented to CMS Leadership. The OMO believes that if CMS redesigned the form, it would experience considerable cost savings as a result of decreased premium billing inquiries. As of the end of FY 2012, the OMO was working with staff from the CMS Office of Communications to develop and test a more beneficiary-friendly form. Following this, the OMO plans to collaborate with the Office of Financial Management to implement changes to the form.

memos, and, most recently, comprehensive studies. Recommendations ranged from updates to key Medicare publications to more complex revisions of Medicare systems and procedures.

As part of the facilitation and tracking process, OMO staff began working with CMS components to determine whether older recommendations had or had not been implemented and why. For newer recommendations, the OMO is leveraging its internal partnerships to determine the feasibility of the recommendations and, in some cases, guiding the recommendations through initial implementation steps. These steps might include scheduling meetings to bring key stakeholders together or drafting language for a form intended for beneficiaries. (See the case example on the Parts B and D direct bill.)

The OMO staff is documenting its efforts for internal and external reporting purposes. To date, nearly 150 recommendations have been suggested to CMS, many of which have been presented in previous reports to Congress. About 30 percent have been addressed, and an additional 20 percent are progressing.

THE COMPETITIVE ACQUISITION OMBUDSMAN

Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 requires the establishment of a Competitive Acquisition Ombudsman (CAO) to respond to complaints and inquiries made by suppliers and individuals related to the DMEPOS Competitive Bidding Program (CBP). In 2009, the Medicare Beneficiary Ombudsman appointed a CAO within the OMO.

In FY 2012, OMO staff supported the CAO in developing a new data management strategy with new reporting and monitoring requirements to provide feedback on the impact of the impending second-round expansion of the DMEPOS CBP in 2013. Furthermore, the CAO held a supplier listening session in FY 2012 with DMEPOS-contracted and non-contracted suppliers to identify significant issues affecting suppliers participating in the CBP. It also conducted demographic studies utilizing Medicare claims data in anticipation of the second round of competitive bidding.

The OMO completed three comprehensive studies to identify the root causes of systemic issues and develop recommendations to address them to improve beneficiaries' experiences.

Issues and Recommendations Regarding Beneficiary Concerns

SECTION HIGHLIGHTS

- Individuals who are newly eligible for Medicare and are covered under a Health Savings Account face complicated Medicare enrollment decisions.

- Employers are an important source of information for both current workers and retirees eligible for or already enrolled in Medicare, but they need more informational resources to serve their current and former employees better.

- Beneficiaries who have just become Medicare-Medicaid enrollees (beneficiaries enrolled in both Medicare and Medicaid) face challenges in understanding the rules and regulations associated with both programs.

INTRODUCTION

In fiscal year (FY) 2012, the OMO completed three comprehensive studies to identify the root causes of systemic issues and develop recommendations to address them to improve beneficiaries' experiences. These studies covered (1) Medicare enrollment decisions related to Health Saving Accounts (HSAs), (2) the Medicare-related information needs of the employer community, and (3) the information needs of new Medicare-Medicaid enrollees. Information was compiled through such methods as data analysis, stakeholder interviews, and environmental scans. In addition, potential topics for new studies were identified.

This section presents an analysis of each study topic and the recommendations made to the Centers for Medicare & Medicaid Services (CMS) Leadership during FY 2012, when the studies were completed. The process of addressing and implementing the recommendations has already begun for some of the recommendations presented in this section. Updates on issues identified in past years are also presented.

HEALTH SAVINGS ACCOUNTS AND INFORMING MEDICARE-ELIGIBLE INDIVIDUALS ABOUT THEIR COVERAGE CHOICES

HSAs, established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, are accounts that individuals can use to pay for qualified medical expenses not covered by insurance, such as deductibles, copayments, or services. To be eligible to contribute tax-free income to an HSA, an individual must be enrolled in a high-deductible health plan (HDHP) and not be enrolled in Medicare. A key benefit of having an HSA is that participants or their employers can contribute pretax income to the savings account.[18] In 2012, the annual HSA contribution limit for individuals with self-only coverage was $3,100 ($6,250 for family coverage), and individuals who were at least 55 years of age but not yet enrolled in Medicare were able to contribute an additional $1,000 annually. In addition, HSA funds accrue as they roll over year to year, and they can earn interest.

Enrollment in HSAs–HDHPs has grown exponentially in recent years and is forecasted to continue growing. It is expected that some individuals with HSAs will continue working after becoming Medicare-eligible. Additionally, enrollment in these plans is projected to grow, partly due to an increased demand for low-cost health insurance plans as a result of the insurance mandates in the Affordable Care Act.

Individuals who become eligible for Medicare due to age, are active workers or spouses of active workers, and receive health coverage under an HSA–HDHP need to consider multiple factors when making enrollment decisions about Part A, Part B, and Part D coverage: (1) the implications of continuing to contribute to an HSA, (2) the possibility of having to pay a late enrollment penalty for Part D coverage if the individual delays enrollment beyond the initial enrollment period without having creditable coverage, and (3) potential tax penalties if HSA contributions are not stopped up to 6 months before Medicare enrollment, as Part A can be made retroactive if enrollment is delayed.[19]

Medicare Part A Enrollment: In general, because most individuals are eligible for premium-free Part A coverage, active workers can enroll in Part A while still retaining their employment-related coverage. Upon enrollment in Medicare Part A, however, HSA–HDHP

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[18] Any individual may contribute to a participant's HSA, although these contributions are subject to applicable taxes.

[19] The creditable coverage standard requires that in order for a Part D eligible individual to avoid the late enrollment penalty, his or her other prescription drug coverage must be expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Although the law requires that plan sponsors provide creditable coverage notification to enrolled individuals, these notifications may not be prominently displayed and may occur within the context of a larger explanation of benefits.

enrollees are no longer permitted to make contributions to their HSAs or receive contributions from their employers or others. As a result, Medicare-eligible individuals enrolled in HSAs–HDHPs may want to delay enrollment in Medicare Part A, which can be done without incurring late enrollment penalties. If a Part A–eligible individual chooses to delay enrollment, the effective date of enrollment will be made retroactive for up to 6 months from the actual enrollment date. Consequently, individuals delaying enrollment may face tax penalties if they do not stop making HSA contributions in anticipation of their retroactive Medicare Part A enrollment dates.

Medicare Part B Enrollment: Because enrollment in Part B involves paying premiums, active workers with employment-related health insurance, such as an HSA–HDHP, are more likely to defer Medicare Part B enrollment. These individuals can enroll in Medicare Part B later during a special enrollment period (SEP) and are not subject to late enrollment penalties, provided they can document having employer-related active worker coverage from the date of Medicare eligibility.

Medicare Part D Enrollment: Individuals are eligible for Medicare Part D coverage if they are entitled to Part A or enrolled in Part B. As with Part B, there is an SEP for individuals who withdraw from employment-related prescription drug coverage and enroll in Medicare Part D. Individuals who delay Medicare Part D enrollment to remain covered by an HSA–HDHP will be eligible for an SEP when withdrawing from HDHP prescription drug coverage. However, to avoid late enrollment penalties, the beneficiary's prescription drug coverage under the HDHP must meet the creditable coverage standard. This standard requires that the employer-related prescription drug coverage be actuarially equivalent to or exceed standard Part D coverage. An individual may incur a late enrollment penalty if there is a continuous period of 63 days or more after the end of an individual's Part D initial enrollment period during which the individual is eligible for but does not enroll in a Medicare Part D plan and does not have any creditable prescription drug coverage.

As with Part B, the late enrollment penalty for the Part D premium is applied for as long as the beneficiary is enrolled in Part D. All Medicare-eligible individuals with employment-related prescription drug coverage need to be made aware of the Part D creditable coverage requirement. Active workers who are HSA–HDHP enrollees are at particular risk of lacking creditable coverage as a result of the high-deductible benefit design. The HSA balance or current-year contributions are not included in the creditable coverage calculations.[20]

> *Special considerations apply to all enrollment decisions when a person has reached Medicare eligibility but his or her spouse has not.*

In addition, special considerations apply to all enrollment decisions when a person has reached Medicare eligibility but his or her spouse has not. In particular, two factors should be taken into account:

- The HSA cannot be used to cover Medicare premiums for dependents or spouses if the HSA account holder is not Medicare eligible. Even though the Medicare-enrolled spouse can no longer contribute to the HSA, the HSA-enrolled spouse can continue to use HSA funds to pay for the Medicare-enrolled spouse's eligible medical expenses.

- If the HSA account holder is Medicare eligible but the spouse is not, then the account holder may want to continue working and maintaining employer-provided health coverage for his or her spouse.

