

OFFICE OF THE MEDICARE OMBUDSMAN

Improving Medicare for Beneficiaries



2011 REPORT TO CONGRESS
Centers For Medicare & Medicaid Services





OFFICE OF THE MEDICARE OMBUDSMAN IMPROVING MEDICARE FOR BENEFICIARIES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

DANIEL J. SCHREINER
MEDICARE BENEFICIARY OMBUDSMAN

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List of Acronyms

Acronym	Term
AHA	American Hospital Association
ACO	Accountable Care Organization
CAO	Competitive Acquisition Ombudsman
CAP	Competitive Acquisition Program
CM	Center for Medicare
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
CPL	Conditional Payment Letter
CSR	Customer Service Representative
CTM	Complaint Tracking Module
CY	Calendar Year
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMOA	Division of Medicare Ombudsman Assistance
DOE	Division of Ombudsman Exceptions
DORTA	Division of Ombudsman Research and Trends Analysis
DRG	Diagnosis-Related Group
FFS	Fee-for-Service
FY	Fiscal Year
FOIA	Freedom of Information Act
GHP	Group Health Plan
HCPCS	Healthcare Common Procedure Coding System
HHS	U.S. Department of Health & Human Services
IRMAA	Income-Related Monthly Adjustment Amount
IVR	Interactive Voice Response (System)

Acronym	Term
MA	Medicare Advantage
MA-PD	Medicare Advantage-Prescription Drug (Plan)
MAC	Medicare Administrative Contractor
MAISTRO	Medicare Administrative Issue Tracker and Reporting of Operations (System)
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMCO	Medicare-Medicaid Coordination Office
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
NGHP	Non-Group Health Plan
OA	Office of Administrator
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OC	Office of Communications
OFM	Office of Financial Management
OIS	Office of Information Services
OMO	Office of the Medicare Ombudsman
PDP	Prescription Drug Plan
QC	Quarter of Coverage
QMB	Qualified Medicare Beneficiary
RAC	Recovery Audit Contractor
RO	Regional Office
SAD	Self-Administered Drug
SHIP	State Health Insurance Assistance Program
SME	Subject-Matter Expert
SNF	Skilled Nursing Facility
SSA	Social Security Administration

Message from the Medicare Beneficiary Ombudsman



I am pleased to present the 2011 Office of the Medicare Ombudsman's (OMO's) Annual Report, *Improving Medicare for Beneficiaries*, to Congress and to the Secretary of the U.S. Department of Health & Human Services. This report, which covers fiscal year (FY) 2011, is the OMO's primary opportunity to inform Congress and the Secretary of the OMO's activities, of systemic issues adversely affecting Medicare beneficiaries, and of recommendations for addressing these issues.

The passage of the Affordable Care Act set in motion a series of Medicare reforms intended to improve the quality of care beneficiaries receive while controlling costs. In a program as large and complex as Medicare, some beneficiaries may experience unforeseen gaps in service or other problems, particularly when program changes are being tested and implemented. For example, the Accountable Care Organization (ACO) initiative is designed to promote the development, testing, and implementation of ACOs for care delivery in the Medicare fee-for-service program. ACOs are new health service entities consisting of groups of providers (such as physicians and hospitals) who agree to work together to coordinate care for Medicare fee-for-service beneficiaries. ACOs will be held accountable for furnishing high quality care while also reducing growth in health care spending. To ensure that beneficiaries' access to care is not limited by the formation of ACOs, the Centers for Medicare & Medicaid Services (CMS) has incorporated several beneficiary protections into the design of the ACOs, described later in this report. While it is expected that Medicare beneficiaries will benefit from better-coordinated care as ACOs focus on quality, the OMO recognizes that if even a small number of beneficiaries encounter problems, the impact on their lives and on Medicare could be significant.

During the changes that lie ahead, Medicare beneficiaries can continue to rely on the OMO as their primary advocate within CMS. Established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the OMO strives to ensure that CMS places beneficiary issues and concerns at the forefront of its policy considerations. As with the MMA's introduction of Part D, the reform measures introduced in the Affordable Care Act will likely spur questions and concerns from beneficiaries and their caregivers. Protecting beneficiaries' access to Medicare-covered care and services will continue to be the OMO's paramount consideration as reform measures are designed and implemented.

Located within the Office of Public Engagement, with direct access to the CMS Administrator, the OMO is in a unique position to improve beneficiaries' experiences with Medicare. Although being housed within CMS presents challenges with maintaining independence, many of the improvements instituted by the OMO over the years have been possible precisely because the OMO has leveraged its position within CMS. Since its inception, the OMO has formed productive and trusting partnerships with other CMS components; a concrete outcome of these partnerships is the OMO's ability to release this annual report more quickly than in the past. Another concrete result of these productive partnerships is the implementation of several recommendations from past OMO reports, which might have been more difficult to implement had the recommendations come from an entity outside CMS. Additionally, the OMO has continued to improve its processes for responding to beneficiary inquiries, in part, by working more effectively with subject-matter experts within CMS. As a result, the OMO has responded to 99.5 percent of beneficiary inquiries within 30 business days of receipt in FY 2011.

In a seemingly ever-changing and dynamic health care landscape, the OMO will continue its work to improve Medicare for all beneficiaries.

Sincerely,



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

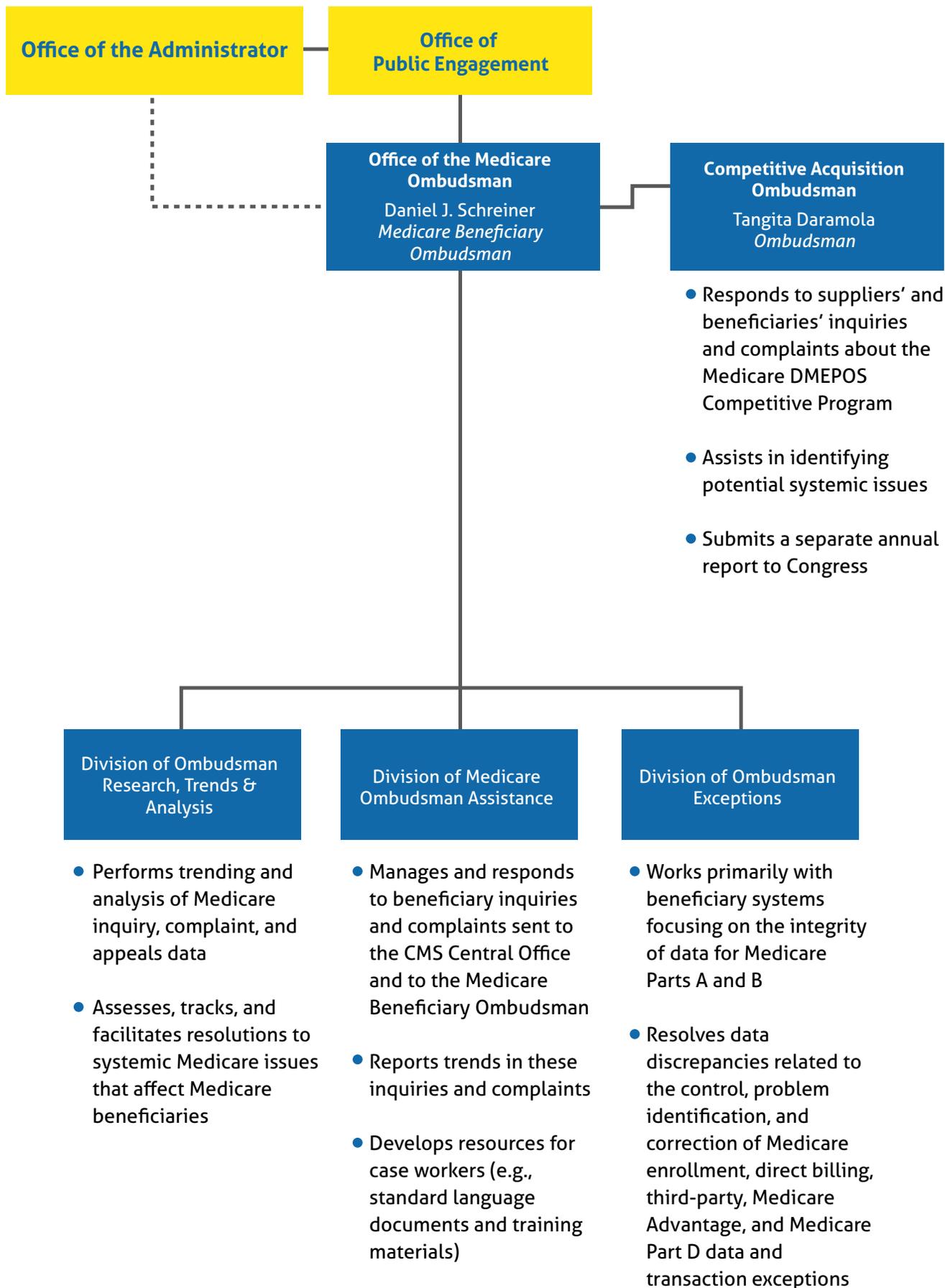
The Office of the Medicare Ombudsman (OMO) provides direct assistance to beneficiaries with their inquiries, complaints, grievances, and appeals. The OMO serves as a voice for beneficiaries by evaluating policies and procedures, identifying systemic issues, making recommendations to Congress and the 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 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 (DORTA). Both DOE and DMOA directly assist beneficiaries through casework. Additionally, DOE works on data transaction issues. DORTA focuses on data reporting and trending and casework collaboration, and it also conducts an Issues Management process, which identifies and addresses systemic problems affecting Medicare and its beneficiaries. The Competitive Acquisition Ombudsman (CAO), 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 CAO also assists the agency in identifying potential systemic issues and submits a separate annual report to Congress in coordination with the OMO's Report to Congress. The activities of each of the OMO's components are discussed in more detail in this report.





Medicare is entering a period of change intended to improve the effectiveness and efficiency of the program.

Executive Summary

With provisions of the Affordable Care Act starting to take effect, Medicare is entering a period of change intended to improve the effectiveness and efficiency of the program. Since Medicare is the largest health insurance program in the United States, these changes will touch millions of Americans who have a broad array of needs. Medicare beneficiaries include those aged 65 years and older, a growing number of whom are still working; those with limited resources; disabled persons; and those with end-stage renal disease. They have multiple coverage options, including enrolling in traditional Medicare or in a Medicare-contracted health care plan.

Given Medicare's size and complexity, it is almost inevitable that some beneficiaries will have problems accessing the benefits to which they are entitled. Some of the gaps between beneficiaries' coverage, care needs, and the benefits received occur because beneficiaries and their caregivers have difficulty accessing or understanding information about the programs through which they receive care. Other gaps can occur because of unintended errors in claims processing or program operations. The consequences for beneficiaries range from frustration on the part of beneficiaries and their families to impeded access to medical care.

This report describes the activities of the Office of the Medicare Ombudsman (OMO) and informs Congress and the Secretary of the U.S. Department of Health & Human Services of the OMO's efforts and recommendations for improving beneficiaries' experiences with Medicare. In 2011, the OMO completed three comprehensive studies designed to increase the organization's understanding of systemic beneficiary issues and to develop specific, actionable recommendations.

KEY ACCOMPLISHMENTS

The following points highlight some of the OMO's key accomplishments in casework, partnership initiatives, Issues Management, and comprehensive studies, the four basic approaches the OMO took in fiscal year (FY) 2011¹ to fulfill its mission:

Direct services to beneficiaries: The OMO's total casework volume was 26,832 cases in FY 2011. Of these cases, the OMO directly assisted with nearly 15,000 cases involving beneficiaries, their caregivers, and advocates. The remaining cases were handled by CMS Regional Offices.

Correction of erroneous Part A premium payments: Using case information provided by the Social Security Administration, the OMO's Division of Ombudsman Exceptions (DOE) oversaw the correction of 6,223 cases in which incorrect Part A premiums were collected. The majority of these cases (4,340) were corrected through system adjustments, and DOE directly processed the remaining 1,883 cases because of their complexity.

Casework response time: Despite a 17 percent increase in the number of inquiries received in FY 2011, the OMO's Division of Medicare Ombudsman Assistance (DMOA) responded to 99.5 percent of inquiries within 30 business days in FY 2011, compared with 93 percent in FY 2010.

National casework calls and caseworker training: In FY 2011, the OMO facilitated 18 National Casework Calls, six of which were devoted to Medicare Parts A and B topics and 12 of which were dedicated to Medicare Parts C and D topics. The OMO also facilitated 10 training sessions for caseworkers to enhance and expand their knowledge of a variety of Medicare topics. According to the survey responses of the trainees, the sessions increased the caseworkers' knowledge.

Comprehensive studies: Continuing its effort to conduct in-depth research on complex issues affecting Medicare beneficiaries, the OMO completed three comprehensive studies in FY 2011 and began working with CMS components to make changes based on the findings from these and previous studies.

The OMO facilitated 10 training sessions for caseworkers to enhance and expand their knowledge of a variety of Medicare topics.

AREAS FOR IMPROVING BENEFICIARIES' EXPERIENCES WITH MEDICARE

The OMO's 2011 comprehensive studies, which resulted in specific recommendations to CMS for improving Medicare, covered the following three topics:

- The Medicare Secondary Payer Recovery Contractor (MSPRC)
- Recovery Audit Contractors
- Observation Services

Medicare Secondary Payer Recovery Contractor

In situations in which Medicare provides secondary coverage for health care, conditional payments are sometimes made by Medicare on behalf of beneficiaries to pay for services that should have been covered by another payer: the primary payer. The process through which Medicare recovers these payments from beneficiaries is administered by the Centers for Medicare & Medicaid Services (CMS) through its Medicare Secondary Payer Recovery Contractor (MSPRC). Certain potential negative effects of this recovery process were first revealed through a comprehensive study on coordination of benefits that the OMO completed in FY 2010.

Medicare is the secondary payer when payment has been made, or can reasonably be expected to be made, for an item or service provided by a group health plan (GHP) or by non-group health plan (NGHP) payers, such as an automobile or liability insurance policy or plan (including self insurance), no-fault insurance, and workers'

¹ Fiscal year 2011 is defined as October 1, 2010 to September 30, 2011.

compensation. In a situation where a payment has not been made or cannot be expected to be made promptly to the provider (as defined by regulation) by the primary payer, Medicare may make a conditional payment to the provider for the items or services delivered to a beneficiary. Once there has been a settlement, judgment, award, or other payment to the beneficiary, Medicare has the right to recover from the beneficiary any conditional payment(s) that it made previously on the beneficiary's behalf. In practice, the many different scenarios through which conditional payments can be made and the fact that Medicare is the secondary payer for only those items or services related to the beneficiary's case add complexity to the payment recovery process. In addition, the process may be lengthy and may not always be transparent to beneficiaries.

The comprehensive study found that beneficiaries and their advocates have limited awareness and understanding of the Medicare Secondary Payer (MSP) recovery process. Furthermore, they have difficulty finding information about the MSP recovery process. The OMO's recommendations, summarized below and described in more detail later in this report, focus on ways to make information about the MSP recovery process more accessible to beneficiaries and their advocates:

- Educate advocates and other beneficiary representatives about the MSP process and the existing resources available on the MSPRC website.
- Revise communication materials to make them more beneficiary friendly.
- Provide a link between www.Medicare.gov (and www.MyMedicare.gov) and the MSPRC website/materials and enhance MSP content on both Medicare websites.
- Monitor MSPRC customer service representatives' performance and revisit training as needed.

Recovery Audit Contractors

Improper payments to Medicare providers for claims in FY 2011 cost taxpayers about \$28.8 billion.² Improper payments are overpayments or underpayments that result from insufficient or missing documentation, lack of medical necessity, incorrect coding, or other errors where

² U.S. Department of Health and Human Services. (2011). *FY2011 HHS Agency Financial Report*. Retrieved April 16, 2012, from <http://www.hhs.gov/afr/2011afr.pdf>



provider claims did not meet billing requirements. These improper payments are recovered through various types of post-payment processes and programs, including the Recovery Audit Contractor (RAC) program.

The auditing process conducted by RACs involves retroactive reviews (automated and manual) of complex health care records and claims histories to identify improper Medicare payments. Payments are then recovered from providers and restored to the Medicare Trust Funds, thereby enhancing the long-term solvency of the funds and of Medicare. While the auditing and recovery processes do not directly impact beneficiaries, they may affect provider practices and how some providers determine what services to offer to patients. For example, a provider who seeks to mitigate the risk of having a medical necessity audit may choose to provide services in a different manner, such as in an outpatient setting rather than in an inpatient setting. In turn, beneficiaries may not be fully aware of which services are covered under Medicare. As Medicare program integrity efforts intensify the focus on medical necessity, beneficiaries are likely to have increased exposure to Medicare coverage issues.

The following two recommendations resulted from the RAC comprehensive study:

- Incorporate considerations of provider behavioral responses and potential implications for beneficiaries into RAC program administration.

- Develop a longer term strategy for beneficiary educational resources related to Medicare’s coverage policy on medical necessity determinations.

Observation Services

For several years, the OMO has been aware of and concerned about the potential negative consequences to beneficiaries of using observation services for extended periods. Observation care is a hospital outpatient service covered by Medicare Part B. It includes short-term treatment, assessment, and reassessment by a physician while he or she is evaluating the need for an inpatient hospitalization or discharge of a beneficiary.

