

FY 2014–2016 Report to Congress



From the Medicare Beneficiary Ombudsman

A MESSAGE FROM THE OMBUDSMAN

I am pleased to present this Medicare Beneficiary Ombudsman (MBO) Report to Congress and the Secretary of the U.S. Department of Health & Human Services (HHS). The Centers for Medicare & Medicaid Services (CMS) has been protecting the health and well-being of millions of American families, saving lives, and improving the economic security of our Medicare beneficiaries for more than 50 years.¹

This report details activities undertaken in support of the MBO's mission by staff within the Offices of Hearings and Inquiries (OHI) and in close coordination with many CMS components. This reporting period has been one of transition, including the reorganization of this work under OHI, resulting in this combined report to Congress spanning three fiscal years: 2014–2016. This report also includes three years of the Center for Medicare's (CM's) Parts C and D Online Complaint Data Report.

Throughout this period, we continued to resolve beneficiary casework, participate in outreach and education initiatives, conduct data analysis, and handle beneficiary records corrections. Special efforts focused on supporting CMS' initiatives to improve education and outreach about Part B enrollment decisions and transitions from the Marketplace to Medicare, as well as reducing the occurrence of improper billing of Qualified Medicare Beneficiaries (QMBs). We also participated in implementing revisions to the Medicare premium bill layout and instructions to improve beneficiaries' understanding of it.

Having initially served as the Acting MBO, I was truly honored to transition into this role permanently in 2016. I would like to thank CMS leadership, my many CMS colleagues, and our external partners who worked with us throughout the years to support our Medicare beneficiaries. I look forward to continuing these efforts.

/Catherine Rippey/
Medicare Beneficiary Ombudsman

ABOUT THE OMBUDSMAN

In 2003, Congress established the MBO to assist Medicare beneficiaries with their inquiries, complaints, grievances, appeals, and requests for information, per Section 1808(c) of the Social Security Act.² The MBO's day-to-day work includes supporting CMS' customer service and administration efforts by receiving and responding to beneficiary and other stakeholder inquiries and complaints, working with partners to provide outreach and education to beneficiaries, and providing recommendations for supporting the administration of Medicare.

Catherine Rippey brings a long history of customer service to the role of the MBO. Prior to accepting her current position, she spent 10 years addressing stakeholder inquiries as a senior caseworker in the CMS Kansas City Regional Office (RO). Ms. Rippey also worked as a senior coordinator for the University of Kansas School of Medicine, where she was a liaison for students, medical site directors, and physicians. Before that she was the recruitment coordinator for the West Central Missouri Area Health Education Center, collaborating with community organizations and counseling Medicare beneficiaries who had questions about the Medicare Drug Discount Card. As the MBO, her objectives are to advocate for fairness, bring the beneficiary experience to the attention of policymakers. She also provides relevant information related to the appeals process, serves as an objective source of information and referrals, and assists in the resolution of beneficiary concerns.

TABLE OF CONTENTS

A Message From the Ombudsman..... 1

About the Ombudsman 1

Assisting Beneficiaries With Part B Enrollment
Decisions..... 3

Improving the Medicare Premium Bill 4

Simplifying the Transition From Marketplace to
Medicare 5

Reducing Improper Billing of Qualified Medicare
Beneficiaries 6

Collaborating With the Competitive Acquisition
Ombudsman 7

CMS Accessible Communications 8

Appendix: Online Complaint Data 10

References..... 12

ASSISTING BENEFICIARIES WITH PART B ENROLLMENT DECISIONS

In some cases, delaying Part B enrollment can lead to enrollment penalties or additional out-of-pocket costs.³

CMS participated in a workgroup focused on updating communication resources related to Part B enrollment in response to requests for enhanced communication about this matter. The decision to enroll in or to defer Medicare Part B can be complex, based on a variety of factors.