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[20] CMS has issued guidance regarding why HSAs are not considered in the calculation of creditable coverage. Some of the reasons include that HSAs do not qualify as group health plans under the Employee Retirement Income Security Act and that both the employer and individual may contribute to the plan, so it is not easy to distinguish between these sources of funding.

FINDINGS

To understand the implications of delaying Medicare enrollment for HSA–HDHP enrollees, the OMO reviewed policy background materials (statutory and regulatory provisions, tax codes, and legislation that governs HSAs–HDHPs and their effect on Medicare enrollment) and data from the HSA market. The OMO also conducted interviews with stakeholders and searched for available guidance for Medicare-eligible HSA holders (or their dependents). Four main findings emerged from this research:

- The legislation is generally clear on the use of HSAs and their interaction with Medicare. However, the fact that Part B and Part D have similar eligibility rules for SEPs but different late enrollment penalty rules can confuse active workers approaching the Medicare eligibility age.

- Individuals are having difficulty understanding the creditable coverage requirement for Medicare Part D. Moreover, determining whether employer-sponsored prescription drug coverage is creditable from an actuarial point of view may be difficult for a layperson. The information on whether the coverage is creditable also may not be readily apparent in health plan materials.

- Individuals trying to determine whether their coverage is creditable may think that their HSA

balances and current-year contributions are included in the calculations and that their benefits are actuarially greater than they are.

- The primary CMS beneficiary resources—Medicare.gov and *Medicare & You*—provide no information about HSAs. In addition, the non-CMS sources that address HSAs and the Medicare enrollment decision do not directly address the issue of creditable coverage for prescription drug insurance plans with HSAs. Because HSAs have tax implications, the Internal Revenue Service (IRS) has a fact sheet on HSAs that includes rules concerning Medicare enrollment.[21] Some advocacy groups, such as the Medicare Rights Center, have produced informative online resources relating to HSAs and Medicare.[22]

RECOMMENDATIONS

To address the need for more accessible resources that provide a thorough explanation of HSA–HDHP implications for Medicare enrollment decisions, the OMO recommends that different types of information and training be developed for beneficiaries, customer service professionals, and employers.

For beneficiaries:

- Develop a fact sheet on HSAs.

- Reference HSAs and the fact sheet in CMS' primary beneficiary resources: *Medicare and You* and Medicare.gov.

- Coordinate with the IRS to include Medicare-relevant information in the IRS HSA publication (969) and on the IRS HSA Web page.

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[21] Health Savings Accounts and Other Tax-Favored Health Plans. Retrieved November 30, 2012, from http://www.irs.gov/pub/irs-pdf/p969.pdf.

[22] Health Savings Accounts (HSAs) and Medicare. Retrieved February 24, 2012, from http://www.medicareinteractive.org/page2.php?topic=counselor&page =script&slide_id=1726.

For customer service professionals:

- Train 1-800-MEDICARE customer service representatives (CSRs) on the new HSA fact sheet, creditable coverage, and the implications of creditable coverage for enrollment decisions.

- Request that the IRS and the Social Security Administration (SSA) train their CSRs regarding HSAs and Medicare enrollment decisions and that they promote the new HSA fact sheet.

For employers:

- Provide information about HSAs–HDHPs and the creditable coverage requirement to employers.

THE MEDICARE-RELATED INFORMATION NEEDS OF THE EMPLOYER COMMUNITY

Employers are becoming an increasingly important information resource for individuals who are eligible for or already enrolled in Medicare. Employers may be approached by their Medicare-eligible employees or retirees with Medicare-related questions on such topics as eligibility, coverage options, premium payments, and coordination of benefits. Additionally, employees may express confusion about the change in the Social Security retirement age and Medicare eligibility. Thus, employers need to have the resources necessary to respond to these individuals' Medicare information needs and be aware of their own responsibilities related to business interactions with Medicare.

Until recently, Medicare eligibility and Social Security retirement were synchronized at age 65. However, in 2009, the Social Security retirement age increased to 66 and will eventually increase to 67, while the Medicare eligibility age remains 65. As a result, issues related to employees' being eligible for Medicare and covered by employer-related health insurance may arise more frequently as more employees delay retirement past age 65. Employees may not know whether to enroll in Medicare Part B or Medicare Part D if they already have coverage through their employers' plans.

> *The key finding is that, even though numerous resources are available to the employer community, no single source consolidates all the relevant resources.*

In addition, coordination-of-benefits (COB) rules depend on the size of the employer and the reason for the individual's Medicare eligibility (age, disability, or end-stage renal disease [ESRD]). These COB rules directly influence an individual's decision to enroll in Medicare. As a result, the employer's guidance depends on the particular characteristics of the employer and the Medicare-eligible employee.

FINDINGS

To determine the Medicare-related information needs of employers, the OMO conducted interviews with stakeholders, including employers and entities that advise employers on health benefits. In addition, the OMO undertook a review of available guidance for employers and identified gaps in the information.

The key finding is that, even though numerous resources are available to the employer community, no single source consolidates all the relevant resources. In addition, the study revealed that employers are less familiar with the issues associated with individuals with disabilities or ESRD than with those associated with beneficiaries who age into Medicare. Some employers have turned to benefit consulting firms to assist their employees.

The study identified four major areas about which employers require more resources and information:

- **Medicare enrollment.** Each of the Medicare parts (Parts A, B, C, and D) involves different enrollment considerations, such as eligibility and premium payments, which may add to the complexity of enrollment decisions. Topics of particular importance include:

  - **Qualification for a Special Enrollment Period.** Distinctions between SEPs for Part B and Part D may cause employer and employee confusion regarding eligibility requirements and the duration of the SEP. In addition, stakeholders reported misunderstanding the relationship between SEPs and late enrollment penalties assessed on Medicare premiums. Also, stakeholders noted confusion about the distinction between Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and group health plan (GHP) coverage. For Medicare purposes, COBRA is not considered employer-sponsored health insurance, and individuals who wait until after COBRA coverage ends may miss their SEP.

  - **Confusion caused by the differences between Part B and Part D requirements for avoiding late enrollment penalties.** In general, an individual will not incur a Part B late enrollment penalty if he or she has GHP coverage based on current employment through his or her own or spouse's employer. Part D has an additional requirement that the coverage must be "creditable"—that is, the coverage must be at least as good as that provided by Medicare Part D.

- **Coordination of benefits.** COB applies to situations in which the individual has more than one source of health care coverage, and it determines the order of payment for the different health care payers. COB rules vary based on the reason for eligibility (age, disability, ESRD) and are further complicated when an individual is covered under a spouse's GHP. Additionally, employers must fulfill COB reporting requirements to avoid potential financial and legal penalties.

- **Employer-provided Medicare-related coverage.** Employers can provide coverage to Medicare beneficiaries via several options, including the Retiree Drug Subsidy (RDS) and Employer Group Waiver Plans (EGWPs). The RDS is a subsidy from CMS to employers for prescription drug coverage for retirees and their dependents. EGWPs are employer-specific Medicare Advantage plans that may provide health and/or prescription drug coverage.

- **Account-based health arrangements.** Several account-based health arrangements are available to individuals, each with different rules for contributions, enrollment, and whether they meet the Part D creditable coverage requirement. These arrangements include:

  - HSAs
  - Health Reimbursement Arrangements
  - Flexible Savings Arrangements
  - Archer Medical Savings Accounts (MSAs)
  - Medicare MSAs

RECOMMENDATIONS

The OMO developed three recommendations regarding improved information and resources for the employer community:

- Create an "Employer Community Portal" located on CMS.gov or Medicare.gov through which employers and other relevant stakeholders can readily locate resources that will help them assist Medicare-eligible and Medicare-enrolled individuals.

- Develop additional employer resources to fill identified gaps. These could include a fact sheet that compares Part B and Part D requirements regarding SEPs and late enrollment penalties, an employer-specific Medicare enrollment publication, and a recorded webinar specifically on COB considerations for disabled and ESRD beneficiaries.

- Employ a multimethod approach to employer outreach and communication.

INFORMATION NEEDS OF NEW MEDICARE-MEDICAID ENROLLEES

The Affordable Care Act, enacted in 2010, established the Medicare-Medicaid Coordination Office (MMCO) to ensure that Medicare-Medicaid enrollees have full access to seamless, high-quality health care and to make the system as cost-effective as possible. In 2012, the OMO and MMCO worked collaboratively to study how to make meaningful improvements to information that is made available to individuals newly enrolled in both programs.