The frequency and length of hospital observation services rendered to Medicare beneficiaries have grown, raising concerns about the potential negative consequences to beneficiaries, including the non-coverage of skilled nursing facility (SNF) care and beneficiary-incurred costs for self-administered drugs (SADs). Because observation care is a Part B outpatient service, the time spent by a beneficiary in this care setting does not count toward the 3-day inpatient hospital “qualifying” stay statutorily required for the coverage of post-hospital SNF care. Beneficiaries who do not have a qualifying 3-day stay as a hospital inpatient are not eligible for Medicare coverage of post-hospital SNF care, regardless of the time spent receiving observation services as an outpatient.

Also, patients who are under observation care may incur costs that they would not incur if they were being treated in an inpatient setting. For example, SADs that the patient takes at home and that would be covered under Part A if dispensed to the beneficiary as an inpatient are not covered by Medicare Part B when dispensed to the beneficiary as a hospital outpatient. A beneficiary is billed by the hospital for these non-covered SADs, generally at a higher dollar amount than a retail pharmacy would charge. While a beneficiary may file a claim with his or her Part D plan to recoup some of the expenses incurred by purchasing the drug from an out-of-network hospital pharmacy, the beneficiary is still responsible for the difference between the hospital’s charges and the amount reimbursed by the Part D plan. Beneficiaries and physicians alike would benefit from a greater

For several years, the OMO has been aware of and concerned about the potential negative consequences to beneficiaries of using observation services for extended periods.

understanding of the appropriate use of observation services and the implications of longer and more frequent treatment in outpatient settings.

The study resulted in a number of recommendations, summarized here:

- 1 Review all policies related to the use of observation services that allow providers to change the status of a beneficiary from inpatient to outpatient and provisions concerning SADs.
- 2 Educate and inform beneficiaries and their families about the use of observation services and the ability of a provider to change a patient’s treatment status.
- 3 Educate physicians about justifying reasonable and necessary hospital admissions and on Medicare coverage of observation services and implications for beneficiaries.
- 4 If proper authority exists, consider requiring hospital utilization review for observation cases lasting 48 hours or more.



The OMO continues to be responsive to beneficiary needs through direct assistance with specific beneficiary inquiries.

Medicare Beneficiary Trends in Complaints and Inquiries

SECTION HIGHLIGHTS

The Affordable Care Act is ushering in a series of reforms designed to ensure the long-term solvency of Medicare while improving the quality of care that beneficiaries receive. Implementing these reforms has the potential to enhance the beneficiary experience in the long-term but may lead to questions and concerns for some.

The main points of this section are listed below:

- Changes to Medicare required by the Affordable Care Act may lead to an increase in beneficiary questions and concerns.
- The total number of Medicare beneficiaries is expected to grow rapidly, by 34 percent between 2010 and 2020, as a growing number of baby boomers reach the age of 65.
- Because of the complexity of the system, some beneficiaries need assistance to better understand Medicare processes and resolve their specific issues. This need may increase over the next few years as Medicare changes and grows.

The Office of the Medicare Ombudsman continues to be responsive to beneficiary needs through direct assistance with specific beneficiary inquiries and analysis of systemic problems identified through interaction with beneficiaries.

INTRODUCTION

With the passage of the Affordable Care Act, Medicare and its beneficiaries face a number of changes over the next several years. A number of provisions of the new healthcare law are designed to improve the quality of medical care provided to Medicare beneficiaries, to reform health delivery systems, to reduce growth in Medicare spending, and to fight fraud, waste, and abuse. These changes bring opportunities for higher quality and better coordinated care and reduced out-of-pocket expenditures for beneficiaries but also may increase impediments to that care. Some changes will affect the entire Medicare population, whereas others may affect only particular segments of the population.



To provide a context for the Office of the Medicare Ombudsman's (OMO's) work, this section describes the legislative and other measures that are bringing changes to Medicare and its beneficiaries and, therefore, to the OMO's work. The discussion then reviews key characteristics of the Medicare beneficiary population and describes their coverage options and the many entities through which those options are administered. This section concludes with a discussion of the trends in beneficiary complaints and inquiries from several Centers for Medicare & Medicaid Services (CMS) data sources.

MEDICARE: A PROGRAM IN TRANSITION

Since its creation in 1965, Medicare has undergone many changes designed to both expand its scope and strengthen its value for beneficiaries. The addition of prescription drug coverage (Part D) through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was, at the time, the most significant program improvement. It was also a challenging change that required targeted outreach to beneficiaries and their advocates. The introduction of Part D spurred the creation of the OMO, as Congress anticipated the need for additional support to handle and resolve beneficiary issues that may arise from the new program or other parts of Medicare. In fact, inquiries and complaints to Medicare increased significantly in the year Part D was implemented and remained high for the following 2 years.

Similarly, the implementation of Affordable Care Act provisions will drive Medicare's continued evolution and may present new challenges for beneficiaries and their caregivers. During the transition phase over the next several years, improved payment, delivery, and administrative systems will be tested and implemented with the goal of transforming Medicare into a high-value health care system that provides high-quality care while remaining solvent for generations to come. This transition has already begun. In fiscal year (FY) 2011, following the passage of the Affordable Care Act, CMS initiated a number of program changes to address the major areas of reform. For example, CMS has:

- *Finalized the rules for Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program.* ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated, high-quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding duplication of services and preventing medical errors. Under the Medicare Shared Savings Program, when an ACO succeeds in both meeting standards for high-quality care and controlling Medicare spending, it is eligible to share in the savings it achieves.

- Established the rules for the Hospital Readmission Reductions Program.* Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days. This translates to approximately 2.6 million seniors, at a cost of over \$26 billion every year.³ While some readmissions are necessary, many readmissions may be avoided through better preparation and education of patients moving from hospitals to other care settings. New Medicare programs, some of which are administered by CMS' Center for Medicare and Medicaid Innovation, are designed to make transitions between care environments smoother for patients and, through changes to payment systems, will reward hospitals that are successful in reducing avoidable readmissions.
- Modified payments to Medicare Advantage (MA) Plans.* As noted by the Medicare Payment Advisory Commission, the private insurance plans that serve Medicare beneficiaries, known as MA Plans or Part C, have been receiving payments for care that would be less costly under traditional Medicare (i.e., fee-for-service [FFS] or Parts A and B).⁴ Modifications will be made to MA Plan payments to better align them with costs under traditional Medicare. In addition, beginning in 2012, high-performing MA Plans qualify for payment bonuses, providing an incentive to provide high-quality care to Medicare beneficiaries.
- Expanded the Medicare Strike Force.* Created in 2007, this joint venture between the U.S. Department of Health & Human Services and the Department of Justice seeks to identify and prosecute health care entities that do not provide legitimate health care services and defraud Medicare and other government health programs. The strike force has recently been expanded to nine cities across the nation and could be expanded further if additional funding is available.

As CMS continues to test and implement changes like the ones described above in a program as large and complex as Medicare, unforeseen gaps in service or other problems are bound to arise. Recognizing the possibility of such

³ Partnerships for Patients: Better Care, Lower Costs. Retrieved April 24, 2012, from <http://www.healthcare.gov/compare/partnership-for-patients>.

⁴ Medicare Payment Advisory Commission. (2011, June). *A Data Book: Health Care Spending and the Medicare Program* (see Chart 9-6). Retrieved December 10, 2011, from <http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf>.

Over the next several years, the Medicare population is expected to grow rapidly, by 34 percent between 2010 and 2020, as a growing number of baby boomers reach the age of 65.

unintended negative consequences, the OMO continually identifies risks to which Medicare beneficiaries may be susceptible and seeks to mitigate them through comprehensive research and partnership initiatives with other components of CMS.

One of the topics that the OMO studied in 2011 illustrates some of these risks. The first concerns the Recovery Audit Contractor (RAC) program, through which third-party contractors retroactively review complex medical claims records to identify payments that were improperly billed to Medicare. A key objective of the RAC program is to decrease improper claims and, thus, decrease payments by Medicare. Some providers, however, may change their care classification in anticipation of denials of payment due to RAC audits. For example, hospitals may become increasingly risk averse and conform to a stricter interpretation of Medicare coverage policy when deciding whether it is medically necessary to admit a patient. This type of risk, which affects care setting decisions and has financial implications related to Medicare coverage for services, spurred the OMO to examine, in two separate in-depth studies, the indirect effects on beneficiaries that can be attributed to RACs and the direct consequences to beneficiaries of using outpatient observation services for extended periods of time.

The OMO also works in partnership with CMS components to identify potential program risks and address them proactively. For example, the OMO initially identified ACOs as a potential area of concern for beneficiaries. Advocates have raised questions about how ACOs will



be established and how patients' access to care will be protected.⁵ In anticipation of these types of concerns, CMS has built several beneficiary protections into the program. For instance, the rules require providers to notify their patients of their participation in an ACO and include protections to ensure that ACOs do not limit patients' care choices. Additionally, CMS measures an ACO's performance on quality across four domains of care and may terminate its agreement with an ACO in cases when the ACO does not accept high-risk beneficiaries and/or fails to meet the performance standards outlined in the rules.⁶ CMS has developed initiatives to educate beneficiaries about the full range of care options available to them and the potential benefits of ACOs.

⁵ Families USA. (2011, September). *A Closer Look at ACOs: Making the Most of Accountable Care Organizations: What Advocates Need to Know*. Retrieved February 8, 2012, from <http://familiesusa2.org/assets/pdfs/health-reform/ACO-Basics.pdf>.

⁶ Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Final Rule. (2011, November 2) *Federal Register*. (76).212: 67802-67990. Retrieved February 20, 2012, from <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>.

After a review of the CMS ACO materials and a discussion with CMS components, the OMO determined that the safeguards intended to protect beneficiaries' access to care appear to be sound. Nonetheless, the OMO intends to monitor the implementation of ACOs, as some beneficiaries may have questions and concerns as the ACOs are established.

MEDICARE: DIVERSE POPULATION WITH VARIED NEEDS

Over the next several years, the Medicare population is expected to grow rapidly, by 34 percent between 2010 and 2020, as a growing number of baby boomers reach the age of 65.⁷ With that growth will come more individuals over the age of 65 who are still in the labor force and may be receiving health care benefits from another source in addition to Medicare. This increasingly common situation highlights the importance of efficient coordination of benefits (COB) between the two sources of benefits, which has been the focus of OMO research in the past.

Another growing segment of the Medicare population that has received much attention in research and policy circles is the Medicare-Medicaid enrollee population: individuals who are enrolled in both Medicare and Medicaid. In 2008, there were over 9 million individuals enrolled in both programs. These Medicare-Medicaid enrollees, previously referred to as "dual eligibles," are among the most chronically ill in both programs and often have multiple chronic conditions and/or long-term care needs, but they also have the lowest incomes. As a result, the costs associated with serving them are disproportionately high.

While the costs of serving a population with these characteristics are high, better coordination between Medicare and Medicaid could improve the cost effectiveness of care for Medicare-Medicaid enrollees and improve their experience. The new Medicare-Medicaid Coordination Office (MMCO), created by the Affordable Care Act, seeks to integrate benefits more effectively under Medicare and Medicaid and improve coordination between CMS and the states to ensure that

⁷ 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. (2011, May). Retrieved February 8, 2012, from <https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>.

Medicare-Medicaid enrollees have full access to the services to which they are entitled in both programs and to ensure they are receiving seamless, high-quality care. Capitalizing on its unique position within CMS, the OMO is communicating with MMCO to determine how the OMO can best support its efforts.

For example, the OMO and MMCO partnered with the Center for Medicaid and CHIP Services in developing an informational bulletin to be distributed to the states. This informational bulletin referred to the regulations and statutes regarding balance billing for services provided to Medicare-Medicaid enrollees who are Qualified Medicare Beneficiaries through the Medicare Savings Program and who receive cost-sharing assistance with their Medicare premiums, deductibles, and copayments. The OMO has also initiated a joint effort with the MMCO to examine how to improve communication with the approximately 100,000 new Medicare-Medicaid enrollees that enter the system each month.

MEDICARE COVERAGE OPTIONS AND ADMINISTRATION

With nearly 49 million beneficiaries, Medicare is the largest health insurance program in the United States, serving individuals who are 65 years and older, as well as disabled persons and those with end-stage renal disease who are under the age of 65. Medicare offers multiple coverage options to meet the varied needs of its beneficiaries. Most people age 65 or older are eligible for Part A, hospital insurance, and may choose to enroll in Part B for medical insurance or Part C (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 (PDP) or through an MA Plan that includes prescription drug coverage. Parts C and D coverage is provided through private insurance companies that contract with Medicare.

Traditional Medicare (Parts A and B) accounts for the bulk of Medicare beneficiaries, while Part C (MA Plans) accounts for 25 percent of the Medicare population, or

Beneficiaries can now submit complaints through an online system that was launched in December 2010.

12.4 million beneficiaries.⁸ Enrollment in Part C (MA Plans) has increased substantially in recent years but is expected to decline after 2012, both in number and as a percent of total beneficiaries. The reason for the decline is the Affordable Care Act's reduction of Medicare payments to private plans, which is expected to result in less generous plan benefit packages and/or higher premiums. Thus, enrollment in these plans is expected to decline between now and 2017, when these changes are fully phased in.

With its size, the diversity of its programs, and the variety of beneficiaries it serves, Medicare is administratively complex. This administrative complexity results in a web of interactions among health care providers, Medicare beneficiaries, their family members and caregivers, and CMS-contracted entities that help to administer Medicare. The following figure (figure 1) lists examples of these many entities.

MEDICARE BENEFICIARIES' INFORMATION SOURCES AND INQUIRIES

Medicare beneficiaries have access to a variety of information sources, such as www.Medicare.gov and www.MyMedicare.gov, which are designed to handle the most common questions about Medicare. Of course, beneficiaries often have questions about their particular situations and, in those cases, need direct assistance from CMS staff and contracted entities. The entities that provide assistance, described in figure 1, consist of CMS entities and components, such as 1-800-MEDICARE (national call center), the CMS Central Office (CO), Regional Offices (ROs), the Coordination of Benefits Contractor (COBC), the Medicare Secondary Payer Recover Contractor, State

⁸ Projected 2011 Part C enrollment from *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. (2011, May). Retrieved February 8, 2012, from <https://www.cms.gov/Report-TrustFunds/downloads/tr2011.pdf>.

Health Insurance Assistance Programs (SHIPs), private health plans, and private Medicare contractors.

In addition to these contact sources for inquiries and grievances, beneficiaries can now submit complaints through an online system that was launched in December 2010. The new electronic complaint form is accessible from the www.Medicare.gov homepage and the Medicare Plan Finder page. The Affordable Care Act required Part C and Part D plan sponsors to feature the complaint form on their websites beginning in January 2012.

Once beneficiaries interact with representatives at these entities and describe their needs, their inquiries are tracked in one of several database systems, depending on the nature of their inquiries. Given the number of entities that handle beneficiary inquiries and the number of systems used to track those inquiries, the likelihood of beneficiaries receiving inconsistent or incomplete information is high. The OMO works with all these entities to improve consistency and responsiveness to inquiries from Medicare beneficiaries.

Figure 1. Entities that administer Medicare

Entity	Role and description
Provide assistance to beneficiaries	
Centers for Medicare & Medicaid Services (CMS) Central Office and Regional Offices 1-800-MEDICARE	Provide assistance, outreach, and education to Medicare beneficiaries and other stakeholders (and administer Medicare) Provides 24-hour, 7-days-a-week assistance to English- and non-English-speaking callers with Medicare-related inquiries
State Health Insurance Assistance Programs	Offer counseling and assistance to Medicare beneficiaries on a wide range of Medicare, Medicaid, and Medigap issues
Coordination of Benefits Contractor	Consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries
Administer Medicare benefits	
Medicare Advantage (MA) Plans	Private companies approved by Medicare that provide beneficiaries with all of their Part A (hospital insurance) and Part B (medical insurance) coverage
MA Prescription Drug Plans	MA plans offering prescription drug coverage
Prescription Drug Plans	Private companies approved by Medicare that provide beneficiaries with prescription drug coverage
Process and audit claims	
Medicare Administrative Contractors	Administer Parts A and B claims for CMS
Recovery Audit Contractors	Identify improper Medicare payments, including both underpayments and overpayments
Process appeals	
Qualified Independent Contractors	Conduct second-level appeals for denial of service or service payment for Medicare Parts A and B
Independent review entities	Conduct second-level appeals for denial of service or service payment for Medicare Parts C and D
Ensure the quality and integrity of the Medicare program	
Medicare Secondary Payer Recovery Contractor	Recovers payments Medicare made when another entity had primary payment responsibility
Program Safeguard Contractors/Zone Program Integrity Contractors (ZPICs)	Promote the integrity of Medicare by helping CMS strengthen its ability to deter fraud and abuse
Quality Improvement Organizations	Monitor the appropriateness, effectiveness, and quality of care provided to Medicare beneficiaries

TRACKING AND ANALYZING BENEFICIARY CONTACTS

The OMO reviews and analyzes data from a variety of sources to assist in identifying potential systemic beneficiary issues and to validate issues that have already been identified through the Issues Management process or by external partners. Information about the number and types of contacts from 1-800-MEDICARE, the Medicare Administrative Issue Tracker and Reporting of Operations (MAISTRO) System, the Complaint Tracking Module (CTM), and SHIPs is presented in this subsection. It should be noted that these systems were designed around business needs and operating purposes; consequently, they measure workloads, such as the number of contacts, and not necessarily the precise reasons for beneficiary contact. Because of the aggregate nature of these data, they cannot always be used exclusively to identify the exact root causes of beneficiary issues or to assess the effectiveness of the OMO's or CMS' interventions to mitigate or address issues. Consequently, the OMO does not rely solely on these data to assess beneficiary issues

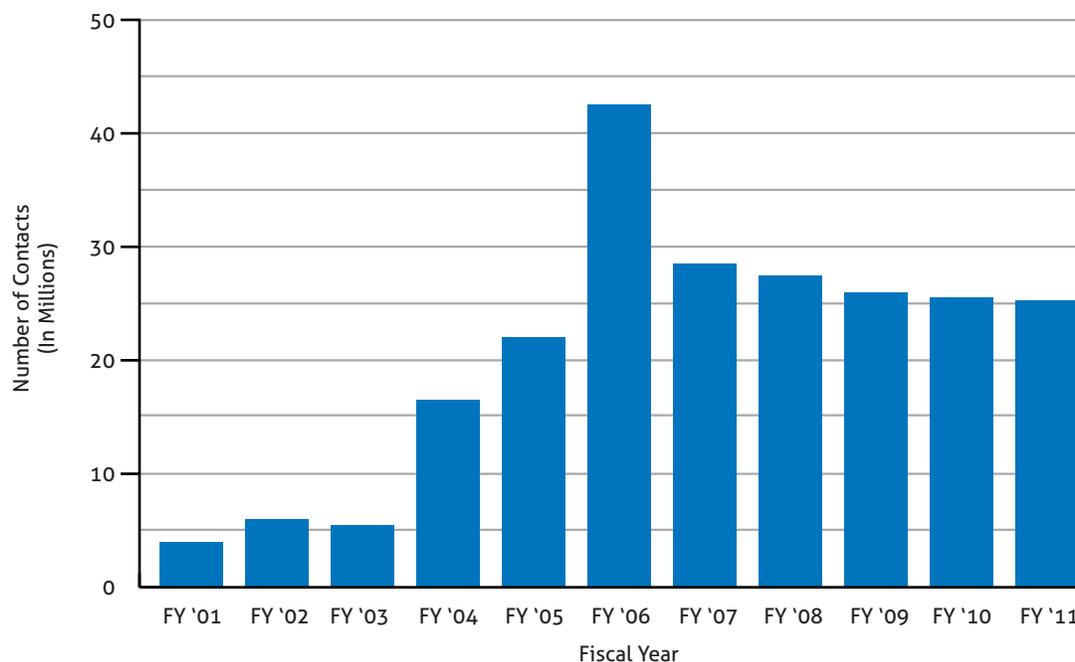
and develop recommendations. Instead, it engages in a wide range of activities, discussed later in this report, to identify systemic beneficiary issues and develop recommendations for addressing them.