The study identifies areas for improving the current state of information through three strategies: identifying the key changes affecting individuals transitioning from Medicaid or Medicare as their only coverage to eligibility for both programs, conducting stakeholder interviews/focus groups, and performing an environmental scan of information for new Medicare-Medicaid enrollees. From these findings, information gaps were identified, and recommendations for improved communication were developed.

"Medicare-Medicaid enrollees" is a term that encompasses divergent subsets of individuals, making a "one-size-fits-all" information strategy impractical. Beneficiaries' pathways to Medicare-Medicaid enrollment, their characteristics, and the level of state

Medicaid involvement offer a picture of a complex population, as seen in figure 9. Beneficiaries' income and health-status characteristics can be very different, depending upon how an individual becomes eligible for both programs.

Medicare-Medicaid enrollees always have access to Medicare benefits. However, being a Medicare-Medicaid enrollee does not necessarily mean that an individual has access to all Medicaid benefits (such as long-term nursing home services and nonemergency transportation). For example, Medicare-Medicaid enrollees who are Qualified Medicare Beneficiaries-Only (QMBs-Only) receive assistance with Medicare premiums and Medicare cost-sharing. However, a QMB-Only is not eligible to receive Medicaid benefits. The nature of state assistance falls into one of three forms of benefits:

- Medicaid-covered benefits

- State Medicaid assistance with Medicare cost-sharing

- State Medicaid assistance with Medicare premiums

Medicare-Medicaid enrollees receive different combinations of these forms of benefits depending upon their income/eligibility group and the state in which they live.

FIGURE 9. PATHWAYS AND CHARACTERISTICS OF MEDICARE-MEDICAID ENROLLEES
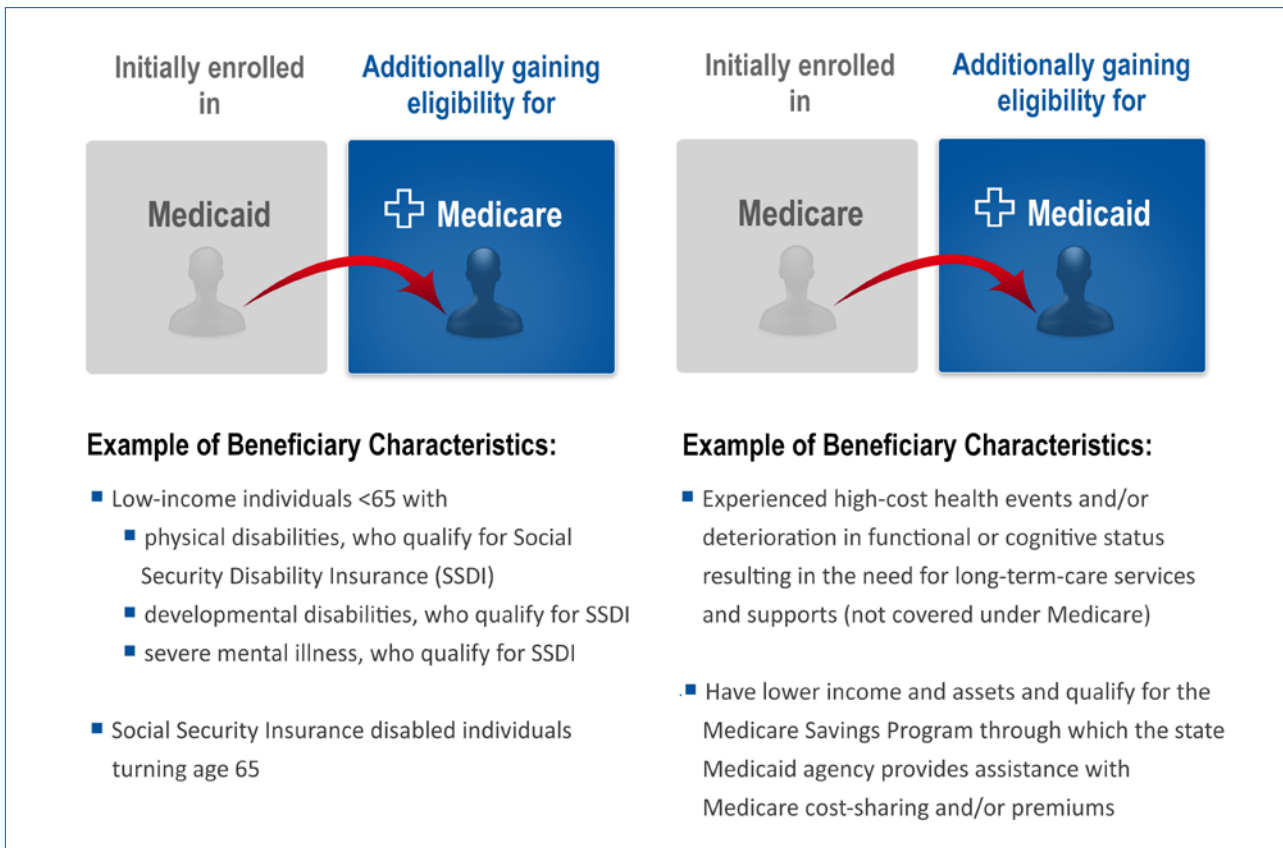
FINDINGS

Stakeholder interviews revealed that the information currently available to new Medicare-Medicaid enrollees can be complex, lengthy, and often in a format that is hard to understand.

In addition, the information is often not specific enough to the beneficiaries' situations, as Medicare-Medicaid enrollees' circumstances can be highly complex. Stakeholders also indicated that many Medicare-Medicaid enrollees are unaware of their eligibility status for both programs and often lack a full understanding of the benefits and services to which they are entitled. It was suggested that individualized counseling may be needed to assist these beneficiaries.

The information gathered from stakeholders was categorized into these areas of concern:

- **Access to benefits and services.** The issue stakeholders raised with the greatest frequency was the importance of new enrollees' understanding how to access their benefits and services. Such issues as how to get prescription drugs and how to access providers, including specialists, were frequently mentioned. Assistance in figuring out which providers can be seen and who will provide services under which plan was another significant need expressed by new enrollees. New enrollees are often concerned about whether they can continue seeing their existing doctors, particularly their specialists.

- **Eligibility rules and processes.** Stakeholders identified the need for information about Medicaid eligibility rules and the redetermination process with the second highest frequency. Many called this an area of

urgent concern, because beneficiaries could lose Medicaid coverage if they fail to understand the requirement. Another concern mentioned was the delay in data exchange related to state Medicare premium buy-in for individuals who become eligible for Medicare upon completing the 24-month waiting period after receiving Social Security Disability Insurance (SSDI) benefits. Some interviewees noted that it can take months before the state assumes payment of the Part B premium, during which time the premium is withheld from the beneficiary's Social Security check. This can cause financial hardship for many beneficiaries.

- **Covered benefits and services.** Beneficiaries who have been in one program and newly enroll into the other need to understand the benefits and services to which they are entitled. Many enrollees assume that everything they need will be covered, but this is not always the case, because Medicaid coverage differs depending on the state in which the beneficiary resides. Specifically, stakeholders mentioned confusion and concern among new enrollees about which types of long-term services and supports are covered, whether and how mental health services and psychiatric drugs are covered, the types of dental and vision benefits included, and which kinds of durable medical equipment are covered.

- **What each program covers.** Beneficiaries may know that they are entitled to certain benefits, but they frequently do not understand which program will cover their needed services. Two issues compound this problem: (1) Many new enrollees cannot identify which programs they are in, and (2) some providers and professionals do not always know what each program covers. In addition, having multiple insurance cards is a source of confusion for new enrollees and their families. Sorting out which program pays for what is notably difficult when beneficiaries are receiving skilled nursing facility (SNF) care.

Many stakeholders observed that the transition from the Medicare SNF benefit to Medicaid long-term-care coverage is an area of great confusion and misunderstanding.

- **Out-of-pocket costs.** Stakeholders reported receiving many questions from new enrollees about their premiums and copays/cost-sharing responsibilities. The biggest areas of confusion are related to Medicare Part D and managed-care programs. Because the Medicare-Medicaid population is predominately low-income and often has a fixed income, this is an issue of concern and consequence to individuals. In addition, some stakeholders discussed the problem of providers "balance billing" (wrongly attempting to bill beneficiaries to fill gaps left by what Medicare or Medicaid does not cover), an issue about which the OMO provided guidance in FY 2011.