Beneficiary Contacts to 1-800-MEDICARE

Medicare beneficiaries, their families, and other members of the public most often contact the 1-800-MEDICARE helpline as a first resource to find answers to their Medicare benefit inquiries. The helpline operates 24 hours a day, 7 days a week and provides assistance to English-speaking and non-English-speaking callers. CMS implemented this nationwide toll-free telephone helpline in 1999 to help beneficiaries obtain information about traditional Medicare and Medicare's managed care program. In FY 2011, 25.3 million contacts were made to the helpline, compared with 25.6 million in FY 2010 and 25.9 million in FY 2009 (see figure 2). It is anticipated that call volume will increase over the next few years as more baby boomers become eligible for Medicare.

When people call 1-800-MEDICARE, they first receive assistance from an automated interactive voice response

Figure 2. Total number of contacts received by 1-800-MEDICARE, FYs 2001-2011



SOURCE: 1-800-MEDICARE National Data Warehouse

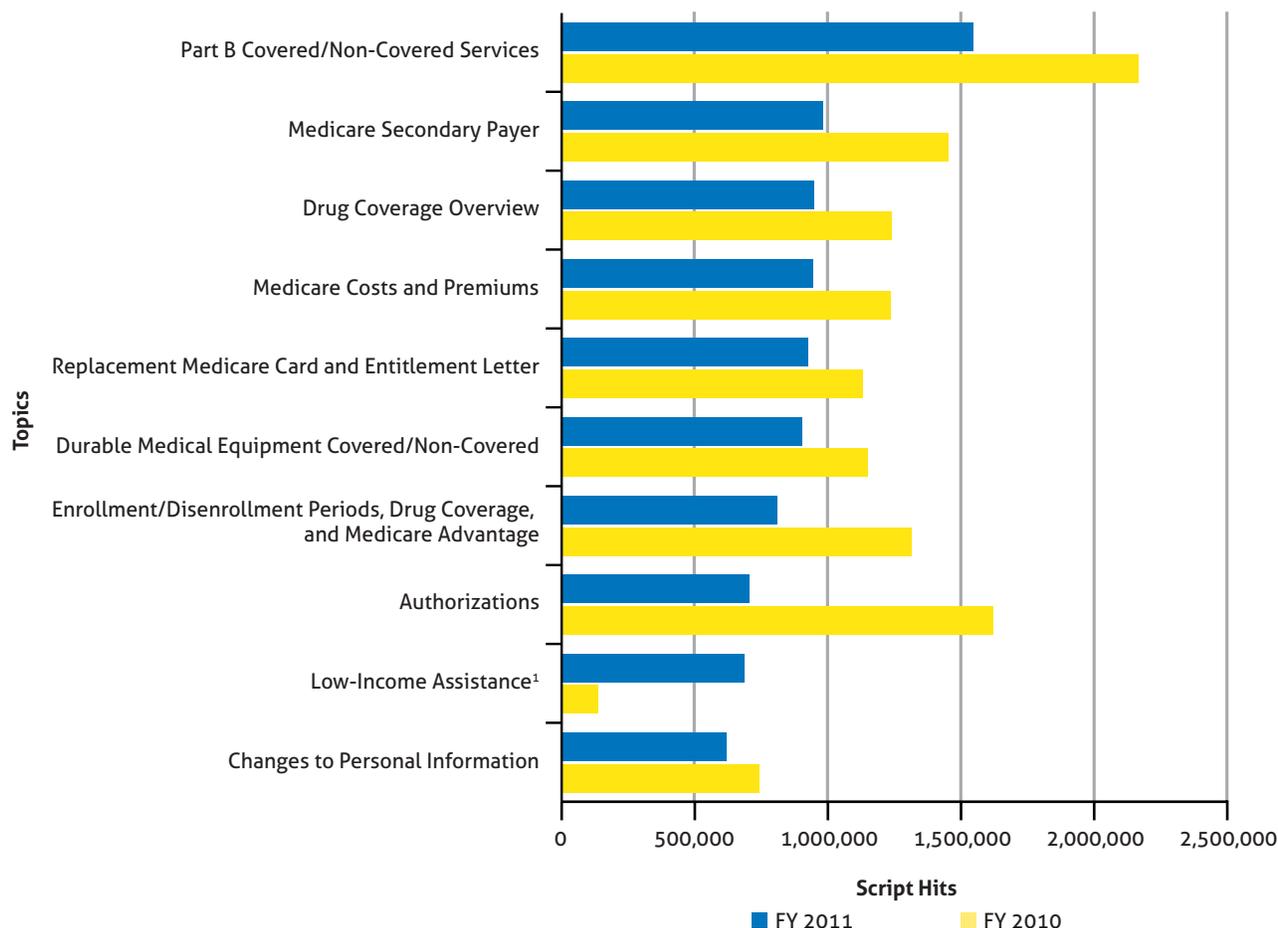
(IVR) system. If the IVR system cannot address the caller’s inquiry or if the caller requests to speak with a person, the IVR system transfers the call to a customer service representative (CSR). The calls transferred to CSRs are classified as one of two primary types of inquiries:

- General Medicare issues, such as general inquiries about Part D coverage or beneficiary address changes.
- Specific inquiries about Medicare Parts A and B claims.

To provide assistance with these two types of beneficiary inquiries, CSRs access defined scripts based on keywords related to the issue the caller describes. The CSRs may log multiple reasons for each call. Figure 3 provides the

top ten scripts accessed by CSRs in FY 2011 as well as the number of hits for the same category of scripts in FY 2010. Between FY 2010 and FY 2011, the total number of script hits declined from 25.6 million to 19.1 million, a 34-percent decrease. The top 10 scripts accounted for nearly half (47.5 percent) of all script hits in 2011. Two of the top three script hits in 2011 were the same as in 2010: Part B-covered/non-covered services and Medicare secondary payer (MSP) issues. Issues related to Part B coverage of services received 1.5 million script hits in 2011, compared with 2.2 million script hits in 2010 (see figure 3). With 44.6 million beneficiaries enrolled in Medicare Part B in FY 2011, it is not surprising that this category continues to be the top category.

Figure 3. 1-800-MEDICARE script hits for FY 2011 and FY 2010



SOURCE: 1-800-MEDICARE National Data Warehouse

¹ The low-income assistance script was introduced in July 2010.

All but one of the top ten categories of contacts remained the same from FY 2010 to FY 2011. Referrals to the Social Security Administration appeared in the top ten in FY 2010 but not in FY 2011, while low-income assistance, a script that was introduced in July 2010, appears in the top ten in FY 2011, but not, understandably, in FY 2010. In FY 2010, authorization issues appeared among the top three scripts, at 1.6 million, which was a significant increase over FY 2009 (769,000). In FY 2011, contacts related to authorizations dropped to 703,422. CSRs use the authorization scripts to give permission for someone else (that is, a representative payee) to speak on behalf of a Medicare beneficiary. The temporary increase in authorization script hits in 2010 may be attributable to public outreach regarding long-term care, which heightened awareness at that time. An analysis of calls for which the CSRs used the authorization script did not reveal a specific reason for the spike in authorization scripts in FY 2010.

The OMO continually works in partnership with other CMS entities to improve the scripts that are used to serve customers. For example, scripts are sometimes consolidated to improve call flow and handle time. Thus, the gradual decline in the number of contacts to 1-800-MEDICARE and the decline in the number of scripts may be explained by the continual focus on these inquiries.

Beneficiary Contacts in the Complaint Tracking Module and Medicare Administrative Issue Tracker and Reporting of Operations System

CMS tracks complaints and complex inquiries from calls to 1-800-MEDICARE or contacts to the CMS CO and ROs in two different systems. Beginning in December 2008, the MAISTRO System started to be used to collect and maintain complaints and complex inquiries related to FFS Medicare (that is, Medicare Parts A and B) that come directly to and are managed by CMS staff. CTM registers and categorizes complaints related to Medicare Parts C and D that are logged by 1-800-MEDICARE and CMS staff. Both of these systems serve as vital tools for tracking and trending beneficiary complaints about all parts of Medicare.

In 2011, nearly 49,000 complex inquiries and complaints related to FFS Medicare were captured in the MAISTRO System, up from 42,321 in 2010. Coverage and payment policies and premiums were again among the top three Parts A and B complaints, as they were in 2010. However, in 2011, the top complaint category was special initiatives/other, with 9,303 inquiries, up from 4,425 in 2010 (an increase of 110 percent). Of the numerous topics included in this category, Freedom of Information Act (FOIA) requests appear to be responsible for the large growth in inquiries, with an increase of 4,435 FOIA-related inquiries from 2010 to 2011.

CTM recorded a total of 101,614 complaints in FY 2011: 45,463 Part C-related complaints and 56,151 Part D-related complaints. The number of CTM complaints received in FY 2011 was 26 percent lower compared to complaints received in FY 2010 (137,404), continuing its decline from FY 2009 (235,630). In FY 2011, there were 32 percent fewer Part C-related complaints and 20 percent fewer Part D-related complaints compared with the previous year. Despite increases in enrollment in both Parts C and D over the time period, CTM volume could have decreased as a result of greater beneficiary and partner awareness of the programs, increased plan accountability in resolving issues, and improvements in CMS systems, such as the system through which CMS exchanges data with MA Plans.

The top three reasons for complaints related to both Parts C and D in FY 2011 remained unchanged from FY 2010 and FY 2009. Across both Parts C and D, the top complaints concerned issues related to enrollment and disenrollment, with 22,301 and 21,667 complaints, respectively. Some of the other reasons for Part C-related complaints included marketing, premium pricing and coinsurance, and benefits access. The reasons for Part D-related complaints were similar, although there were far more complaints related to premium pricing and coinsurance: for this category, there were 17,246 Part D complaints, compared to 5,285 complaints for Part C. The high number of Part D complaints reflects the larger number of beneficiaries enrolled in Part D than in Part C.

BENEFICIARY CONTACTS RECEIVED THROUGH THE NEW ONLINE COMPLAINT FORM

Following a mandate in the Affordable Care Act, CMS established an online complaint form in December 2010, which is featured on:

- The www.Medicare.gov homepage
- The Medicare Plan Finder page

As of August 30, 2011, a total of 1,722 complaints were received via the online complaint form. Because the online complaint form is widely accessible to all Medicare providers, beneficiaries, and their caregivers, all types of inquiries and complaints are received. Of the 1,722 total inquiries and complaints, 49 percent were related to Parts A or B, and 51 percent were related to Parts C or D.

Of the 860 inquiries and complaints related to Parts C or D, 618 were informational inquiries that were resolved by customer service representatives at the 1-800-MEDICARE call center. Another 242 were determined to be related to Parts C or D and requiring action, and, thus, were entered into CTM. Approximately 28 percent of the online CTM inquiries and complaints were related to pricing issues such as copayment and coinsurance, 20 percent were related to problems with customer service, and about 16 percent were related to beneficiaries experiencing problems when trying to enroll in or disenroll from a plan. The remaining 36 percent of the online CTM inquiries and complaints were spread among the remaining categories.

Although the top three online complaint categories were pricing, customer service, and enrollment/disenrollment issues, the top three complaint categories received directly by 1-800-MEDICARE were enrollment/disenrollment, pricing, and marketing. In addition to complaint categories, CTM also contains information on the “issue level” of complaints (immediate need, urgent, and routine) and the dates on which complaints were filed and resolved. Most online inquiries/complaints were not related to beneficiaries at risk of running out of their medication and were, therefore, considered routine.

SHIPs now offer counseling and assistance to Medicare beneficiaries on a wide range of Medicare, Medicaid, and Medigap issues.

Beneficiary Contacts to the State Health Insurance Assistance Programs

In addition to contacting 1-800-MEDICARE and the CMS CO and ROs, Medicare beneficiaries and their families can seek assistance from the SHIPs. The state-based program was established by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). This Act authorized CMS to give grants to states to provide information, counseling, and assistance to help Medicare beneficiaries obtain adequate and appropriate health insurance coverage. SHIPs have accomplished this through one-on-one counseling, public education presentations and programs, and media activities. Since its inception, the program has expanded greatly by building the SHIP network nationwide to include over 1,300 local sponsoring organizations with over 12,000 counselors, who are mostly volunteers.

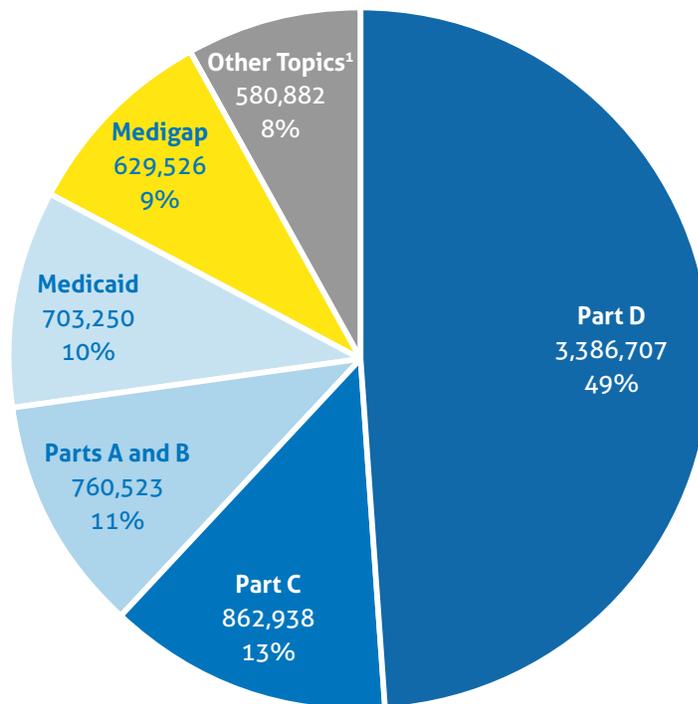
Originally, SHIPs focused on helping beneficiaries understand the reforms to Medigap (Medicare supplement insurance) made by OBRA 90. However, SHIPs now offer counseling and assistance to Medicare beneficiaries on a wide range of Medicare, Medicaid, and Medigap issues, including enrollment in Medicare PDPs, MA options, long-term care insurance, and claims and billing problem resolution. In FY 2011, SHIP staff and volunteers responded to about two million contacts from Medicare beneficiaries, their families, and their caregivers, roughly the same amount as in FY 2010. The total number of reasons for contact amounted to a little under seven million, or about 3.4 reasons per contact, indicating that beneficiaries often seek assistance from the SHIPs for multiple reasons.

As in 2010, topics related to Part D presented the most frequent reason for contact in 2011, accounting for over 3 million reasons for contact (49 percent of all reasons; see figure 4). The reasons for Part D contact most often included issues related to plan eligibility and benefit comparisons, low-income subsidy eligibility, and enrollment and application assistance.

Inquiries related to Medicaid, Medicare Part C, and Medicare Parts A and B accounted for over one-third (34 percent) of all reasons for contact in 2011. Medigap-related reasons represented 9 percent of all contacts, with a combination of all other topics⁹ accounting for the remaining 8 percent.

⁹ "Other topics" include long-term care, fraud and abuse, military benefits, employer health plans or the Federal Employee Health Benefits Program, and Consolidated Omnibus Budget Reconciliation Act (COBRA).

Figure 4. SHIP reasons for beneficiary contact, FY 2011



SOURCE: SHIP National Performance Report



The OMO improves beneficiaries' experiences with Medicare by using several complementary strategies.

How the OMO Identifies and Manages Beneficiary Issues

SECTION HIGHLIGHTS

The Office of the Medicare Ombudsman (OMO) tries to improve beneficiaries' experiences with Medicare by using several complementary strategies, including:

- Providing direct assistance to beneficiaries with their inquiries, grievances, and complaints.
- Identifying systemic beneficiary issues through collaborations with external organizations (e.g., advocacy groups).
- Developing comprehensive studies to identify the root causes of beneficiary issues and then providing actionable recommendations to the Centers for Medicare & Medicaid Services (CMS).
- Collaborating with other CMS components to address beneficiary issues.

The OMO also continues to serve as an active customer service partner by working with CMS components and Regional Offices to provide more efficient and effective customer service to beneficiaries.

INTRODUCTION

The Office of the Medicare Ombudsman (OMO) strives to ensure that beneficiaries have access to the health care and coverage to which they are entitled. The OMO carries out its mission by providing direct assistance to beneficiaries with their inquiries, grievances, and complaints and by collaborating with other Centers for Medicare & Medicaid Services (CMS) components and advocacy groups to identify and address systemic issues that affect Medicare beneficiaries. Since its establishment in 2005, the OMO has been part of CMS. The OMO currently reports directly to the Office of Public Engagement with direct access to the CMS Administrator.

Although being positioned within CMS creates challenges in maintaining an appropriate level of independence, it also allows the OMO to leverage its close association with other CMS components to enhance its advocacy for Medicare beneficiaries. For example, the OMO has access to subject-matter experts (SMEs) and can participate in internal CMS discussions on the implementation of new policies and regulations. The OMO's level of access to experts and decision makers within CMS is not typical in most relationships between an ombudsman and the entity it is critically reviewing.

The OMO has established a set of core activities that, in part, build on its unique position and enhance its ability to carry out its mission:

- **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 and CMS Central Office's (CO's) and Regional Offices' (ROs') caseworkers to provide more effective and efficient customer service to beneficiaries.
- **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 recommendations are presented to CMS Leadership in the OMO's Quarterly Issue Reports.

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 an advocate 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 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.



- **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.

In 2011, the OMO also placed great emphasis on collaborating with various CMS stakeholders and CMS Leadership to validate the feasibility of the recommendations stemming from its comprehensive studies and to begin implementing them. In addition to carrying out these activities, in the past year, the OMO broadened its partnership initiatives with CMS components by initiating a new effort aimed at proactively identifying beneficiary issues as new policies and regulations are implemented. The OMO will continue to build on these activities and efforts during 2012, as it continually looks for ways to improve beneficiaries' experience with Medicare. The following subsections provide a more detailed overview and specific examples that illustrate how the OMO assisted beneficiaries and their caregivers in 2011.

CASEWORK

Most beneficiaries have no problems accessing the benefits to which they are entitled; however, when issues arise, OMO's caseworkers can provide direct assistance to

beneficiaries with their inquiries, complaints, grievances, and appeals.

Volume of Direct Services to Beneficiaries

Throughout the year, CMS' CO receives inquiries and complaints via telephone, mail, and email. These contacts come not only from beneficiaries and their families, caregivers, and advocates, but also from legislators. The OMO's Division of Medicare Ombudsman Assistance (DMOA) and Division of Ombudsman Exceptions (DOE) share responsibility for handling these cases. Although both divisions provide direct assistance with beneficiary inquiries sent to CMS' CO, DOE also works to resolve data system anomalies and errors.

DMOA Casework

Following a decline from 32,019 cases in FY 2008 to 22,949 cases in FY 2010, DMOA's casework volume increased by 17 percent to 26,832 cases in FY 2011. The trend of decreasing inquiries between FY 2008 and FY 2010 was likely due to the maturation of Medicare Part D, as beneficiaries became more comfortable with the program. The increase in casework volume over the past year could be attributed to the implementation of some of the Affordable Care Act's provisions, such as the Part D income-related monthly adjustment amount (IRMAA) and the Part D beneficiary drug rebate. Of the total number of complaints and inquiries DMOA received in FY 2011, 11,908 (44 percent) were referred to the ROs (see figure 5).

DMOA applies several criteria when deciding whether a case should be referred to an RO or whether it should be handled in CMS' CO. In general, inquiries consisting of postal mail from the general public and previous RO casework are referred to the ROs. The CO responds to inquiries if they fall into one of the following categories: priority mail, email, telephone calls, inquiries addressed to the Medicare Beneficiary Ombudsman, dire-need inquiries, foreign language correspondence, and inquiries from high-priority sources, such as Congress.

As part of its collaboration efforts with the CMS ROs in 2011, the OMO visited several CMS ROs to gain a better understanding of how they manage Medicare Parts C and D casework. During these visits, the OMO identified a

number of common casework practices it shares with the ROs, such as:

- Reporting and managing casework resolution timeliness.
- Prioritizing dire and urgent-need casework.
- Conducting quality analysis for accuracy and completeness of responses to beneficiary inquiries.

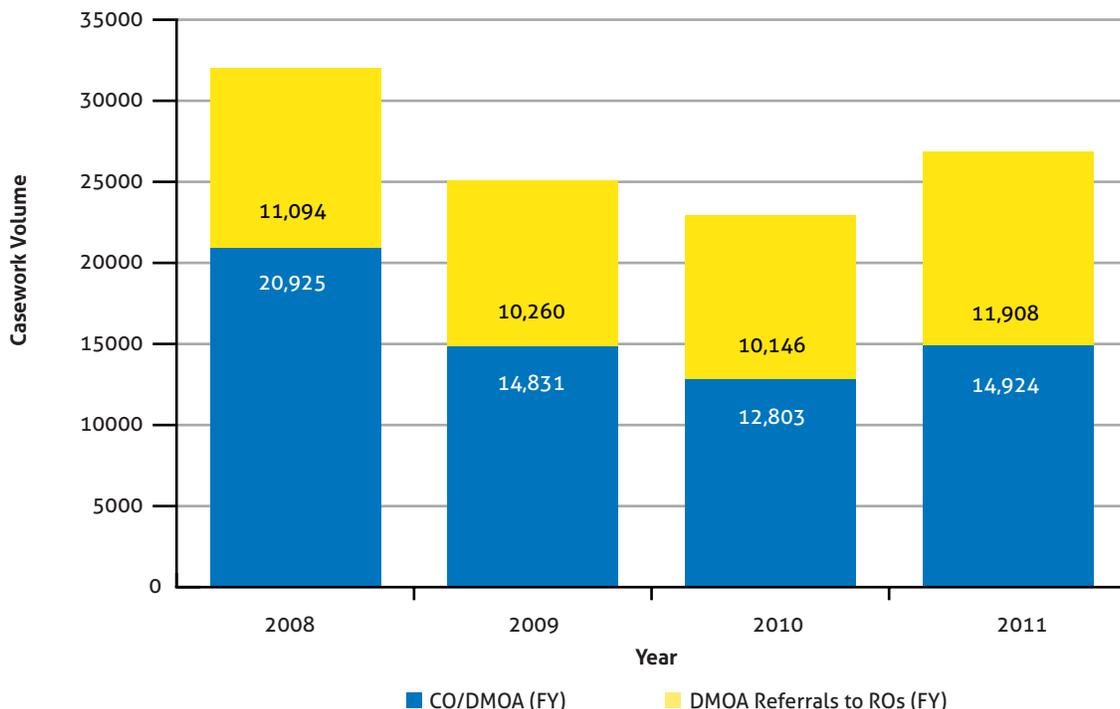
Figure 6 compares the top reasons for beneficiary contacts to DMOA in 2010 and 2011. While many of the top reasons for DMOA contact in 2010 remained top reasons in 2011, some categories experienced large changes. For example, issues related to premiums, which was the top reason for beneficiary contacts to DMOA in 2010, continued to be the top reason for beneficiary contacts in 2011, but it experienced a 49-percent increase in the number of contacts. The categories of health insurance replacement cards and disenrollment/enrollment/withdrawal also experienced significant increases in DMOA contacts.

DOE Casework

DOE works primarily with beneficiary data systems to maintain the integrity of Medicare Parts A and B data. DOE also manages and enables the resolution of data discrepancies related to Medicare enrollment, direct premium billing,¹⁰ third-party premium billing,¹¹ MA, and Part D data and transaction exceptions. In FY 2011, DOE reduced critical casework backlogs in three areas: direct premium billing, entitlement update transactions, and third-party premium billing. The timely resolution of these cases prevented beneficiary loss of entitlement benefits and averted claim and payment issues. DOE processed 29,330 direct billing cases; of the 29,330 cases, 3,046 (10 percent) involved beneficiary or representative contact. It also processed 46,725 third-party billing cases; of the 46,725 cases, 5,088 cases (10 percent) involved beneficiary or representative contact.

¹⁰ 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.
¹¹ Third parties include states, private entities, local governments, and the Office of Personnel Management.

Figure 5. DMOA/RO casework volume, FYs 2008-2011



SOURCE: OMO Casework Reports

Figure 6. Comparison of FY 2010 and FY 2011 beneficiary contacts to DMOA

Reason for contact	Contacts, FY 2010	Contacts, FY 2011	Percent change from FY 2010 to FY 2011
Premiums	9,142	13,622	49%
Medicare eligibility/ enrollment	2,164	1,880	-13%
Coordination of benefits	1,797	1,502	-16%
Medicare coverage	1,121	1,131	1%
Medicare Advantage	1,018	797	-22%
Inquiries not Medicare/ Medicaid specific	834	605	-27%
Low-income subsidy	601	586	-2%
Claims inquiries/complaints	516	530	3%
Health insurance replacement cards	244	345	41%
Disenrollment/enrollment/ withdrawal	152	300	97%
Other	5,360	5,534	3%
Total	22,949	26,832	17%

SOURCE: DMOA

In FY 2011, DOE continued its effort to analyze and categorize cases of incorrect Part A premium payments, some of which resulted in refunds to beneficiaries. Individuals who have paid their Medicare payroll deductions for 40 or more quarters of coverage (QCs) qualify for premium-free Part A coverage. Individuals who have made contributions for 30-39 QCs are responsible for a portion of their Part A premium but are eligible for reduced premiums. The Social Security Administration (SSA) is responsible for tracking the number of QCs individuals have accumulated and for classifying their premium status as premium-free, reduced premium, or full Part A premium. Once SSA makes this determination, the information is sent to CMS, which bills beneficiaries or the third-party payer directly based on SSA's premium classification.

In 2010, when SSA identified incorrect Part A premium payments, it provided CMS with approximately 7,000 records for manual processing. DOE led this effort and developed specifications for a program that would sort and categorize the records' type and priority. In 2011, DOE oversaw the correction of 6,223 such cases, the majority

of which (4,340 cases) involved system adjustments and were processed by DMOA and the ROs. DOE processed the remainder of the cases (1,883 cases), which were more complex in nature as they involved beneficiary refunds and other issues.

DOE's casework also involves assisting Medicare-Medicaid enrollees: low-income seniors and disabled individuals under the age of 65 enrolled in both Medicare and Medicaid. States use Medicaid funds to buy Medicare coverage and pay for these beneficiaries' premiums, deductibles, coinsurance, and/or copayments. This assistance is referred to as the Medicare Savings Programs (e.g., Qualified Medicare Beneficiary program, Specified Low-Income Medicare Beneficiary program). Because coordination among states, SSA, and CMS is necessary to carry out these programs, premium billing issues may arise for some of the approximately 9 million Medicare-Medicaid enrollees in these programs. In 2011, DOE developed a process to communicate and collaborate more efficiently with states and SSA about buy-in program cases. For these types of cases, the state Medicaid and Social Security offices send information to DOE

for verification and updates and to request changes to beneficiaries' "buy-in" status. DOE's process allows for the transfer of cases among the government entities involved with the provision of these programs. This effort has helped to improve the timeliness of assisting beneficiaries with issues related to buy-in programs.

Performance Monitoring

Throughout 2011, the OMO continued to improve its processes for managing casework, allowing it to assist beneficiaries more efficiently and effectively. This was demonstrated by the OMO's quick response time to beneficiary inquiries and the results from the 2011 beneficiary customer service survey.

Casework has been one of the OMO's cornerstone activities since the office was established in 2005. During the early years, the time it took to respond to inquiries and complaints averaged around 21 business days, and in some cases, responses could take up to 30 business days. Over the past 6 years, the OMO has worked to improve the efficiency and effectiveness of its responses to beneficiary inquiries and complaints, leading to an average response time of 11 business days in FY 2011. Over the past year, the OMO was able to respond to 99.5 percent of inquiries

Casework has been one of the OMO's cornerstone activities since the office was established in 2005.

it received within 30 business days, compared to 93 percent of all inquiries received in FY 2010. This decrease in response time was achieved despite the 17-percent increase in inquiries that DMOA handled.

In addition to seeking to improve its response time to beneficiary inquiries, the OMO also seeks to ensure that beneficiaries are satisfied with its customer service. Approximately every other year, the OMO administers a beneficiary customer service survey to obtain feedback on a number of areas concerning its responses to beneficiary inquiries. The survey, which is available in Spanish and English, is sent with written responses to inquiries and to beneficiaries who contact the OMO via telephone or email and who agree to participate in the survey. Upon completing each survey cycle, the OMO analyzes the

CASE EXAMPLE

Resolving Complex Beneficiary Cases

The Office of the Medicare Ombudsman (OMO) and the Centers for Medicare & Medicaid Services' (CMS') Regional Offices (ROs) often work together to resolve complex problems that have a serious impact on beneficiaries' medical insurance coverage and financial stability. In one case, a beneficiary contacted the OMO because his benefits had been terminated by his Medicare Advantage Prescription Drug (MA-PD) Plan for the third time. The beneficiary's first and last name had been incorrectly associated with that of another beneficiary with the same name who was deceased. Records revealed that the beneficiary's insurance coverage had been terminated due to a report of death in the system. As a result of this error, the beneficiary paid out of pocket for services that should have been covered under his MA Plan.

The OMO caseworker contacted the account manager at the beneficiary's MA Plan and the hospital to investigate the issue. The RO and hospital confirmed that there were two beneficiaries with the same name and that their records were mixed up. Additionally, the caseworker assisted the beneficiary with correcting this error with his MA-PD Plan. With the OMO's assistance, all denied claims were resubmitted.

results in an effort to identify deficiencies and improve its customer service performance. For instance, in previous years, survey results indicated that beneficiaries were sometimes dissatisfied with the OMO's response time to their inquiries. To improve in this area, the OMO began tracking each caseworker's response time to identify whether additional training was needed. Cases are also reassigned to the initial caseworker if beneficiaries need additional assistance. Moreover, caseworkers now receive copies of beneficiaries' responses to the survey, so they can use this information to improve their performance.

The OMO initiated its most recent survey in July 2011. As of the end of FY 2011, the OMO had surveyed 487 individuals with the ultimate goal of sending the survey to 2,242 individuals (the limit approved by the Office of Management and Budget). From the 190 responses it received in FY 2011, the OMO obtained an overall survey score of 4.3 on a scale of 1 to 5, with 5 denoting the highest quality. The final survey results will be available sometime in FY 2012.

CUSTOMER SERVICE INITIATIVES

Over the past several years, the OMO has served as an active customer service partner within CMS, helping the agency to improve beneficiaries' experiences with Medicare. To this end, the OMO facilitates National Casework Calls, trains caseworkers, develops standard language letters, and ensures that assistance is available for foreign-language beneficiary inquiries. These activities are described in greater detail below.

National Casework Calls and Training Program

The OMO facilitates National Casework Calls to disseminate and exchange information among the CMS CO and RO casework staff regarding the implementation of new policies, changes in regulations, or other important modifications that might affect the complex inquiry and complaint workload. The OMO also uses these calls to conduct training sessions aimed at fostering quality customer service and continual inquiry and complaint management improvement. CO and RO caseworkers participate in the training sessions to obtain the knowledge and skills necessary to efficiently

and effectively resolve beneficiary inquiries. Training participants also include representatives from other CMS components, including the Office of Public Engagement, the Center for Medicare (CM), and the Office of Financial Management.

In 2011, the OMO conducted 18 National Casework Calls: six of the calls were dedicated to Medicare Parts A and B topics, and the remaining 12 calls were dedicated to Medicare Parts C and D topics. One of the Parts A and B call topics was an overview of the Part D IRMAA provision because it led to changes to Form CMS-500, which CMS sends to beneficiaries who pay their premiums directly rather than through a withholding from their Social Security check. The OMO is pursuing additional improvements to Form CMS-500, which will be discussed in the 2012 Report to Congress. Another National Casework Call focused on the change in the timeline for claims submission, which is set to 12 months from the time of service; Medicare rejects claims submitted after the 12-month deadline. Submitting a claim past the deadline may cause a tremendous financial burden for beneficiaries, as they might be required to pay out of pocket or the provider might not be reimbursed. Some of the topics discussed during the Parts C and D calls included:

- Low-income subsidy redeeming, which provided an overview of the process for informing those Medicare beneficiaries who no longer qualify for this benefit in the upcoming year.
- An overview of the Retiree Drug Subsidy Assistance program.
- A discussion about Complaint Tracking Module (CTM) system changes.

The role of the newly created Medicare-Medicaid Coordination Office, CMS' privacy policy, and Health Insurance Portability and Accountability Act privacy rules were also discussed with participants of the National Casework Calls.