> " *Beneficiaries who have been in one program and newly enroll into the other need to understand the benefits and services to which they are entitled.*

- **Understanding choices and rights**. Many new enrollees are surprised by having to make choices between types of plans and do not feel equipped to make informed decisions. Furthermore, stakeholders frequently expressed concern that beneficiaries, especially those who are older and those with greater levels of disability, do not understand their rights and entitlements. Appeals and grievances were also raised as another area of concern.

- **How and whom to ask for information and help.** It was commonly noted that these beneficiaries frequently have difficulty understanding written documents.

CHANGES EXPERIENCED BY BENEFICIARIES: AREAS OF HIGH IMPACT

When becoming newly eligible for both Medicare and Medicaid, beneficiaries experience significant changes in the following areas:

- **Number of insurance cards.** Beneficiaries who transition from Medicaid-only to Medicare-Medicaid shift from having a single insurance card to having three insurance cards.
- **Eligibility redeterminations.** Beneficiaries who were initially Medicare-only and are accustomed to having a single eligibility determination at the start of that coverage shift to recurring Medicaid determinations that are performed at least annually and sometimes as frequently as quarterly.
- **Prescription drugs.** Beneficiaries who were initially Medicaid-only must move to the Medicare Part D program and plans and learn a new system for obtaining prescription drugs.
- **Long-term care.** Medicare-only beneficiaries who experience a serious health care event may lose their ability to care for themselves and pay their Medicare expenses. They may become eligible for Medicaid-covered benefits and receive coverage for the costly long-term services and supports not covered under the Medicare program.
- **Provider selection.** Whether a Medicare-only or a Medicaid-only enrollee initially, a Medicare-Medicaid enrollee with full Medicaid benefits must be sure that his or her provider accepts both Medicare and Medicaid, because Medicare now pays first, and Medicaid covers the cost-sharing expenses.

Stakeholders recommended that written materials clearly and prominently indicate who should be called for help interpreting the information provided, who to ask about the benefits and services covered, and who to call if beneficiaries encounter any problems accessing benefits.

- **Managed care.** New enrollees in managed-care programs frequently have questions about which services are covered, how to access providers, and the process for identifying and seeing specialists. If they have a choice between traditional services and managed care or a choice among managed-care providers, they need additional information and assistance with making these decisions. Another issue raised in this category was the confusion that people experience when they go from being enrolled in a Medicaid managed-care program to being eligible for Medicare.

In addition to these eight areas, stakeholders also identified issues regarding the content, presentation, and delivery of information. The most common theme to emerge was that most information provided to new enrollees is in a written form that is too complex to understand. Stakeholders reported that written materials do not match the literacy level, cognitive and physical capacity, or preferred communication style of the intended audience.

In addition, stakeholders described the particular challenges faced by people who speak English as a second language, people with dementia, and people with intellectual disabilities when trying to understand the materials. Lastly, stakeholders agreed that enrollees receive too much written information and that the materials are too lengthy. Consequently, enrollees do not know what information is important, which results in enrollees not reading or discarding important material.

The Financial Alignment Demonstration, aimed at integrating primary, acute, behavioral health, prescription drug, and long term services and supports for Medicare-Medicaid enrollees, may address some of these issues facing this population.

ENVIRONMENTAL SCAN OF ONLINE RESOURCES

An environmental scan was conducted to aid in identifying areas for improving the current state of information for new Medicare-Medicaid enrollees. To complete the environmental scan, the following Internet resources were assessed: the CMS Web site; Medicare.gov; Web-based resources from each of the 50 states and the District of Columbia; and national consumer advocacy and foundation organization resources.

The environmental scan found that the topics of health insurance cards and Medicaid eligibility redeterminations, which were noted by the stakeholders as confusing areas for new Medicare-Medicaid enrollees, were inadequately dealt with in the resources identified through the scan. Additionally, another area identified by interviewees as particularly confusing for beneficiaries and their families was Medicare coverage of SNFs versus Medicaid coverage of nursing facilities (NFs). Resources that address Medicare SNF coverage or Medicaid NF coverage were identified, but no resources on the transition between these programs' coverage were located. There were

also few information resources about Medicare summary notices/explanation of benefits for beneficiaries whose eligibility pathway is from Medicaid to Medicare.

The environmental scan uncovered a range of common styles of information sources, from shorter frequently asked questions or fact sheets to longer handbooks. Although handbook resources were often more comprehensive, key informant interviews noted that lengthy documents, such as handbooks, can be overwhelming. Interviewees consistently reported that shorter, one-page targeted topic resources were more helpful. The scan did find that numerous resources limited information to one or two topics. But from the perspective of introducing new enrollees to being eligible for both programs, there is a gap in the provision of concise explanatory resources that are focused on a limited number of key topics for these individuals.

RECOMMENDATIONS

The recommendations resulting from this study are categorized into three groups: (1) those for improving communication with enrollees and their families, (2) those for assisting professionals who work with these beneficiaries, and (3) those related to program administration.

For enrollees and their families:

- Create brief, targeted "welcome kits" for new Medicare-Medicaid beneficiaries based on eligibility categories and benefits. It is recommended that three basic welcome kit templates be created to target the different eligibility groups based on the nature of the benefits they receive.
- Produce a set of targeted "one-pagers" to address key topic areas relevant to Medicare-Medicaid beneficiaries. The OMO identified a short list of topics that were frequently mentioned in stakeholder interviews as meriting explanation to beneficiaries newly eligible for both programs.

- Develop a Web page dedicated to Medicare-Medicaid enrollees that can be accessed from the Medicare.gov home page.[23]

For professionals working with Medicare-Medicaid enrollees:

- Develop a single-query process that health professionals and institutional providers can use to obtain information that indicates whether a Medicare beneficiary is also potentially eligible for Medicaid.

- Produce a set of topic-specific one-pagers on the interaction of Medicare and Medicaid for professionals and providers.

- Develop technical assistance presentations to benefit counselors and other professionals that can be used in group settings with Medicare-Medicaid enrollees.
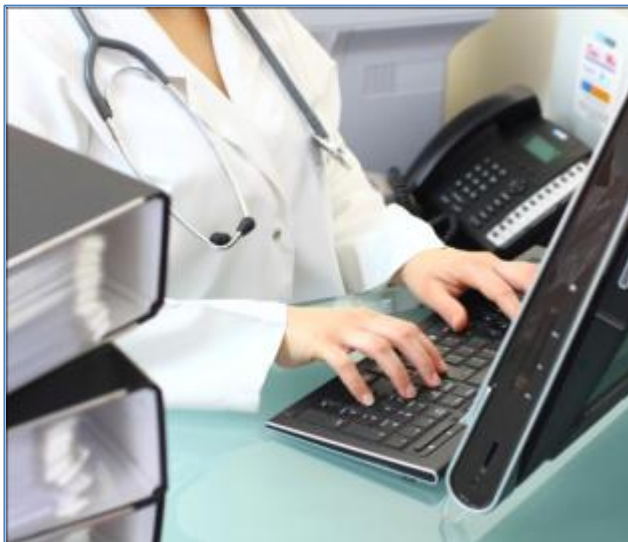
For program administrators:

- Develop Medicare Summary Notices (MSNs) tailored specifically to Medicare-Medicaid beneficiaries, if feasible. Because of the claims crossover process that exists between the two programs, it is possible that CMS claims data

systems could support a MSN designed for Medicare-Medicaid enrollees who are eligible to have their cost-sharing liability covered by Medicaid. If specific MSNs could be designed for these categories of Medicare-Medicaid enrollees, it would help address the issue of provider balance billing and beneficiary confusion regarding MSNs.

- Provide a timely process for the initiation of Medicaid buy-in for Medicare Part B premiums (if feasible) and give advance notice[24] to state Medicaid agencies regarding disabled individuals receiving Supplemental Security Insurance (SSI) and SSDI who are near the end of their 24-month waiting period for Medicare eligibility. Because of data-exchange delays in some states, some new Medicare-Medicaid enrollees whose eligibility for Medicare is based on disability experience delays in Medicaid's assumption of Medicare Part B premium payments. For these beneficiaries, the Part B premium is taken out of their Social Security checks until the data exchange takes place, causing financial hardship pending system updates. Because these beneficiaries have both SSI and SSDI, SSA could identify these individuals and provide CMS with an advance notice identifying SSI/SSDI individuals with impending Medicare eligibility, which CMS could then share with state Medicaid agencies. However, this would require special arrangements with SSA. Consequently, the OMO recommends that CMS examine the feasibility of providing advance notice to states of SSI/SSDI beneficiaries becoming eligible for Medicare so that the states can initiate the state buy-in process of Medicare Part B premiums at the start of Medicare eligibility.