As part of the National Casework Calls, the OMO conducts the national casework training program, which facilitates CO and RO casework staff training. The objective of this

program is to ensure that caseworkers are knowledgeable about various Medicare topics, allowing them to respond to the complex questions and concerns they receive from Medicare beneficiaries and their caregivers. The OMO facilitated 10 training sessions in FY 2011 to provide a detailed overview of the 1-800-MEDICARE call center's operations and a review of the casework management protocol, among other topics. From evaluation surveys following the sessions, the OMO determined that the training sessions increased most caseworkers' knowledge.

Standard Language Letters

To help ensure that CMS caseworkers provide consistent information in response to beneficiary inquiries, the OMO develops standard language letters, which allow caseworkers to respond more accurately and efficiently to inquiries on various Medicare topics. The OMO developed 31 standard language letters in FY 2011, some in collaboration with the ROs, bringing the total number of standard language letters to 511. In 2011, the OMO also made some improvements to the standard

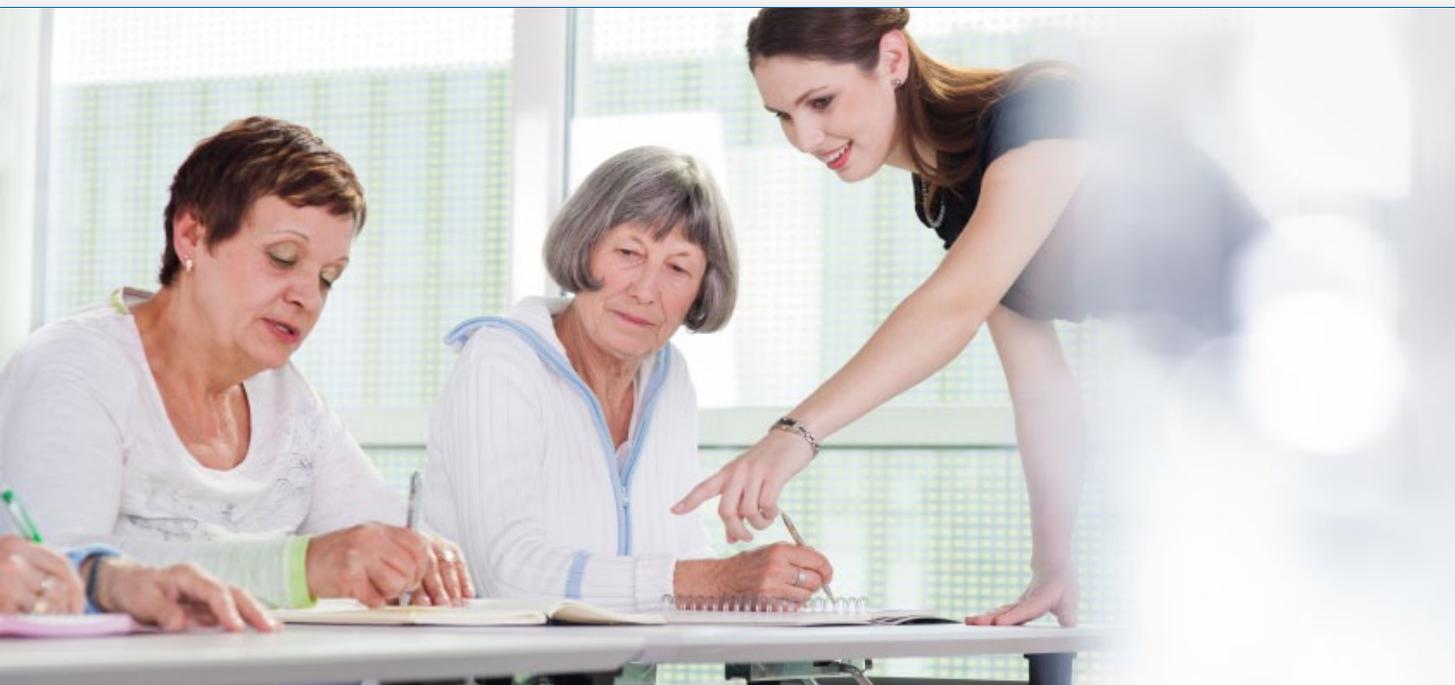
language letters based on information obtained from the Medicare Tone of Voice Workgroup presentations, which provided recommendations regarding the uniformity and appropriate delivery of information in these types of beneficiary correspondence.

Foreign Language Correspondence

Along with providing consistent responses to beneficiary inquiries, the OMO also needs to ensure that it can respond to inquiries in a variety of languages, especially given Medicare beneficiaries' increasing ethnic diversity. Over the past year, the OMO has streamlined its response process, allowing it to respond effectively to beneficiary inquiries in more than 40 languages. As in previous years, correspondence in Spanish accounted for the greatest number of foreign language inquiries, with a total of 925 Spanish language inquiries. The OMO responded to 417 of these inquiries, referring the remainder to the ROs. In 2011, the OMO received fewer than 10 inquiries each in Albanian, Chinese, French, Greek, Japanese, Russian, German, Hmong, Italian, and Vietnamese.

Figure 7. OMO's strategic relationships with other CMS components

Entity	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 Medicare and Centers for Medicare & Medicaid Services' (CMS') processes and to develop standard case-work procedures. The OMO also directs beneficiary casework inquiries and complaints to the ROs, when appropriate.
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), including exiting payment policy and concerns or programs involving Medicare fee-for-service contractors. The Competitive Acquisition Ombudsman, located within the OMO, interacts with CM on Durable Medical Equipment, Prosthetics, Orthotics, and Supplies issues.
Office of Communications (OC)	The OMO collaborates with OC to facilitate updates to existing CMS publications and the development of new publications or fact sheets, as needed. The OMO also works with 1-800-MEDICARE, which is located within OC, to resolve a small percentage of highly complex beneficiary issues.
Office of Information Services (OIS)	The OMO engages components within OIS 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.



The OMO works with the Creative Services Group within the CMS Office of Communications (OC) to facilitate responses to foreign language inquiries. If the beneficiary needs assistance from another federal agency, the OMO will contact that agency on the beneficiary's behalf. Along with sending a response to the inquiry in the foreign language in which the original letter was written, the OMO sends a response in English because the beneficiary might be getting assistance from another organization (e.g., advocacy group).

PARTNERSHIP INITIATIVES

The OMO seeks to identify systemic beneficiary issues and to develop and facilitate recommendations to address such issues through its partnership activities. In 2011, the OMO continued to collaborate with other CMS components and external organizations such as beneficiary advocacy groups and the State Health Insurance Assistance Programs (SHIPs).

Internal Partnerships

The OMO leverages its unique position within CMS by working with other CMS components to validate and resolve beneficiary issues. As in previous years, the OMO continued to work with CMS SMEs to validate issues and

obtain relevant policy information for issues identified through its Issues Management process (see figure 7 for a full list of components with which the OMO collaborates regularly). The OMO also collaborated with other CMS components to develop its comprehensive studies and subsequently to facilitate the implementation of its recommendations.

During the past year, the OMO collaborated most extensively with CM, 1-800-MEDICARE, and OC. The OMO worked with CM to validate an issue related to MA nonrenewal letters that beneficiaries receive when plans exit the market. Beneficiary advocates noted that the nonrenewal letter contained inaccurate and confusing information. Because CM serves as CMS' focal point for formulating, coordinating, integrating, implementing, and then evaluating national Medicare policies and operations, the OMO worked with CM staff to validate the issue. CM determined that a particular plan sent an incorrect nonrenewal letter and informed the OMO that when this type of issue occurs, CM sends the correct letter to affected beneficiaries. In another instance, the OMO worked with 1-800-MEDICARE to review and update call scripts related to calls from family members who need access to deceased Medicare beneficiaries' Medicare Summary Notices to obtain evidence of payment of medical bills.

External Partnerships

In addition to direct interaction with thousands of beneficiaries each year through casework, the OMO partners with external organizations that provide valuable information for identifying issues that might be affecting the larger Medicare population.

The OMO communicates with these external partners through the following forums:

- Medicare Ombudsman partner and beneficiary advocate meetings
- National conferences
- SHIPs' conversations with the Medicare Beneficiary Ombudsman
- The Annual SHIP Directors' Conference

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

In 2011, 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, and Medicare Access for Patients Rx. One of the issues raised by these organizations concerned the limited time between when updated plan information becomes available on the Medicare Plan Finder and the start of the open enrollment period. Prior to 2011, the open enrollment period took place from November 15 through December 31, which provided sufficient time to update the Medicare Plan Finder. However, to ensure that beneficiaries received essential plan materials

COMPETITIVE ACQUISITION OMBUDSMAN

Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 required the establishment of a Competitive Acquisition Ombudsman (CAO) to respond to complaints and inquiries made by suppliers and individuals related to the application of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. In 2009, the Medicare Beneficiary Ombudsman appointed a CAO within the Office of the Medicare Ombudsman.

In 2010, the CAO developed the Customer Service Triage Guide for DMEPOS Competitive Bidding Inquiries and Complaints. Initially released in January 2011, this guide is being used by all CMS customer service segments to ensure appropriate response timeliness to supplier inquiries. In fiscal year 2011, the CAO also developed and implemented 15 comprehensive trainings on complex technical components of the Competitive Bidding Program for CMS caseworkers. These trainings, which were conducted in November and December 2010, resulted in nearly all of those who were trained reporting a significant increase in knowledge.

To assist CMS in identifying potential systemic issues, the CAO developed a data management strategy to track supplier and beneficiary inquiries and complaints. The CAO's beneficiary advocate meetings and supplier listening sessions provided yet another source for identifying potential systemic issues. In 2011, the CAO held two beneficiary advocate meetings with 15 disability partners and two supplier listening sessions with DMEPOS-contract and non-contract suppliers. The CAO informed the appropriate CMS components of the concerns and information shared by the beneficiary and supplier groups. Examples of issues covered by the CAO in 2011 include concerns regarding supplier and beneficiary understanding of competitive bidding program policies on power wheelchair repair and replacement. The CAO will present a further discussion of these and other issues in its annual report to Congress.

when their new coverage started on January 1, 2012, the open enrollment period was changed to October 15 through December 7 by the Affordable Care Act. The OMO acknowledged this concern and informed its partners that the CMS CO and ROs were prepared to provide assistance to beneficiaries to alleviate issues that might arise during this transition period. The OMO also addressed concerns the partners raised regarding the Annual Wellness Visit benefit that was established by the Affordable Care Act, as well as durable medical equipment repair for Medicare-Medicaid enrollees.

National Conferences

In 2011, as part of its national conference support partnership activity, the OMO staff represented CMS at several conferences throughout the nation, including those organized by the National Council of La Raza, the National Urban League, the National Association of Mental Illness, the Congressional Black Caucus, and AARP. In addition to helping the OMO learn about beneficiary issues, these conferences provide the OMO with the opportunity to conduct beneficiary and caregiver outreach.

Communication and Collaboration with SHIPs

In addition to collaborating with these advocacy organizations, the OMO works with SHIPs, in accordance with Section 923 of the MMA. These organizations are federally funded state programs that provide free health insurance counseling to beneficiaries via telephone and face-to-face interactive sessions. The OMO collaborates with SHIPs to identify issues that affect Medicare beneficiaries. At the same time, the OMO also seeks to gain an understanding about the challenges SHIPs face when providing support to beneficiaries and their caregivers.

As in previous years, the OMO attended the 2011 Annual SHIP Directors' Conference, which had a combined audience of 800 SHIP directors and counselors. The OMO presented information on several topics, including:

- An overview of the OMO's role.
- How the OMO works to provide information and assistance to people with Medicare.
- How CMS provides support and technical assistance to SHIPs.

Some of the issues that attendees raised concerned the Medicare Savings Programs, provider transfer of Part D true out-of-pocket costs, and the new Annual Wellness Visit benefit. The OMO also attended SHIP Coordinators' Conferences in Pennsylvania and Missouri.

The OMO continued leading the effort to authorize SHIPs' access to CTM, which tracks Parts C and D beneficiary complaints and inquiries. Access to CTM leads to more efficient resolution of beneficiary complaints because SHIPs can directly enter complaints into the system. As of the end of 2011, over 315 SHIP users in 35 states and territories had access to the CTM system.

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 examination of casework trends. The process involves:

- Facilitating monthly internal Issues Management meetings.
- Facilitating Medicare Ombudsman partner and beneficiary advocate meetings.
- Performing issue validation and tracking.
- Developing Quarterly Issue Reports.
- Issuing Beneficiary Contact Trend Reports, which summarize beneficiary inquiries, complaints, and appeals from several CMS data sources (see figure 8).

The Issues Management meetings give OMO leadership and analysts the opportunity to introduce and validate new issues and to develop effective strategies for addressing complex issues. The issues that enter the Issues Management process are tracked in a database, which enables a centralized view of the entire effort for each issue. This information is used to develop the OMO's Quarterly Issue Reports. These reports are internal CMS documents that provide a synopsis of the issues the OMO is investigating as well as the OMO's interventions and recommendations to CMS for improving beneficiaries' experiences with Medicare.

The OMO employs qualitative methods, such as

Figure 8. Beneficiary Contact Trend Report data sources

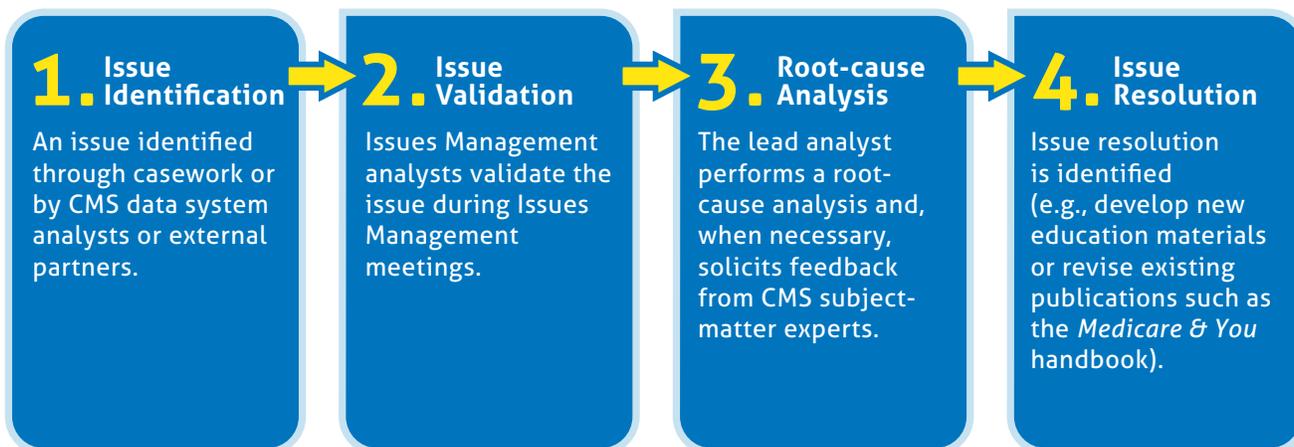
CMS Source	Information Collected
1-800-MEDICARE	<ul style="list-style-type: none"> • Total 1-800-MEDICARE call volume • Top 10 reasons and associated volume for contact (i.e., script hits)
State Health Insurance Assistance Programs (SHIPs)	<ul style="list-style-type: none"> • SHIP contact volume • Reasons for contact (i.e., topics discussed)
Division of Medicare Ombudsman Assistance	<ul style="list-style-type: none"> • Volume of contacts handled by the Office of the Medicare Ombudsman (OMO) • Reasons for contacting the OMO or the Centers for Medicare & Medicaid Services' Central Office (CO)
Medicare Administrative Issue Tracker and Reporting of Operations System	<ul style="list-style-type: none"> • Parts A and B volume of complaints • Reasons for complaints
Components logging inquiries in the Complaint Tracking Module: <ul style="list-style-type: none"> • 1-800-MEDICARE • CMS' CO and Regional Offices • SHIPs 	<ul style="list-style-type: none"> • Parts C and D volume of complaints • Reasons for complaints
Medicare Administrative Contractors	<ul style="list-style-type: none"> • Parts A and B Level II appeals volume • Volume of inquiries
Qualified Independent Contractors	<ul style="list-style-type: none"> • Parts A, B, C, and D total Level II appeals volume • Volume by type of appeals

investigating issues raised by beneficiary advocates, and quantitative methods, such as CMS data system analysis, to identify beneficiary issues. The Division of Ombudsman Research and Trends Analysis (DORTA) analyzes CTM and MAISTRO data to identify trends that might indicate systemic problems across the different parts of Medicare. For instance, in 2011, following the receipt of a complaint from a beneficiary regarding his MA Plan's refusal to cover a certain diabetic supply, the OMO analyzed data from CTM, which tracks Medicare Parts C and D complaints, to validate the issue. The OMO also reached out to SMEs from other CMS components to gain a better understanding of the policies and regulations guiding this issue.

The Issues Management process has several distinct phases, as indicated in figure 9.

COMPREHENSIVE STUDIES DEVELOPMENT

In 2009, the OMO established a comprehensive studies development process designed to increase the office's capacity to better identify the root causes of beneficiary issues and to develop specific, actionable recommendations for addressing the issues. Initially, the issues that were selected for the development of comprehensive studies emerged from the Issues Management process; however, over the past year, new issues were identified during the process of developing the first set of comprehensive studies. For instance, the Medicare Secondary Payer Recovery Contractor study was prompted by the comprehensive study regarding coordination of benefits, which was first presented in the 2010 Report to Congress.

Figure 9. Issues Management workflow

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

- Environmental scans of pertinent legislation, Medicare regulations, and relevant websites.
- A review of beneficiary communication materials.
- Interviews with CMS SMEs, beneficiary advocacy groups, CMS contractors, and providers, among other stakeholders.
- Analyses of CMS data (e.g., claims data) or data from external sources.