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[23] Content is available on Medicare.gov for Medicare-Medicaid individuals. Subsequent discussions within CMS indicate that providing access from the Medicaid.gov home page would also be desirable.

[24] Subsequent discussions within CMS indicate that advance notice is already provided to the states for Part D. Therefore, CMS guidance to the states on how to use this information for Part B would be beneficial.

OTHER ISSUES ADDRESSED BY THE OMO

Another notable issue that the OMO examined in FY 2012 was the erroneous use of the date-of-death code. In 2011, the OMO identified a system coding issue affecting beneficiaries. Upon discharging patients from inpatient settings, providers must enter on the medical claim a patient discharge status code: a two-digit code that identifies where the patient is going at the conclusion of his or her hospital stay. The codes for date-of-death and date-of-discharge were susceptible to input errors, because they are referred to by the same acronym—"DoD"—and their numerical codes were easily transposed.

The Division of Ombudsman Exceptions (DOE) and CMS Regional Offices revealed that a number of date-of-death discharge-code errors had occurred in the Medicare Beneficiary Database, causing beneficiaries to be incorrectly marked as deceased. Each year, these coding errors cause several hundred

Medicare beneficiaries to temporarily lose primary and secondary coverage for months until the mistake is resolved. These errors also tie up significant amounts of CMS casework resources and affect other individuals and health plans nationwide, as these codes are uniform across payers.

DOE took the lead in exploring options for addressing the issue of discharge-code errors. In working with other CMS components, including the Center for Medicare and the Office of Information Systems (OIS), the OMO helped frame the issue and identify and facilitate the implementation of a solution. The OIS recommended to the National Uniform Billing Committee (NUBC), which has jurisdiction over patient discharge codes, that the date-of-death discharge code be changed. The OIS and the NUBC reached an agreement to change the date-of-death code to a new occurrence for all claim types (i.e., electronic, paper, and direct data entry) on which the code can be entered, effective October 2012. The OIS agreed to add an extra layer of system validation that requires entering the specific date of death whenever the date-of-death code is used.

Appendix A:
Trends in Medicare Beneficiary Contacts

The OMO reviews and analyzes data from a variety of systems to assist in identifying trends in beneficiary concerns. These systems were designed around business needs and operating purposes and track workloads, such as the number of contacts and broad reasons for beneficiary contact. Because of the aggregate nature of these data, they are not used to identify the exact root causes of beneficiary issues or to assess the effectiveness of OMO or CMS efforts to mitigate or address issues. The OMO engages in a wide range of activities, such as the casework and external partnerships described throughout the 2012 Report to Congress, to identify systemic beneficiary issues and develop recommendations for addressing them.

CONTACTS RECEIVED THROUGH 1-800-MEDICARE

To find answers to their Medicare benefit inquiries, beneficiaries, their families, and other members of the public most often contact the 1-800-MEDICARE helpline first. When people call 1-800-MEDICARE, they first receive assistance from an automated interactive voice response (IVR) system. If the IVR system cannot address the caller's inquiry or if the caller requests to speak with a person, the IVR system transfers the call to a customer service representative (CSR). To provide assistance with beneficiary inquiries, CSRs access defined scripts based on keywords related to the caller's issue.

FIGURE A-1. TOTAL NUMBER OF CONTACTS RECEIVED BY 1-800-MEDICARE:
FY 2001–2012, PER THOUSAND BENEFICIARIES
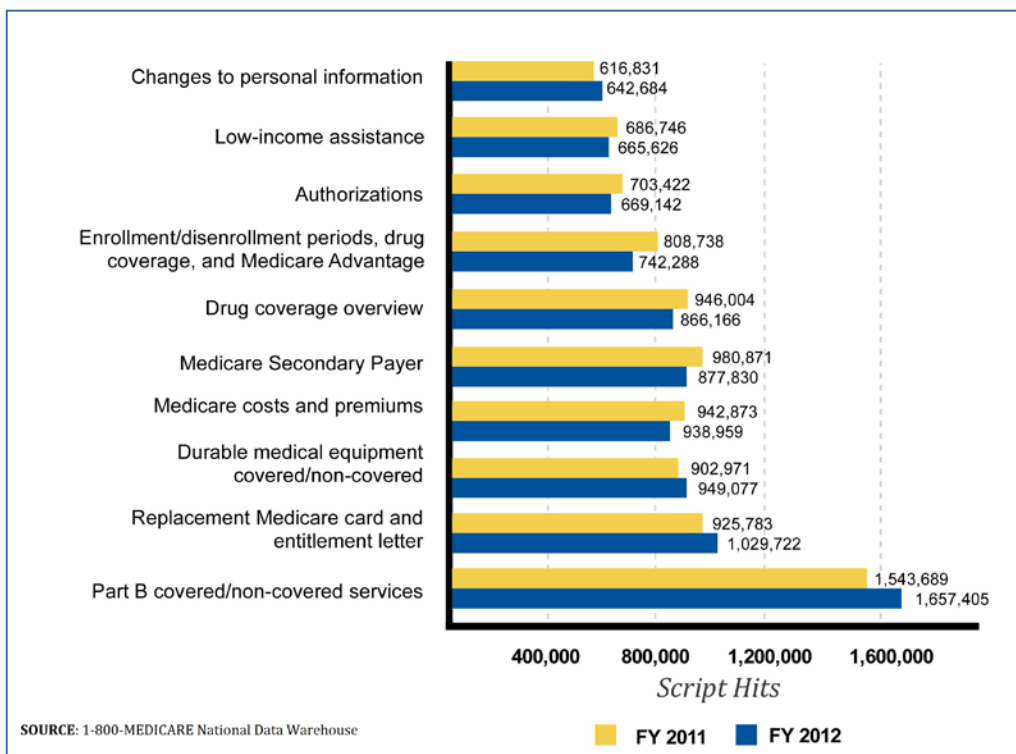

SOURCE: 1-800-MEDICARE National Data
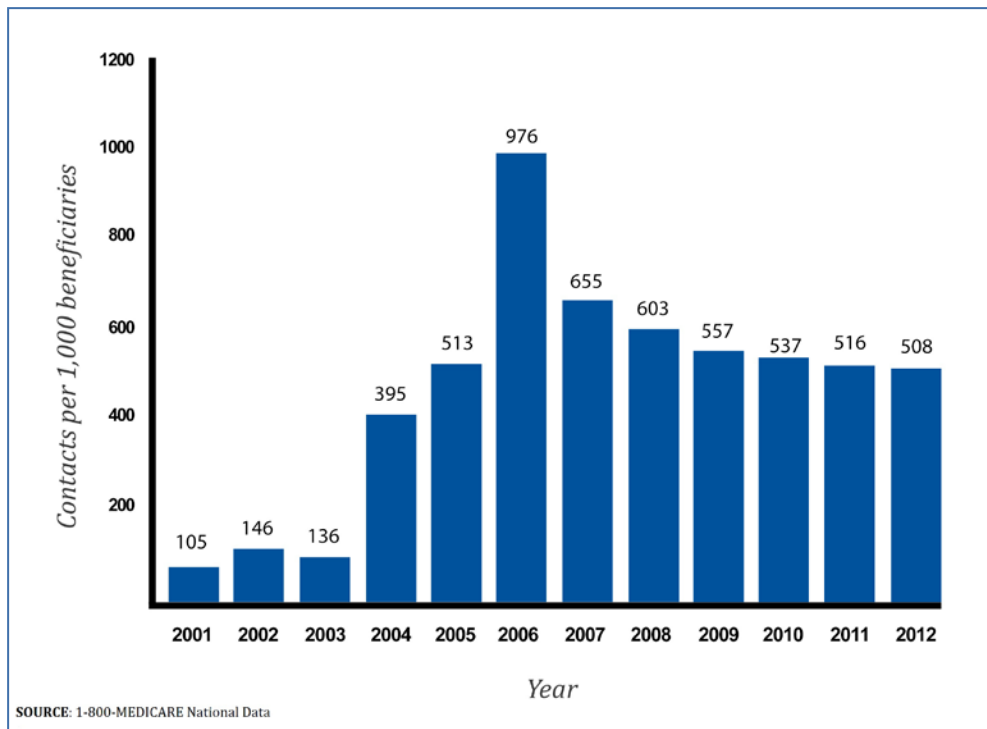
- The total volume of calls to 1-800-MEDICARE per 1,000 beneficiaries has decreased every year since 2006, the year Part D was implemented.