The information obtained from these sources is used to look for patterns across a number of areas that might reveal the source of the issue. Each comprehensive study section of this report provides a detailed description of the study findings.

In 2011, the OMO completed three comprehensive studies, bringing the total number of comprehensive studies developed since this effort was initiated to eight. The most recent study topics, described in more detail in the next section, are:

- Recovery of conditional payments from beneficiaries by the Medicare Secondary Payer Recovery Contractor.
- Recovery Audit Contractors' retroactive identification

and recovery of improper FFS Medicare payments, which have indirect effects on beneficiaries.

- Negative consequences for beneficiaries stemming from the use of observation services for extended periods of time.

Due to the evidence-based nature of this process, the OMO is able to develop specific, actionable short-term and long-term recommendations that can be implemented efficiently and effectively. The OMO presents each study to CMS Leadership and actively seeks to work with the appropriate CMS components to validate the feasibility of implementing the recommendations and to facilitate their implementation. For example, one of the recommendations from the 2010 Part B enrollment comprehensive study was to create an employer community section on www.Medicare.gov to make resources available to employers, so they could assist their employees with questions related to enrolling in Medicare Part B. The OMO is collaborating with the Web and New Media Group within CMS' OC to gather existing information to support the employer community. The OMO is also collaborating with CM to ensure that the information on the employer community website is accurate and appropriate. Furthermore, the OMO is determining what new informational resources need to be developed to meet employers' needs and how

best to promote the Employer Community website, in part through meetings with external stakeholders. In particular, the OMO is meeting with both large and small employers, aggregator companies that contract

with employers by providing support to employees for health care and retirement issues, and government agencies, including the Small Business Administration and the Internal Revenue Service.

CASE EXAMPLE

Observation Services

The Office of the Medicare Ombudsman (OMO) received an inquiry from a beneficiary's wife regarding his hospital stay. The beneficiary went to the emergency room with persistent pain and was kept in the hospital for 3 days. Once the beneficiary was released, he was transferred to a skilled nursing facility (for rehabilitation services). The beneficiary's stay at the hospital was billed as observation services. As a result, Medicare could not cover the beneficiary's skilled nursing facility services since the 3-day-minimum inpatient hospital stay requirement had not been met.

In addition, the beneficiary's wife contended that her husband was not informed of the inpatient stay requirement for Medicare to cover the costs of the skilled nursing facility services until the day he was discharged from the hospital. The OMO caseworker informed the beneficiary's wife about the Medicare coverage policy, and suggested that the beneficiary contact the appropriate hospital representatives. The beneficiary's wife contacted her State Representative, who, in turn, contacted the president of the hospital. The hospital agreed to take the case under advisement.



The OMO investigates issues that could negatively affect the well-being of beneficiaries, their families, and caregivers.

Recommendations Regarding Beneficiary Concerns

SECTION HIGHLIGHTS

During 2011, the Office of the Medicare Ombudsman (OMO) completed comprehensive studies with recommendations addressing three main topics:

- Medicare Secondary Payer Recovery Contractors
- Recovery Audit Contractors
- Observation Services

While these studies include a number of specific recommendations, one common theme that emerged from the studies is the importance of making information about Medicare processes easily accessible to beneficiaries, their caregivers and advocates, and providers.

In addition to the three issues noted above, the OMO investigated other issues that could negatively affect the well-being of beneficiaries, their families, and caregivers. These issues include understanding the Annual Wellness Visit benefit, the process for enabling family members to access deceased Medicare beneficiaries' Medicare Summary Notices, and Medicare coverage of chiropractic services.

INTRODUCTION

In 2011, the Office of the Medicare Ombudsman (OMO) completed three comprehensive studies to identify the root causes of systemic issues and to develop recommendations for improving beneficiaries' experiences with Medicare. The studies concerned (1) the Medicare Secondary Payer Recovery Contractor (MSPRC), (2) Recovery Audit Contractors (RACs), and (3) observation services. The OMO presented findings and pertinent recommendations from these studies to Centers for Medicare & Medicaid Services (CMS) Leadership. Upon releasing the studies, the OMO began assessing the feasibility of implementing its recommendations related to the MSPRC, RACs, and observation services or, in some instances, is already facilitating their implementation.

This section presents a detailed description of the issues analyzed in the comprehensive studies and the recommendations made about the issues, as well as other issues the OMO addressed in 2011.

DETAILED REVIEW OF SELECT ISSUES

Through its work, the OMO identified three issues that required further investigation to better understand their root causes and potential effects on beneficiaries:

- Recovery of conditional payments from beneficiaries by the MSPRC when non-group health plans (liability insurance, no-fault insurance, and workers' compensation) are primary and Medicare is secondary.
- Retroactive identification and recovery of improper fee-for-service (FFS) Medicare payments by RACs that may have indirect effects on beneficiaries.
- Potential negative consequences for beneficiaries stemming from the use of observation services for extended periods of time.

The OMO initiated comprehensive studies on these three topics because they represented complex and systemic issues and concerns whose potential negative impact may be minimized through the implementation of actionable recommendations. The comprehensive studies were finalized in 2011.

SPOTLIGHT:

Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007

The Centers for Medicare & Medicaid Services (CMS) has reported that the Medicare Secondary Payer Recovery Contractor (MSPRC) might be aware of half or even fewer of non-group health plan Medicare secondary payer situations due to the MSPRC's reliance on self-reporting by beneficiaries and/or their designated representatives or insurer voluntary self-reporting. Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 (P.L. 110-173) mandates that liability insurance, no-fault insurance, and workers' compensation settlements, judgments, awards, or other payments must be reported to CMS whenever the claimant is or was a Medicare beneficiary. Section 111 responsible reporting entities face a \$1,000 penalty per claim per day for noncompliance with Section 111's reporting requirements beginning on July 1, 2009. The Section 111 reporting requirements for workers' compensation and no-fault insurance went into effect on January 1, 2011, with most reporting for liability insurance beginning on January 1, 2012.

MEDICARE SECONDARY PAYER RECOVERY CONTRACTOR

Administration of the MSPRC program involves a complex process to recover conditional payments made by Medicare when another payer is primary. These conditional payments are made by Medicare to ensure beneficiaries' continued access to services, but they also constitute significant expense outlays by Medicare. The work of the MSPRC has demonstrated success in identifying and collecting conditional payments requiring recoupment, allowing these funds to be returned to the appropriate Medicare Trust Funds.¹² However, due to the complexity of the process and the possibility

¹² Centers for Medicare & Medicaid Services. (2011, May). *How is Medicare Funded* (CMS Product No. 11396). Retrieved November 1, 2011, from <http://www.medicare.gov/Publications/Pubs/pdf/11396.pdf>.

of unintended negative effects that might result from the recovery of payments from beneficiaries, the OMO decided to examine the beneficiary experience with this process.

The MSPRC concern was first raised in a comprehensive study regarding coordination of benefits (COB), which the OMO completed in 2010. The study found that COB issues most often arise in situations when Medicare is the secondary payer. The objectives of the current MSPRC study were to understand the Medicare Secondary Payer (MSP) recovery process for beneficiary debts, examine beneficiaries' (and their representatives') understanding of the process, and identify potential areas to better assist beneficiaries with the MSP recovery process.

Medicare is the secondary payer when payment has been made or can reasonably be expected to be made for items or services by a group health plan (GHP) or a non-group health plan (NGHP), such as an automobile or liability insurance policy or plan (including self insurance), no-fault insurance, and workers' compensation. When the primary payer is an NGHP, it is responsible for paying primary to Medicare. However, if payment has not been made or cannot be reasonably expected to be made promptly (as defined by regulation) by the primary payer, Medicare may make a conditional payment. Once there has been a settlement, judgment, award or other payment to the beneficiary, Medicare has the right to recover from the beneficiary any conditional payment(s) that it made.¹³

¹³ The recovery of conditional payments when a GHP is the primary payer was not included in the study of the MSPRC. Generally, the beneficiary is not the identified debtor for a MSP GHP recovery claim. The focus of this OMO study was those situations in which the beneficiary is a key component of the recovery process.

SPOTLIGHT: When Does Medicare Make a Conditional Payment?

The two most common scenarios in which Medicare makes a conditional payment when liability insurance, no-fault insurance, or workers' compensation is primary or potentially primary are:

- *When there is no dispute regarding the beneficiary's underlying claim, and the Centers for Medicare & Medicaid Services and/or the relevant providers are unaware of liability insurance, no-fault insurance, and workers' compensation situations and the likelihood that Medicare is not the primary payer.* For example, if a Medicare beneficiary is treated by a provider for a medical condition allegedly resulting from an accident, illness, or injury, but the provider is unaware that the condition is related to a liability insurance, no-fault insurance, or workers' compensation situation, he or she may submit the claim to Medicare. Medicare, also unaware of the situation, pays the claim. Later when Medicare is made aware that it is, in fact, the secondary payer, the Medicare Secondary Payer Recovery Contractor (MSPRC) contacts the primary payer and/or the beneficiary to inform them of Medicare's right to recover the conditional payment that Medicare made.
- *When the responsibility for payment is in dispute.* Liability insurance claims are routinely disputed. Moreover, there are situations when a beneficiary's workers' compensation or no-fault insurance claim is in dispute (For example, when workers' compensation does not agree that an injury is work related.) In such a scenario, a Medicare beneficiary might be treated by a provider for a medical condition allegedly resulting from an injury for which he/she has filed a workers' compensation claim or for which he or she has filed a liability insurance claim. The beneficiary informs the provider of the claim, and the provider bills the workers' compensation carrier (or the liability insurance, as applicable). However, because responsibility is in dispute, the provider's claim to the workers' compensation or liability insurance is denied. The provider then bills Medicare, which makes a conditional payment. In these cases, the pending workers' compensation claim or liability insurance claim is self-identified to Medicare, or the settlement, judgment, award, or other payment is reported through the Section 111 process, and the MSPRC takes appropriate recovery action.

In addition, it is anticipated that due to Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 (see Section 111 Spotlight), there will be an increase in the number of reported claims in which Medicare is secondary to another insurer and, therefore, an increase in the number of cases reviewed and processed by the MSPRC to recover Medicare's conditional payments. This will ultimately result in more funds recovered and returned to the Medicare Trust Funds through additional collection of conditional payments. It also means more beneficiaries will be contacted by the MSPRC, highlighting the need to better understand the effect of the MSPRC process on Medicare beneficiaries.

The MSPRC is responsible for identifying conditional payments and for taking recovery actions, as appropriate. (See Spotlight: *When Does Medicare Make a Conditional Payment?* for a description of the two most common scenarios in which Medicare makes a conditional payment when a NGHP is primary or potentially primary and then subsequently recoups the payment from the beneficiary.) To fulfill this responsibility, when a case is identified, the MSPRC sends communications to the beneficiary/designated representative that includes the conditional payment amounts made to date as well as the rights and responsibilities of the beneficiary during the recovery process. The MSPRC is also responsible for resolving beneficiary appeals and disputes, waiving recovery determinations, and referring delinquent MSP debt cases, when appropriate, to the U.S. Department of Treasury. A fact that adds complexity to this process is that Medicare is the secondary payer only to specific claims and not to all items and services the beneficiary may be entitled to under Medicare. This specificity requires the MSPRC to differentiate between Medicare reimbursed items or services related to a workers' compensation, liability insurance, or no-fault insurance case and those items or services not related to the case.

Figure 10 is a graphical depiction, available on the MSPRC website, of the standard process for recovering conditional payments from beneficiaries when workers' compensation, liability insurance (including self

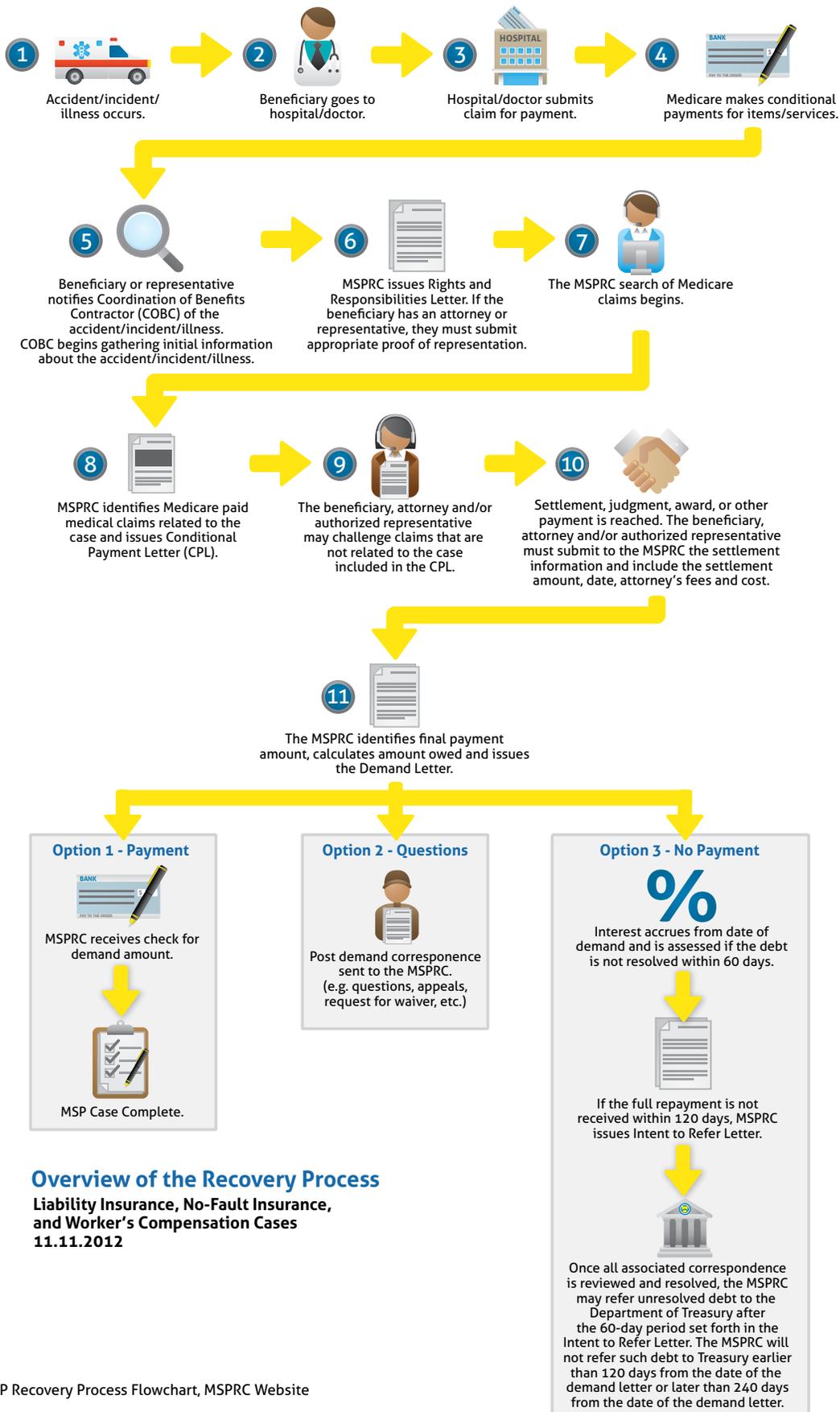
insurance), or no-fault insurance is primary.¹⁴ The recovery flow diagram includes key steps from the time of the incident, accident, illness, or injury up until the final recovery payment is made to the MSPRC. However, the actual process used by the MSPRC to recover conditional payments from beneficiaries can differ. For instance, the length of time between each of the key steps highlighted in the flow diagram can vary greatly case by case. Because of the often lengthy insurance settlement process or other legal proceedings, it can be months or years from the time of an accident to the MSPRC Demand Letter. In addition, the points of communication between the MSPRC and the beneficiary/designated representative may differ by case.

A thorough environmental scan of information on the recovery of MSP conditional payments from beneficiaries, a detailed review of CMS and MSPRC beneficiary communication materials, interviews with CMS MSP subject-matter experts (SMEs), and interviews with beneficiary advocacy group representatives resulted in the following study findings:

- Among beneficiary advocates, there is limited awareness and understanding of the MSP recovery process and resources available to beneficiaries. Beneficiaries and their advocates and representatives have difficulty finding information about the MSP recovery process, which may be the result of the limited availability of appropriate resources describing the process. For example:
 - The www.Medicare.gov and www.MyMedicare.gov websites do not discuss NGHP insurance in the "Other Insurance" section.
 - There is no link between www.Medicare.gov and/or www.MyMedicare.gov and the MSPRC website.
 - The *Medicare & You 2011* handbook and the *Medicare and Other Health Benefits: Your Guide to Who Pays First* publication do not mention the MSPRC or its website.
- MSPRC-related communication materials are written using terminology more suited to those who represent beneficiaries (e.g., lawyers) than Medicare beneficiaries themselves. Although CMS

¹⁴ Medicare Secondary Payer Recovery Contractor. *MSPRC Recovery Process Flowchart*. Retrieved January 4, 2011, from <http://www.msprc.info/processes/nghp%20flowchart.pdf>.

Figure 10. MSPRC Recovery Workflow



Overview of the Recovery Process
Liability Insurance, No-Fault Insurance,
and Worker's Compensation Cases
11.11.2012

SOURCE: GHP Recovery Process Flowchart, MSPRC Website

SMEs indicate that most beneficiaries involved with MSPRC recovery actions have representatives, both the representatives and the beneficiaries receive the communications.

- The MSP recovery process often encounters delays due to resource constraints and a backlog of cases on which the MSPRC is working.

To address these findings, the OMO recommends that CMS:

- *Educate advocates and other beneficiary representatives about the MSP recovery process and the existing resources available on the MSPRC website.* Interviews with beneficiary advocates revealed that advocates and beneficiary representatives do not understand the MSP recovery process or why information is or is not available at certain points in the process. In addition, some advocates were not aware of resources existing on the MSPRC and www.MyMedicare.gov websites. Therefore, the OMO recommends that CMS provide education to the advocacy organizations and continue its outreach to professional organizations and the legal community regarding the MSP process and the availability of existing resources. These organizations can then disseminate this information to their members who assist beneficiaries with the MSP recovery process.
- *Revise communication materials to make them more beneficiary friendly.* Interviews with advocates revealed a few areas of confusion for beneficiaries and their advocates that could be alleviated by modifying existent MSPRC communication materials with beneficiaries as the target audience. These modified communication materials would use language similar to that in the *Rights and Responsibilities* brochure, the MSP tutorial on the MSPRC website, and the *Medicare and Other Health Benefits: Your Guide to Who Pays First* publication. Specifically, the OMO recommends that the modified materials include content on where to locate additional resources by noting reference materials and resources already available on the MSPRC

website and by including additional information on the overall MSP process.

- *Provide a link between www.Medicare.gov (and www.MyMedicare.gov) and the MSPRC website/materials and enhance MSP content on both Medicare websites.* The www.Medicare.gov and www.MyMedicare.gov websites are trusted and frequently visited sources of information for Medicare beneficiaries, their representatives, and advocates. However, these websites provide little information on how Medicare works with liability insurance (including self insurance), no-fault insurance, and workers' compensation. Furthermore, the websites provide no information regarding the MSPRC or any reference to the MSPRC website where additional information can be located. As a result, the OMO recommends that CMS include additional paragraphs in the "Other Insurance" section of both websites concerning how Medicare works with NGHPs. The OMO also recommends that the new text on the "Other Insurance" page include a link to the MSPRC website to direct beneficiaries to additional resources and information. Finally, the OMO recommends that CMS enhance the www.Medicare.gov and the www.MyMedicare.gov search functions so that inquiries related to workers' compensation, automobile accidents, and other accidents or injuries will all link to the text added to "Other Insurance" and to the MSPRC website.
- *Monitor MSPRC customer service representatives' (CSRs') performance and, as needed, revisit training.* Advocates stated that when they or beneficiaries call the MSPRC, even if they have called before, they seem to be starting the process all over again; any previous conversations with an MSPRC CSR do not seem to be documented for future reference. The OMO recommends that CMS monitor the CSRs' performance and revisit the MSPRC CSR training, if needed. The training should aim to ensure that, when speaking with a beneficiary or a representative, CSRs are appropriately entering notes into the tracking system for each call and are retrieving any previous call records related to the case. In addition, the OMO

LEVERAGING INTERNAL PARTNERSHIPS TO IMPLEMENT OMO RECOMMENDATIONS

The Office of the Medicare Ombudsman (OMO) undertakes a variety of activities, ranging from comprehensive studies to collaborative efforts with CMS components, with the ultimate goal of identifying concrete actions that will improve the beneficiary experience. OMO recommendations are provided to CMS Leadership and to the Secretary of the U.S. Department of Health & Human Services through the OMO's Report to Congress. In 2011, the OMO started an initiative to proactively seek the implementation of its recommendations by leveraging its partnerships within the organization.

The OMO has made dozens of recommendations in its Reports to Congress on issues such as coordination of benefits and balance billing of Qualified Medicare Beneficiaries. Through its new initiative, the OMO is working with the appropriate CMS components to assess the feasibility of implementing its recommendations in the near future or long term and to provide assistance with implementing those that are determined to be readily actionable. To date, several recommendations have been implemented through this collaborative effort, and results are expected to be discussed in future Reports to Congress.

recommends that the CSRs should initially inform the beneficiary or representative that they may be asking questions that might already have been asked in previous calls to protect the beneficiary's privacy.

Recovery Audit Contractors

Congress established the RAC program to address improper payments made to Medicare providers through

a post-payment auditing process.¹⁵ (See section spotlight on Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 for more information.) In FY2011, the U.S. Department of Health & Human Services estimated that approximately \$28.8 billion (8.6 percent of Medicare FFS payments) in claims were improper.¹⁶

A key objective of the RAC program is to decrease improper claims and, thus, decrease payments by Medicare.¹⁷ To achieve this goal, Medicare RACs are responsible for retroactively identifying and correcting improper payments in FFS Medicare, thereby protecting the Medicare Trust Funds. CMS contracts with RACs to conduct automated reviews and manual reviews of complex medical records, audit for medical necessity, and focus on claims histories in order to find improper Medicare payments.

Although not intended to have a direct beneficiary interface or impact, the RAC program could affect beneficiaries. On the positive side, recoveries of improper payments as a result of RAC audits restore financial assets to the Medicare Trust Funds and, thus, help to improve the program's financial solvency and the ability of Medicare to pay for health care services on behalf of beneficiaries. Moreover, RAC oversight may result in changes in health care delivery, over the long term, resulting in improved efficiency in care delivery and quality. However, changes in the delivery of care in anticipation of potential denials of payment due to RAC audits may involve unintended negative consequences for beneficiaries, as hospitals become increasingly risk averse and conform to a more strict interpretation of Medicare coverage policy. It is the potential for such unintended consequences that is of concern to the OMO.

The OMO became aware of these indirect effects and of the potential negative consequences for Medicare beneficiaries as a result of the RACs' scrutiny of the

¹⁵ An improper payment is defined as an overpayment or an underpayment due to insufficient or missing documentation, absence of medical necessity, incorrect coding, or other errors where provider claims did not meet billing requirements, such as those concerning expenses not covered, unallowable services, and duplicate claim submissions.

¹⁶ U.S. Department of Health and Human Services. (2011). *FY2011 HHS Agency Financial Report*. Retrieved April 16, 2012, from <http://www.hhs.gov/afr/2011afr.pdf>.

¹⁷ Centers for Medicare & Medicaid Services. *Implementation of Recovery Auditing at the Centers for Medicare & Medicaid Services: FY 2010 Report to Congress as Requested by Section 6411 of Affordable Care Act*. Retrieved November 1, 2011, from <https://www.cms.gov/Recovery-Audit-Program/Downloads/FY2010ReportCongress.pdf>.

medical necessity of inpatient stays, which is believed to influence hospital use of outpatient observation services. The OMO has separately examined the use of observation services. As part of that work, the OMO learned that hospitals sometimes use outpatient observation services as an alternative to inpatient hospital admission because of RAC scrutiny of short inpatient stays. The OMO undertook this separate comprehensive study on RACs to better understand the potential indirect impact of RAC recovery activities on Medicare beneficiaries and to identify potential approaches for mitigating any negative effects.

The comprehensive study found the following three impacts of RACs on providers and beneficiaries:

- 1 *Impact of RAC activity on providers.* The RACs alter the behavior of hospitals in that hospitals must consider the costs and benefits of re-engineering their fiscal risk management and/or care management decision-making processes in light of the possibility of a RAC audit.

To the extent that RAC medical necessity audits target specific diagnosis-related groups (DRGs) and their associated clinical services, providers can choose to either reduce the supply of these services or attempt to provide clinically appropriate services in a different manner (e.g., by shifting services from an inpatient to an outpatient setting).¹⁸ RAC activity further exacerbates long-standing issues in interpreting the meaning of medical necessity in the context of Medicare coverage and payment policy.

To document and provide evidence of providers' response(s) to RAC auditing activity, the American Hospital Association (AHA) instituted a project known as RACTrac. RACTrac is a quarterly electronic survey of hospitals that provides current information about the scope of provider concerns relating to the RAC program. RACTrac began data collection in the first quarter of calendar year (CY) 2010 (see figure 11). During the first two quarters of CY 2010,

¹⁸ Diagnosis-related groups (DRGs) is a classification system used to group patients that are similar in terms of their condition(s) and inpatient resource needs. Under the Medicare Inpatient Prospective Payment System, Medicare pays a hospital for a case based on its DRG assignment and any hospital-specific adjustments.

972 out of 1,389 hospitals voluntarily engaged in RACTrac reporting experienced a RAC audit. Additionally, half of the RACTrac participants reported increased administrative costs, 38 percent initiated a new internal task force, and nearly one in five

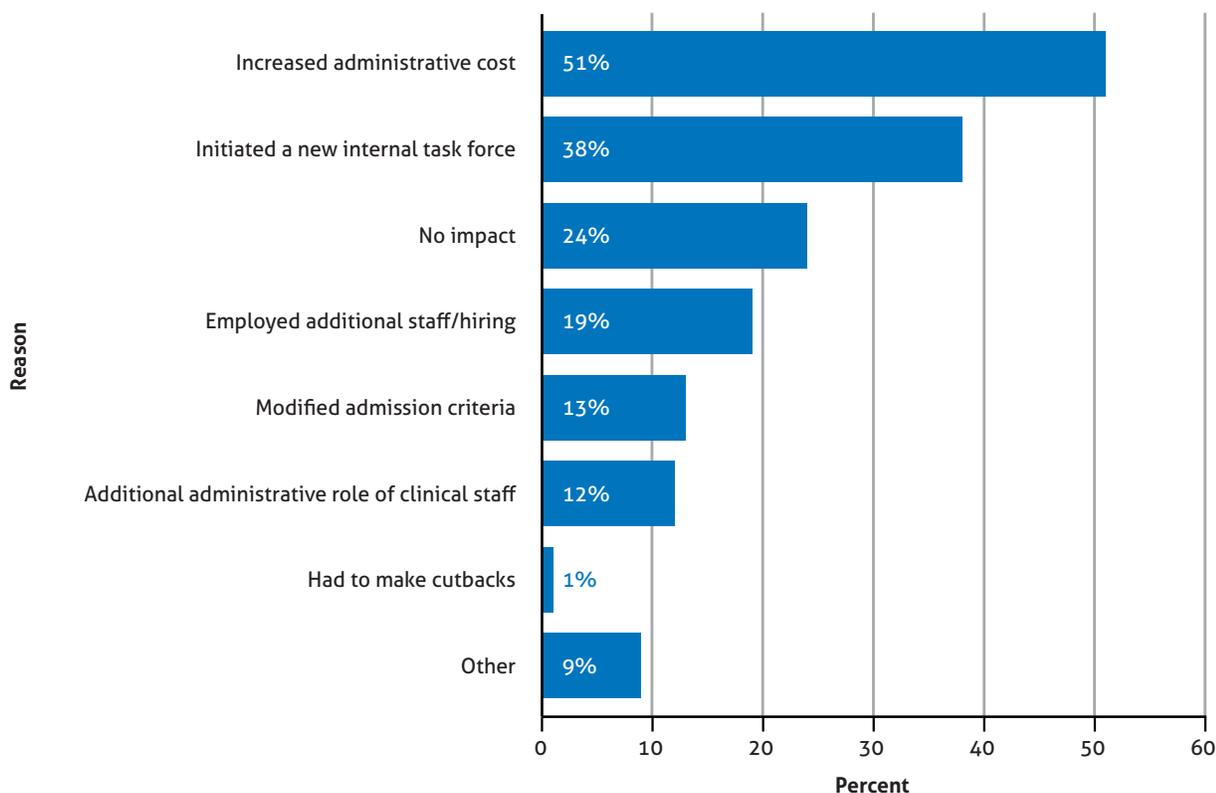
SPOTLIGHT: Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Recovery Audit Contractor Demonstration

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated that the Centers for Medicare & Medicaid Services (CMS) establish a Recovery Audit Contractor (RAC) demonstration program. The intent of this initiative was to identify and be reimbursed for improper Part A and Part B Medicare payments using a contingency fee auditing model, in which the auditors' revenue derives from a percentage of the over-payments it accurately identifies and recovers.

The RAC demonstrations began in March 2005 in California, Florida, and New York. In these states, RACs identified more than \$300 million in improper payments, not including pending appeals. In 2007, the demonstration expanded to Massachusetts, Arizona, and South Carolina before ending in March 2008. During the demonstrations, the RACs collected \$992.7 million in over-payments, had \$60 million over-turned on appeal and because of inpatient rehabilitation facility claim re-reviews, and paid \$37.8 million in under-payments. The RAC demonstration cost \$201.3 million to operate and the net savings to the Medicare Trust Funds was \$693.6 million. In general, CMS estimates that the majority of hospitals had their revenue impacted by less than 2.5 percent by the RACs.

The success of the demonstration led Congress to enact Section 302 of the Tax Relief and Healthcare Act of 2006, which required CMS to establish a national and permanent RAC program by January 1, 2010.

Figure 11. Impact of RAC on responding hospitals by type, through the second quarter of 2010



NOTE: The figure includes responding hospitals with and without RAC activity. AHA analyzed survey data collected from 1,389 hospitals: 972 reporting activity and 417 reporting no activity from January 2010 through June 2010. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, and inpatient observation hospitals.

SOURCE: AHA. (2010, August). *RACTrac Survey*.

institutions reported employing or hiring additional staff to handle RAC issues. Notably, 13 percent of hospitals reported modifying admissions criteria, whereas 12 percent took some actions to change the administrative role of clinical staff; these two particular hospital behavioral responses have the potential to affect beneficiaries. For example, in a separate study on the use of observation services under Medicare, the OMO consistently heard from stakeholders (hospital emergency room physicians, case managers, and administrators) that concerns related to RAC audits and similar oversight activities by other payers were influencing hospitals' inpatient admission decision-making processes.

2 *RACs' effects on Medicare beneficiaries.* As hospitals become increasingly risk averse and conform to a strict interpretation of Medicare coverage policy, both advocates and AHA staff emphasized the importance of CMS focusing on providing education in simple and direct language for beneficiaries and their representatives. Beneficiary advocates observed that Medicare beneficiaries are increasingly expressing uncertainty about coverage and medical decisions that do not make sense to them or appear to be arbitrary. Similarly, AHA representatives reflected that given RAC scrutiny of admissions criteria, beneficiaries should understand clearly, in simple and direct language, that situations exist in which a person may be admitted but not qualify for Medicare coverage.

The possibility of a RAC audit may result in hospitals having Medicare beneficiaries sign an Advance Beneficiary Notice, which allows the provider to bill the beneficiary for the cost of services and items not covered by Medicare.¹⁹ The advocates interviewed consistently noted that the use of observation services is the major area of beneficiary impact related to RACs.

3 *Medical necessity issues and the impact on beneficiaries.*

An underlying fundamental element in RAC auditing involves the concept of medical necessity. The key to fully appreciating the indirect effects of RACs on Medicare beneficiaries is to understand how clinicians interpret or view medical necessity when they are approached by compliance professionals and hospitals' administrative leadership. Access to Medicare-covered services is ultimately tied to physician judgment. Physicians bear sole responsibility for justifying hospital or other facility care and services and providing the necessary documentation to support their rationale for providing services. However, a RAC denial of a hospital claim generally has no or limited financial ramification for physicians, who continue to predominantly view the meaning of medical necessity from a medical, not reimbursement, perspective. If claims are denied, it is beneficiaries who may face an added and unexpected financial burden. Thus, as Medicare program integrity efforts intensify the focus on medical necessity, beneficiaries are likely to have increasing exposure to Medicare coverage issues.

The following two recommendations resulted from the RAC comprehensive study:

- *Incorporate considerations of provider behavioral responses and potential implications for beneficiaries into RAC program administration.* The OMO recommends that CMS' RAC Issue Review Board, perhaps with the OMO's participation, takes into consideration how current and future areas of RAC program



vulnerabilities may affect beneficiaries and identify steps that CMS needs to take to mitigate unintended negative beneficiary impacts.

- *Develop a longer-term strategy for beneficiary educational resources related to Medicare coverage policy on medical necessity determinations.* Improving beneficiaries' understanding of medical necessity determinations for payment purposes needs to receive greater attention as part of longer-term planning for beneficiary education, especially given the increasing focus on the consumer's role in health care. Educational resources for beneficiaries need to be written carefully, with consumer-friendly terminology. Additionally, the materials should emphasize that beneficiaries have certain actionable rights and that Medicare is governed by laws and regulations, messages that would bolster beneficiary confidence in the program and alleviate concerns.

Observation Services

Observation care is a hospital outpatient service covered by Medicare Part B. It includes short-term treatment, assessment, and reassessment by a physician while he or she is evaluating the need for inpatient hospitalization or discharge of the beneficiary. Advocacy groups have raised concerns to the OMO regarding the frequency and length of hospital observation services rendered to Medicare beneficiaries. This issue was first discussed in the 2007-

¹⁹ Engle, Carla. (2010, Spring). Are You RACKing your Brain Over RAC Audits? Innovations in Access Management. 10. Retrieved January 5, 2012, from http://www.scheduling.com/access-management/documents/SCI_IAM_2010Article6.pdf.



2008 Report to Congress and again in the 2010 Report to Congress, where initial findings were reported. The OMO's comprehensive study of observation services began in 2010. The full report with recommendations was released to CMS in 2011.

For several years, the OMO has been aware of and concerned about potential negative consequences to beneficiaries resulting from the use of observation services for extended periods. These negative consequences include the non-coverage of skilled nursing facility (SNF) care and beneficiary-incurred costs for self-administered drugs (SADs).

1 *Post-hospital SNF care may not be covered.* Because observation care is a Part B outpatient service, the time spent by a beneficiary in this care setting does not count toward the 3-day inpatient hospital "qualifying" stay required for the coverage of post-hospital SNF care. Even when the beneficiary is admitted as an inpatient subsequent to the receipt of observation care, the time in observation care is not credited toward the qualifying stay of at least 3 inpatient hospital days. With the growing use of the observation care services and the increase in the length of stay of these services, the OMO became concerned that observation services were being used in lieu of inpatient hospitalization, a phenomenon that would negatively impact coverage of SNF care for Medicare beneficiaries.