- This trend likely reflects both the maturation of the Part D program and the growing availability and use of online resources to address beneficiary questions, among other factors.
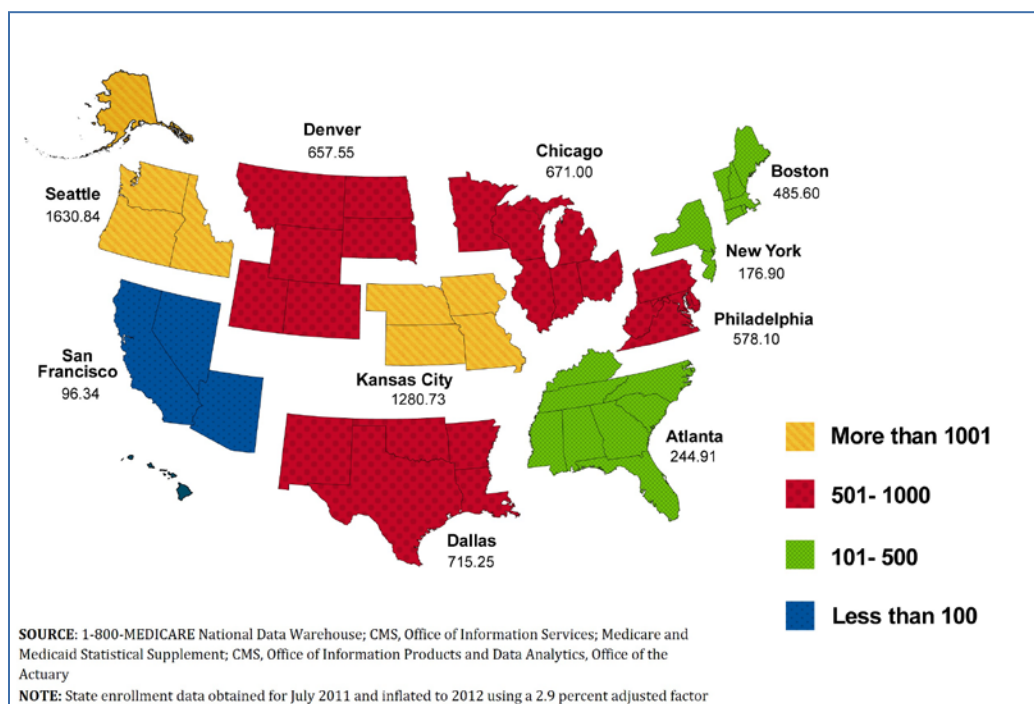
FIGURE A-2. COMPARISON OF 1-800-MEDICARE SCRIPT HITS IN 2011 AND 2012, BASED ON THE TOP 10 SCRIPT HITS IN 2012

- Consistent with prior years, CSRs accessed scripts on Part B covered/noncovered services more than any other issue in 2012.

- Between 2011 and 2012, reductions in script hits were seen in six of the top 10 categories.

- Of the four categories that increased, the largest percent change was in the top two categories: replacement Medicare card and entitlement letter (11 percent) and Part B covered/noncovered services (7 percent).

	FY 2011	FY 2012
Changes to personal information	616,831	642,684
Low-income assistance	686,746	665,626
Authorizations	703,422	669,142
Enrollment/disenrollment periods, drug coverage, and Medicare Advantage	808,738	742,288
Drug coverage overview	946,004	866,166
Medicare Secondary Payer	980,871	877,830
Medicare costs and premiums	942,873	938,959
Durable medical equipment covered/non-covered	902,971	949,077
Replacement Medicare card and entitlement letter	925,783	1,029,722
Part B covered/non-covered services	1,543,689	1,657,405

Script Hits

SOURCE: 1-800-MEDICARE National Data Warehouse

FIGURE A-3. MAP OF 1-800-MEDICARE CONTACTS PER THOUSAND BENEFICIARIES, BY REGION: FY 2012

Denver 657.55
Chicago 671.00
Boston 485.60
Seattle 1630.84
New York 176.90
Philadelphia 578.10
San Francisco 96.34
Kansas City 1280.73
Atlanta 244.91
Dallas 715.25

More than 1001
501- 1000
101- 500
Less than 100

- The number of contacts to 1-800-MEDICARE varied considerably across CMS regions, with as few as 96 calls per 1,000 beneficiaries in the San Francisco Regional Office (RO) states to 1,631 calls per 1,000 beneficiaries in the Seattle RO states.

SOURCE: 1-800-MEDICARE National Data Warehouse; CMS, Office of Information Services; Medicare and Medicaid Statistical Supplement; CMS, Office of Information Products and Data Analytics, Office of the Actuary

NOTE: State enrollment data obtained for July 2011 and inflated to 2012 using a 2.9 percent adjusted factor
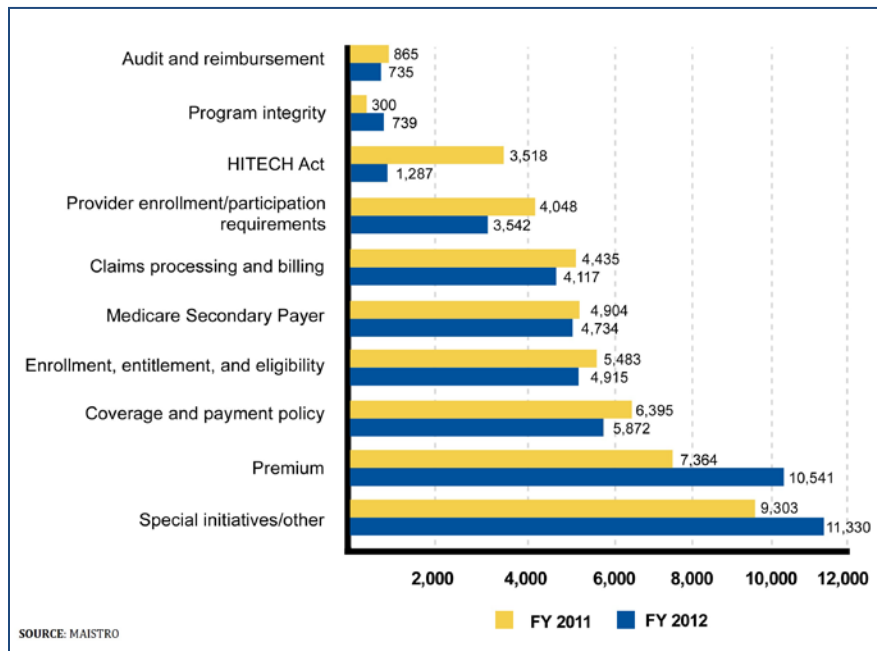
COMPLAINTS RELATED TO MEDICARE PARTS A AND B

The Medicare Administrative Issue Tracker and Reporting of Operations System (MAISTRO) is used to collect and report complaints and inquiries related to fee-for-service Medicare (that is, Medicare Parts A and B) that come directly to and are managed by CMS staff.

FIGURE A-4. TOP 10 REASONS FOR BENEFICIARY INQUIRY RECORDED IN MAISTRO: FY 2011 AND FY 2012

- Although seven of the top 10 categories showed reductions between 2011 and 2012, the top two categories (premium and special initiatives/other) increased by 43 and 22 percent, respectively.

- The category of program integrity, for which the number of contacts more than doubled from 300 to 739, was among the three categories that increased.

SOURCE: MAISTRO

COMPLAINTS RELATED TO MEDICARE PARTS C AND D

The Complaint Tracking Module (CTM) registers and categorizes complaints related to Medicare Parts C and D that are logged by 1-800-MEDICARE and CMS staff.

FIGURE A-5. CTM'S TOP 10 REASONS FOR PART C AND PART D CONTACT: FY 2011 AND FY 2012
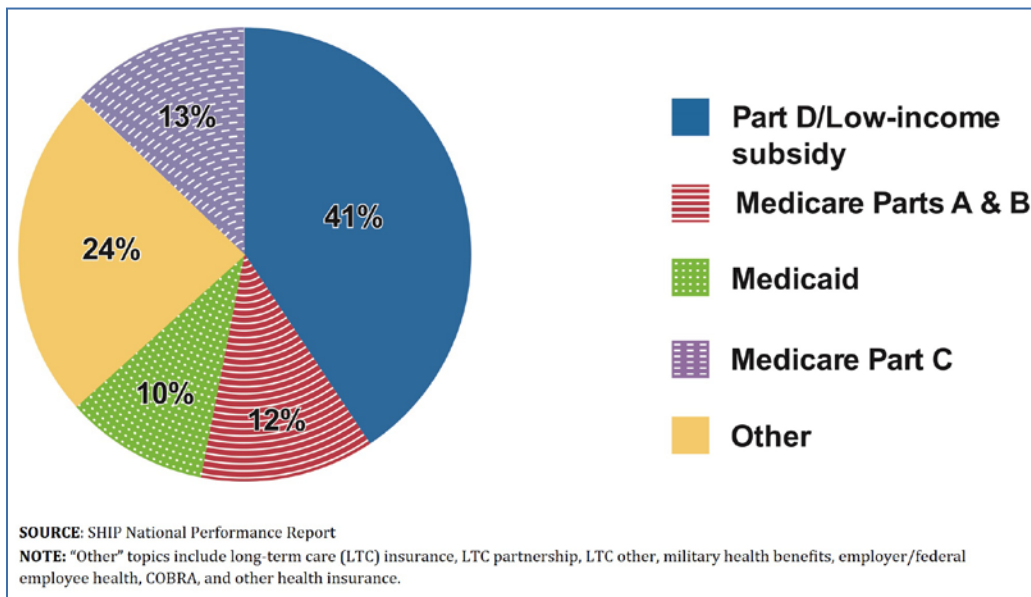

SOURCE: CTM
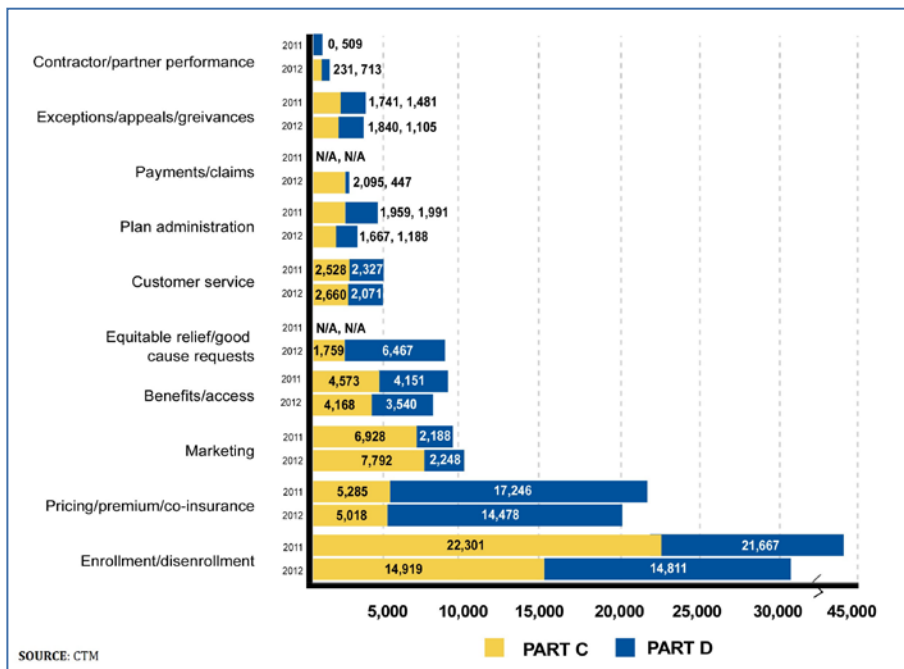
- Across both Parts C and D, the top complaints concerned issues related to enrollment and disenrollment.

- Across categories in 2012, the number of complaints was similar to or lower than the number in 2011.

- Two new categories— payment/claims and equitable relief/good cause requests—were added in 2012.

CONTACTS TO STATE HEALTH INSURANCE ASSISTANCE PROGRAMS

In addition to contacting 1-800-MEDICARE and the CMS Central Office and ROs, Medicare beneficiaries and their families can seek assistance from State Health Insurance Assistance Programs (SHIPs). SHIPs offer counseling and assistance to Medicare beneficiaries on a wide range of Medicare, Medicaid, and Medigap issues.

FIGURE A-6. REASONS FOR BENEFICIARY CONTACT OF SHIPS: FY 201

Pie chart with legend:
- **Part D/Low-income subsidy** — 41%
- **Medicare Parts A & B** — 12%
- **Medicaid** — 10%
- **Medicare Part C** — 13%
- **Other** — 24%

SOURCE: SHIP National Performance Report
NOTE: "Other" topics include long-term care (LTC) insurance, LTC partnership, LTC other, military health benefits, employer/federal employee health, COBRA, and other health insurance.

- Responding to more than 9.6 million reasons for contacts in 2012, SHIPs remained an important resource for Medicare beneficiaries and their caregivers.

- Topics related to Part D represented the most frequent reason for contact in 2012.

Appendix B:

FY 2012 Medicare Part C and D Online Complaint Form Data Analysis

BACKGROUND

Parts 417, 422, and the 423 of Title 42 of the Code of Federal Regulations enact revisions of the Medicare Advantage (MA) Program (Part C) and Prescription Drug Benefit Program (Part D). Specifically, this legislation implements provisions outlined in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act [ACA]) and makes other changes based on the Centers for Medicare & Medicaid Services' (CMS') experience with administering Parts C and D. The revisions also clarify various program participation requirements, make changes to strengthen beneficiary protections, remove consistently poor performing health plans, and make other clarifications and technical changes. As required under section 3311 of ACA, CMS implemented an electronic complaint form.

The Center for Medicare at CMS worked closely with other CMS staff to develop a technical approach to implementing the complaint form that used existing infrastructure and required minimal changes to business processes. For example, to ensure consistency with existing business processes, a subset of data elements to be included in the form was selected from the agency's existing mechanism for collecting Medicare Parts C and D complaints: the Medicare Complaint Tracking Module (CTM). The CTM is a tool that allows complaints to be recorded and systematically analyzed and aggregated, providing an early indication of new or emergent policy issues that may have an impact on health plan operations and require immediate resolution.

To ensure user accessibility, the online complaint form was placed in three locations by CMS: (1) on the www.medicare.gov homepage, (2) on the Medicare Plan Finder homepage, and (3) on the Office of the Medicare Ombudsman homepage. As outlined in section 3311 of ACA, effective January 1, 2012, MA organizations and prescription drug plan (PDP) sponsors are required to display this electronic complaint form prominently on their websites. In a November 10, 2011 Health Plan Management System memoranda, CMS provided guidance instructing MA organizations and Part D sponsors on how to comply with this requirement.

COMPLAINT PROCESS

While the number of complaints filed with CMS and the time needed to resolve these complaints have diminished as the Part D program has matured, complaint data indicate that there is still opportunity for improvement. CMS requires that plan sponsors provide information about whether they notified beneficiaries about the status and resolution of their complaints. This allows CMS to determine if sponsors are closing complaints in a timely manner. CMS routinely monitors the status of complaints and works with plan sponsors who fail to comply with requirements for the complaints process, illustrated in figure B-1.

Since the release of the online complaint form in December 2010, customer service representatives (CSRs) at 1-800-MEDICARE have been the first to review online complaints and are responsible for determining if a submission is an inquiry or a true complaint. True complaints are assigned a category and