2 *Part D prescription coverage may not adequately cover medications provided during outpatient observation care.* Throughout the period of observation care, beneficiaries should continue taking their SADs. However, in consideration of the significant liability connected with patients' self-administering drugs that they or their companions bring with them, typically hospital policies mandate that drugs be prepared and dispensed by their own qualified staff despite encouragement from CMS to allow beneficiaries to take SADs. These drugs, otherwise covered under the Part D benefit, are not covered by Medicare Part B when dispensed in a Part B hospital setting. A beneficiary is then billed by the hospital for these non-covered SADs, generally at higher rates than used by retail pharmacies. While a beneficiary may go through the burden of filing a claim with his/her Part D plan to recoup some of the incurred expenses for receipt of the drug from an out-of-network pharmacy, he or she is still responsible for the difference between the hospital's charges and the amount reimbursed by the Part D plan for its retail pharmacy network. The OMO is concerned about the financial burden to which beneficiaries may be subjected.

The OMO undertook the 2011 comprehensive study to better understand the causes of the significant increase in the frequency and length of stay of observation services as well as the full scope of the potential impact on beneficiaries. Findings from this comprehensive study have been grouped into three areas:

- 1** Factors contributing to the growth in the frequency and length of observation services.
- 2** Findings related to CMS observation policies versus health care needs and practices.
- 3** Issues concerning beneficiaries' and physicians' awareness of the potential adverse implications of the use of observation services.

1 *Factors contributing to the growth in the frequency and length of observation services:*

- **Payment categories and the expansion of eligibility for observation services.** In 2002, the creation of a separately payable category

for observation services for three common qualifying conditions (chest pain, congestive heart failure, and asthma), under the Outpatient Prospective Payment System, provided limited additional payment to hospitals for these services. The potential pool of eligible patients was expanded in 2008 through the elimination of the requirement that a patient has one of these three qualifying conditions.

- **Growth in the very elderly population who may have a greater need for observation services.**

Between 2003 and 2009, the number of individuals aged 80 years and older grew by 1.4 million. Growth in the very elderly population increases demand for services involving clinical situations that require longer periods of time to stabilize a patient, although the patient may not be so ill as to meet inpatient admission criteria. Interviews conducted as part of the comprehensive study consistently indicated that observation services are being used to care for and stabilize these frail elderly patients.

- **Increased scrutiny of short-stay inpatient admissions.** Because of the cost of inpatient care, both Medicare and other payers have increased scrutiny of the use of inpatient care by focusing attention on short inpatient stays and determinations of whether or not they were medically necessary. According to interviewees, this increased scrutiny has resulted in an increase in the use of the outpatient observation setting of care.

2 *Findings related to CMS observation policies versus health care needs and practices:*

Medicare policy requires observation care to be a period of short-term treatment, assessment, and reassessment during which a physician can evaluate whether a patient needs inpatient care or is able to be discharged from the hospital. Individuals interviewed for this comprehensive study who are involved in the care delivery process consistently indicated that some beneficiaries are kept in

Interviewees consistently reported that beneficiaries and their caregivers do not understand the ramifications of being in observation care.

observation care because they are not sufficiently stable to be safely discharged, even though they do not meet inpatient admission criteria. In addition, interviewees indicated that the types of care provided to patients in observation are often similar to those provided to patients in inpatient care. In fact, patients in observation care are sometimes in the same hospital units as inpatients.

3 *Issues concerning beneficiaries' and physicians' awareness of the potential adverse implications of the use of observation services:*

Interviewees consistently reported that beneficiaries and their caregivers do not understand the ramifications of being in observation care. The interviews with administrators of SNFs indicated, however, that there has been a growing awareness among hospital staff and hospital discharge planners of the potential implications of the use of observation services on Medicare coverage of a subsequent SNF admission. Interviews also indicated that generally physicians were not aware of the potential financial implications for beneficiaries of the use of observation services (i.e., the impact on Medicare coverage of SNF care or the cost of medications delivered during the period of observation services).

Based on these findings, the OMO recommends that CMS:

- *Revise provisions concerning SADs.* As was also recommended in the 2010 Report to Congress, the OMO suggests that CMS consider a requirement that Medicare Part A provider hospitals participate in Part D plan pharmacy networks. At the same time, CMS

Medicare covers two types of prevention exams at no cost to beneficiaries: the Initial Preventive Physical Examination and the Annual Wellness Visit.

also could consider requiring Part D plans to include hospital pharmacies in their pharmacy networks, similar to the requirement that CMS developed for nursing homes' long-term-care pharmacies.

- *Require notification of outpatient status to beneficiaries and their families/representatives during the time of delivery of observation care.* Because beneficiaries and/or their family members or representatives might not always realize whether they are hospital inpatients or hospital outpatients receiving observation services, the OMO recommends that CMS require hospitals to provide notification to beneficiaries and/or their representatives of placement in observation care status and its potential ramifications at the time the patient is placed in observation care.
- *Educate physicians about justifying reasonable and necessary hospital admissions and on Medicare coverage of observation services and implications for beneficiaries.* Improved education of physicians concerning how appropriate documentation for supporting an admission decision may help to dampen provider overreaction to the increased scrutiny of inpatient admissions is needed. In addition, physicians should be aware of the financial responsibilities that beneficiaries may incur related to SADs and SNF care resulting from the use of observations services. CMS could develop additional educational materials for physicians and hospitals regarding Medicare coverage of observation services, including information on both SADs and SNF coverage.

- *If proper authority exists, consider requiring hospital utilization review for observation cases lasting 48 hours or more.* Medicare guidance indicates that, in general, observation services are not expected to last longer than 48 hours. A provision requiring an additional hospital utilization review may provide greater protection to beneficiaries so that observation services are used appropriately; the additional hospital review could be accompanied by notification of beneficiary protection rights.

OTHER ISSUES ADDRESSED BY THE OMO

In addition to conducting the three comprehensive studies presented above, the OMO investigated other issues that may negatively affect beneficiaries and/or their caregivers. These issues were identified through casework analysis or were brought to the OMO's attention by its internal and external partners. The OMO worked with other CMS components to validate and/or address these issues.

Annual Wellness Visit

Medicare covers two types of prevention physical exams without requiring Part B coinsurance or deductibles: the Initial Preventive Physical Examination and the Annual Wellness Visit. The Initial Preventive Physical Examination was authorized by the MMA, while the Annual Wellness Visit benefit was authorized by the Affordable Care Act and became effective on January 1, 2011. All Medicare beneficiaries with Part B coverage are eligible for an Annual Wellness Visit exam once every 12 months. Beneficiaries who have received the Initial Preventive Physical Examination must wait 12 months before being eligible for the Annual Wellness Visit benefit.

Beneficiary advocates alerted the OMO that some physician associations may have published incorrect information about the Annual Wellness Visit benefit. Additionally, the OMO was informed that some providers are using the routine physical Healthcare Common Procedure Coding System (HCPCS) code instead of the Annual Wellness Visit HCPCS code because the Annual Wellness Visit code is not widely known in the provider community. As a result of the misapplication of the HCPCS code, Medicare beneficiaries might experience increased out-of-pocket costs because,

with the exception of the Initial Preventive Physical Examination and the Annual Wellness Visit, Medicare usually does not cover routine physical exams.

The OMO investigated the causes of this issue and found that:

- The information published on www.Medicare.gov, on www.HealthCare.gov, in the 2011 *Medicare & You* handbook, and in the draft version of the 2012 *Medicare & You* handbook regarding the Annual Wellness Visit is limited, although information is provided regarding benefit eligibility, how often the benefit is covered, and the associated costs. However, CMS' publication, *Your Guide to Medicare's Preventive Services*, provides a checklist of activities that providers will conduct as part of the Annual Wellness Visit. In addition, CMS published more information on the Annual Wellness Visit through the rulemaking process. Furthermore, the OMO reviewed the 1-800-MEDICARE script about the Annual Wellness Visit benefit and determined that it provided comprehensive information. Therefore, updates are not required.
- The OMO's review of physician association websites revealed that these associations were not publishing information about the Annual Wellness Visit benefit

that conflicted with or differed from the information published by the CMS sources described above. Additionally, the physician associations provide links to CMS documents regarding the benefit.

- The OMO determined that the HCPCS code misapplication issue has already been largely addressed, as procedures are in place to appropriately process claims that may have been miscoded by providers. The memo instructs MACs not to automatically deny "routine service" diagnoses because some providers are not aware of the HCPCS code for the Annual Wellness Visit. Instead, the memo indicates that these claims should be reprocessed so that beneficiaries are not charged for their Annual Wellness Visit.

Based on its review, the OMO considers the available information provided by CMS and physician associations about the Annual Wellness Visit benefit accurate and sufficient for providers to properly apply the Annual Wellness Visit HCPCS. Nevertheless, to ensure that beneficiaries have access to comprehensive information about the Annual Wellness Visit benefit, the OMO suggests that a link to *Your Guide to Medicare's Preventive Services* be included in the *Medicare & You* handbook in the section about the benefit.

CASE EXAMPLE

Family Member Access to Deceased Medicare Beneficiaries' MSNs

The son of a deceased Medicare beneficiary called 1-800-MEDICARE and was referred to the Office of the Medicare Ombudsman (OMO). The beneficiary's son had contacted Medicare to determine what documentation and course of action were necessary for him to be able to pay any remaining health care bills on his father's behalf. The beneficiary's son did not know that he needed his father's Medicare Summary Notices (MSNs), and the customer service representative (CSR) was unable to assist him. The OMO intervened and facilitated revisions to the call scripts used by the CSRs so that, in cases like these, CSRs would offer to send the deceased Medicare beneficiary's MSNs to the beneficiary's address of record. In addition, the OMO called the service center with the beneficiary's son on the phone. As a result, the CSR ordered the necessary MSNs, and the situation was resolved.

AMOUNT CHARGED BY PROVIDER	DISCOUNT AMOUNT	YOUR RESPONSIBILITY	
		COPAY-MENT	CHARGES NOT COVERED
150.00	85.82	15.00	0.00
Total: \$150.00	\$85.82	15.00	0.00

Your Total Responsibility To Your Provider: \$15.00

127
50-1291/219

Family member access to deceased Medicare beneficiaries' Medicare Summary Notices

When surviving spouses or family members need to resolve the outstanding financial matters of deceased beneficiaries, they need access to the deceased beneficiary's Medicare Summary Notice (MSN). A MSN shows all the items and services or supplies that providers and suppliers billed to Medicare during a 3-month period on behalf of a particular beneficiary. It includes what Medicare paid and what the beneficiary may owe the provider and/or supplier.²⁰ Spouses or children of deceased beneficiaries frequently contact the 1-800-MEDICARE helpline to request access to the MSN to obtain evidence of payment of medical bills related to an illness or injury that resulted in the death of the beneficiary. During the first quarter of 2011, the OMO received complaints from family members who were unable to access the deceased beneficiary's MSN.

Upon receiving these complaints, the OMO worked with 1-800-MEDICARE to review relevant call records, which revealed that family members were not asking for the deceased Medicare beneficiary's MSN. Instead, they were seeking assistance from the CSR with settling the financial matters of the deceased beneficiary. However, CSRs

²⁰ Medicare Summary Notice. Retrieved January 17, 2012, from <http://www.medicare.gov/navigation/medicare-basics/understanding-claims/medicare-summary-notice.aspx>.

cannot provide such assistance unless the family member has the deceased Medicare beneficiary's MSN. As a result, the CSRs were forwarding these types of calls to the OMO for further assistance.

The OMO worked with 1-800-MEDICARE to update the content of the relevant scripts. The updated scripts ensure that when family members call to handle accounts for deceased beneficiaries, CSRs know that they can offer to send the deceased beneficiary's MSN to the address on file if the caller does not have access to the MSN. In addition to this intervention, the OMO also drafted guidance titled Requesting Help With Deceased Medicare Beneficiaries, which will be published as a webpage in the Medicare Basics section of www.Medicare.gov. The OMO will continue to monitor beneficiary complaints and contacts to 1-800-MEDICARE related to this issue to ensure that the information available to family members allows them to settle the financial matters of deceased beneficiaries.

Medicare Coverage of Chiropractic Services

Medicare covers chiropractic care for manual manipulation of the spine to correct a subluxation and does not reimburse patients for any other diagnostic or therapeutic services that a chiropractor might offer or order.²¹ Although there is no numerical limit for covered chiropractic services, the number of services that Medicare covers is based on medical necessity (that is, acute and chronic subluxation treatments, not preventive or maintenance-care treatments). Chiropractors are expected to provide beneficiaries with an Advance Beneficiary Notice if they have reason to believe that Medicare will not pay for a particular service on a specific occasion due to a lack of medical necessity for that service.²²

During 2010, the OMO received concerns from an advocacy group that some Medicare beneficiaries were experiencing billing issues for chiropractic services and might be unaware of Medicare's coverage policies for such

²¹ Subluxation is a procedure that is defined "as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact" in the *Medicare Benefit Policy Manual*, Chapter 15, Section 240.12. Centers for Medicare & Medicaid Services, Publication 100-01. Retrieved April 16, 2012, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html>.

²² Centers for Medicare & Medicaid Services. (2011, October). Addressing Misinformation Regarding Chiropractic Services and Medicare. Retrieved April 18, 2012, from https://www.cms.gov/MLNProducts/downloads/Chiropractors_fact_sheet.pdf.

care. According to the advocacy group, some chiropractors are providing Medicare beneficiaries with misleading or incorrect information about service coverage and billing, leading beneficiaries to believe that Medicare would cover all of the costs associated with the chiropractic services they receive.

The OMO's investigation found that beneficiary issues with chiropractic coverage and billing may be a result of:

- Miscommunication between patients and chiropractors about Medicare coverage.
- Beneficiaries' desire to receive chiropractic services due to the health benefits from these services.
- Beneficiaries misinterpreting the language describing Medicare reimbursement limits for chiropractic services in the *Medicare & You* handbook.

The findings of the *Report to Congress on the Evaluation of the Demonstration of Coverage of Chiropractic Services Under Medicare* (2009), commissioned by the Office of Research, Development, and Information, highlighted some of the reasons behind beneficiaries' issues with chiropractic coverage and billing. The findings indicated that if Medicare expands coverage for chiropractic services, beneficiaries will use these services more frequently.²³ Furthermore, analysis of the claims data showed that even though payment would be denied, chiropractors were submitting Medicare claims for expanded services at a high rate before the demonstration began in both demonstration and comparison areas. The CMS 2009 Report to Congress noted that "chiropractors appeared to be submitting these claims either at the beneficiary's request or to obtain Medicare's denial so they could bill other carriers."²⁴ The OMO's analysis of this issue also indicated that the language in the 2011 *Medicare & You* handbook about coverage for chiropractic services should be more explicit to help beneficiaries understand which chiropractic services are covered by Medicare.

To improve beneficiary understanding of Medicare

²³ Centers for Medicare & Medicaid Services. (2009). *Report to Congress on the Evaluation of the Demonstration of Coverage of Chiropractic Services Under Medicare*. Retrieved September 20, 2010, from www.cms.gov/reports/downloads/Stason_Chiro_RTC_2010.pdf.
²⁴ Ibid.

coverage for chiropractic services, per the OMO's suggestion, the 2012 *Medicare & You* handbook informs beneficiaries that they are responsible for the cost of any services or tests, other than subluxation, ordered by a chiropractor. The OMO also worked with 1-800-MEDICARE to add a "chiropractic services" qualifier to the Part B covered/non-covered services subtopic to track and trend the number of beneficiary calls related to this issue.

Erroneous Use of Date-of-Death Code

Upon discharging patients from inpatient settings, providers must enter on the medical claim a patient discharge status code, which is 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 are susceptible to input errors because they are referred to by the same acronym, "DoD," and their numerical codes are easily transposed:

- Date-of-discharge code (which indicates that the patient has been discharged/transferred to a short-term general hospital for inpatient care) value: 02
- Date-of-death code (which indicates that the patient has died) value: 20

When the discharging medical facility provides an erroneous date-of-death code on a claim that is submitted to Medicare, CMS discontinues Medicare benefits for the beneficiary once the claim is processed. Consequently, the erroneous use of a date-of-death code can have serious consequences for a beneficiary. Once benefits are terminated, a beneficiary may be billed directly by health care providers and institutions and have to pay out of pocket for any services, supplies, and/or prescription drugs that otherwise would be covered by Medicare. Additionally, secondary coverage claims (e.g., Medigap, TRICARE) may be denied because their payment is dependent on the approval of the primary claim (i.e., Medicare).

An OMO investigation revealed that several hundred beneficiaries temporarily lose primary and secondary coverage for months because of errors in reporting a date-of-death code. The record correction process is



often lengthy and can consume a significant amount of CMS casework resources to resolve. During this process, beneficiaries and their families must deal with the temporary interruption of coverage, which may result in financial hardship and can impede access to care for some affected beneficiaries.

The OMO collaborated with staff from other CMS components, including the Center for Medicare and the Office of Information Systems, to identify means for addressing the issue. The options included:

- Changing either the date-of-death or date-of-discharge code to avoid errors on claims.
- Requiring documented verification of the date of death in CMS systems, a process currently used by the Social Security Administration to record a beneficiary death.

The OMO worked with these other CMS components to implement a change to address this issue and will report the outcome in the next annual Report to Congress.

2011 REPORT TO CONGRESS
Centers For Medicare & Medicaid Services