FIGURE B-1. COMPLAINT TRACKING MODULE (CTM) PART D COMPLAINT PROCESS
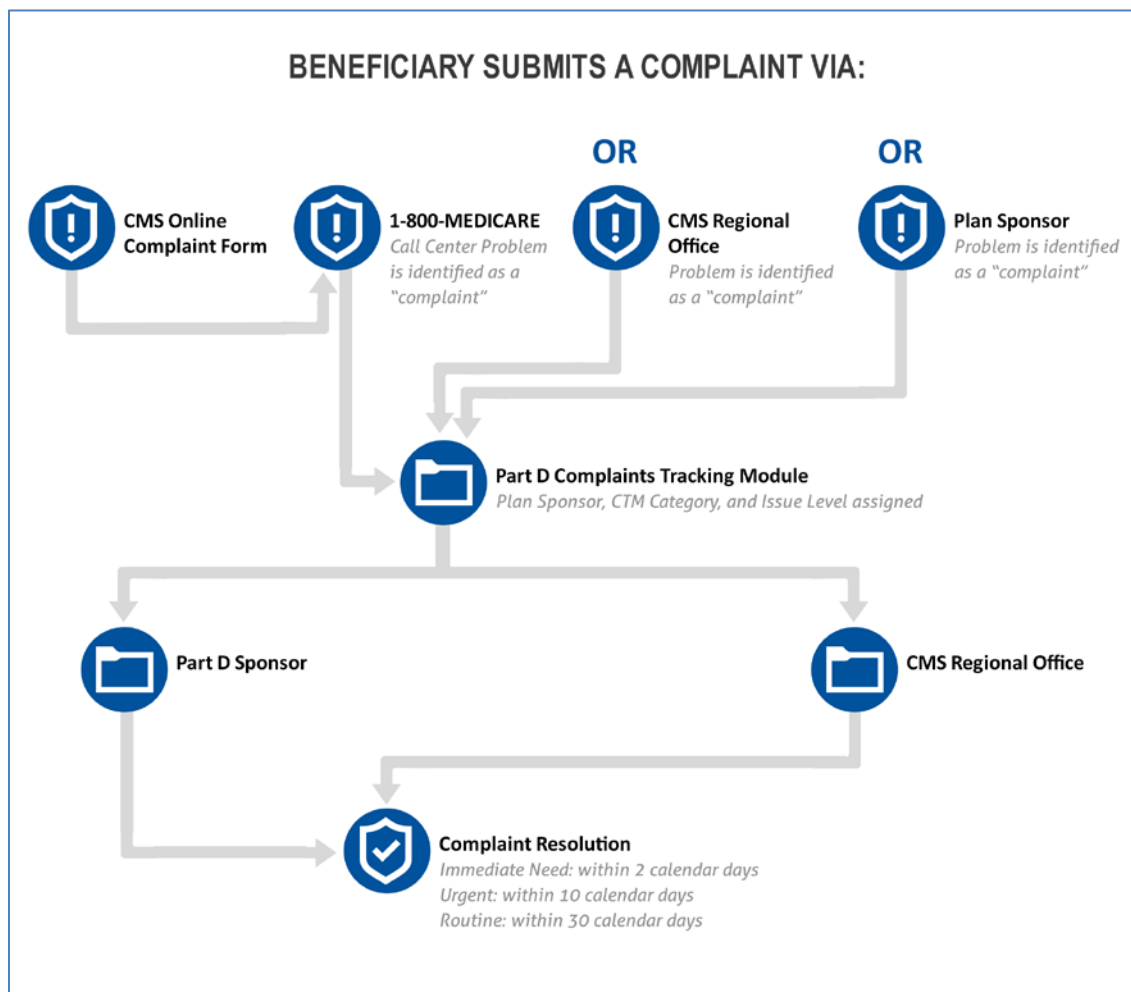
the data are loaded into CTM for casework and resolution (figure B-1). Part A and Part B fee-for-service (FFS) inquiries are also handled by 1-800-MEDICARE Customer Service Representatives (CSRs). CSRs have access to FFS claims systems and are able to respond to a majority of inquiries related to Part A and Part B. The call center escalates inquiries that 1-800-MEDICARE is not contractually able to handle (i.e. appeals determinations, check reissues, claims adjustments, Medicare Secondary Payer payment issues, etc.) to the appropriate Medicare Administrative Contractor (MAC). Less than 2 percent of the total 1-800-MEDICARE call volume is routed to MACs.

DATA ANALYSIS AND RESULTS

In fiscal year 2012, a total of 2,514 complaints were received via the online complaint form, a 32 percent increase from the previous year when 1,722 online complaints were submitted.

Considering that the online complaint form is widely accessible to all Medicare providers, beneficiaries, and their caregivers, various types of inquiries and complaints are received. Of the 2,514 total online submissions received, 862 (34 percent) were related to Parts A or B, and 479 (19 percent) were related to Parts C or D. The remaining 47 percent fell into the

"general" category, which includes complaints related to partner referrals, coordination of benefits, and general information about Medicare. Figure B-2 provides the number and percentage of overall CTM and online form complaints by category.

Of the 479 complaints related to Parts C and D that were submitted via the online form, 421 were determined to be true complaints and were, consequently, resolved by a CSR at the call center and entered into CTM. Figure B-3 shows the number of complaints submitted via the online form by month and

FIGURE B-2. ONLINE COMPLAINTS ENTERED INTO THE CTM: FY 2012

Complaint category	CTM complaints	Percent of overall CTM complaints	Online form complaints	Percent of overall online complaints
Acquiring Medicaid eligibility information	679	0.73%	0	0.00%
Benefits/access	7,954	8.55%	69	14.44%
Confidentiality/privacy	72	0.08%	1	0.21%
Contractor/partner performance	1,021	1.10%	5	1.05%
Coverage gap discount program	233	0.25%	1	0.21%
Customer service	4,751	5.11%	124	25.94%
Enrollment/disenrollment	29,795	32.04%	36	7.53%
Equitable relief/good cause requests	8,221	8.84%	1	0.21%
Exceptions/appeals/grievances	2,964	3.19%	85	17.78%
Marketing	10,128	10.89%	23	4.81%
Payment/claims	4,180	4.50%	7	1.46%
Plan administration	2,865	3.08%	21	4.39%
Pricing/premium/co-insurance	19,963	21.47%	105	21.97%
Program integrity issues/potential fraud, waste, or abuse	159	0.17%	0	0.00%
Grand total	**92,985**	**100.00%**	**479**	**100.00%**

FIGURE B-3. COMPLAINT CATEGORIES IN CTM: FY 2012

| Month and Year	Count
October 2011	30
November 2011	30
December 2011	29
January 2012	69
February 2012	58
March 2012	60
April 2012	47
May 2012	41
June 2012	43
July 2012	26
August 2012	22
September 2012	24
Grand Total	**479**

year. Approximately 26 percent of the online complaints recorded in CTM were related to problems with customer service, 22 percent were related to pricing issues such as co-pays and co-insurance, and about 18 percent were related to beneficiaries experiencing problems when trying to file an appeal/grievance or requesting a plan exception. The remaining 34 percent of the CTM complaints that came in via the online form were spread among the remaining complaint categories. The top three categories of complaints received directly by 1-800-MEDICARE were related to enrollment/disenrollment, pricing, and marketing. Figure B-4 compares the top three complaints by 1-800-MEDICARE to those received via the online form.

In addition to complaint categories, the CTM also contains information about the "issue level" of complaints (immediate need, urgent, routine), and the dates on which complaints were filed and resolved. The majority of online complaints were not related to beneficiaries at risk of running out of their medication and were, therefore, considered routine.

Based on initial review, CMS' implementation of an online complaint form enhanced complaint resolution for beneficiaries and CMS partners by improving the consistency, reliability, and usefulness of complaint information

FIGURE B-4. TOP THREE COMPLAINTS BY DATA SOURCE: FY 2012
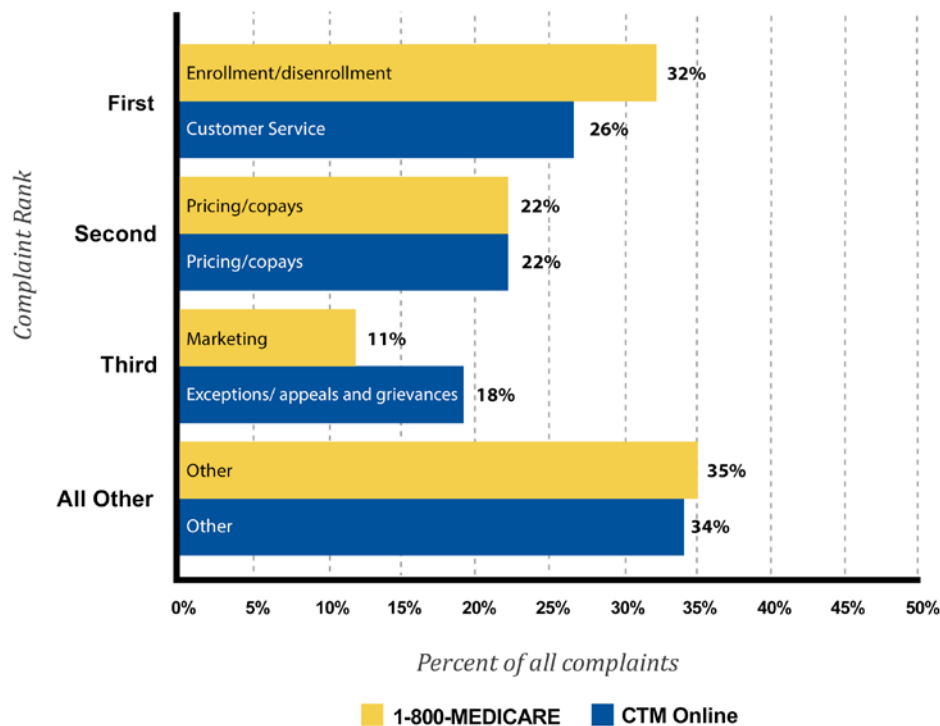
SOURCE: CTM
NOTE: FY 2012 is defined as October 1, 2011 - September 30, 2012.