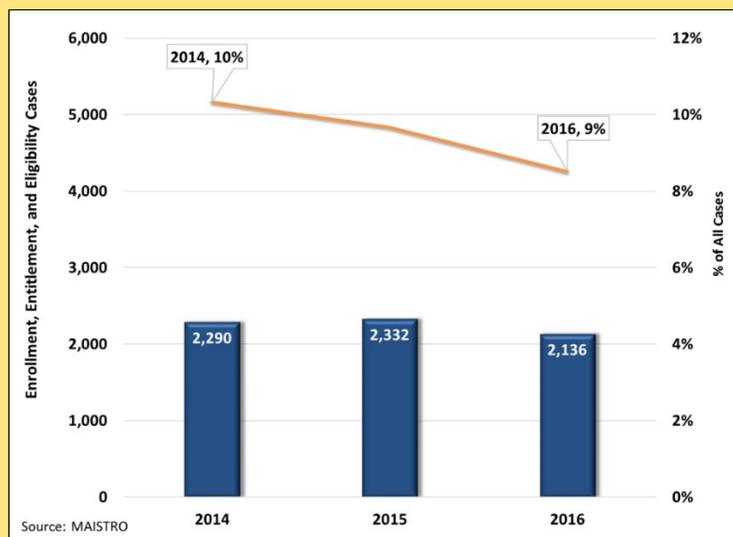
In response to reports from 44 advocacy organizations regarding the need for enhanced communication with individuals who are approaching Medicare eligibility or who are newly eligible, an interagency workgroup was convened in 2015 to address concerns about Part B enrollment outreach and education. CMS participated in this interagency workgroup, along with representatives from the Social Security Administration (SSA), the Department of Labor, and other agencies/staff from HHS. The workgroup developed a comprehensive plan to update Part B enrollment communication resources. To aid in this effort, CMS formed an internal workgroup to determine how to best leverage partnerships and establish a communication strategy, including materials development and dissemination. OHI provided members of the CMS internal workgroup with recommendations from a review it conducted of Part B enrollment resources and considerations in 2010.⁴ OHI also shared

recommendations from its 2015 review of available Medicare enrollment materials. Per the interagency workgroup's plan, the following key publications were updated: Parts A and B enrollment sections of Medicare.gov and CMS.gov, relevant sections of the *Medicare & You* 2016 handbook, and articles on www.blog.Medicare.gov.^{5 6 7} The Social Security statement was also revised to more prominently feature content about Medicare enrollment. 1-800-MEDICARE customer service scripts and CMS National Training Program materials were also updated to provide the most current information to beneficiaries and their advocates who contact Medicare. The work to improve Part B enrollment resources was highlighted at the White House Conference on Aging in July 2015.

A key part of these efforts was the launch of an employer community Web page on CMS.gov in September 2015.⁸ As more beneficiaries continue to work after becoming eligible for Medicare, the site will help connect employees and retirees to sources of up-to-date, official information about Medicare enrollment. This Web page, geared toward employers, includes information on Medicare enrollment and provides a reference list of Medicare publications, such as decision-making fact sheets, to share with employees and retirees. To aid in this effort, OHI shared an additional review with CM and CMS' Office of Communications (OC) that it conducted in 2012 on types of information that employers may find helpful and could share with their employees and retirees.⁹

Data Highlight: Enrollment, Entitlement, and Eligibility Cases

Fee-for-service (FFS) casework regarding Enrollment, Entitlement, and Eligibility decreased from FY 2015 to FY 2016, as shown in the bar graph, which uses the left-hand scale. The subcategory of enrollment-related cases was the most common.¹⁰ The line graph plots these cases as a percentage of all cases. The percentage of all cases that were categorized as Enrollment, Entitlement, and Eligibility decreased slightly between FY 2014 and FY 2016. The data represent cases from beneficiaries, beneficiary representatives, advocate groups, and congressional offices.



IMPROVING THE MEDICARE PREMIUM BILL

Inquiries about the Medicare premium bill are a top source of beneficiary inquiries.

For most beneficiaries, Medicare premiums are automatically deducted from their Social Security, Civil Service, or Railroad Retirement benefits. If an individual's premiums cannot be withheld—for example, because he or she is not collecting Social Security benefits—the beneficiary receives a Medicare premium bill. Premium bills are also sent to high-income beneficiaries who owe an income-related monthly adjustment amount (IRMAA) on their Medicare Parts B and D premiums, except in the case of Medicare Part B IRMAA, where the amount owed may be automatically deducted from another benefit source.¹¹ During the reporting period, the number of beneficiaries directly billed for their premiums rose to 1.9 million.

In 2014, to improve beneficiaries' understanding of the premium bill, a link to the brochure *Understanding Your Notice of Medicare Premium Payment Due Form (CMS 500)* was added to the "Ways to Pay Part A & Part B Premiums" page under "Your Medicare Costs" on the Medicare.gov Web site. In addition, the brochure was added to the Medicare.gov publications database. CMS also disseminated online notifications to 958,318 beneficiaries who received premium bills and had MyMedicare.gov accounts.

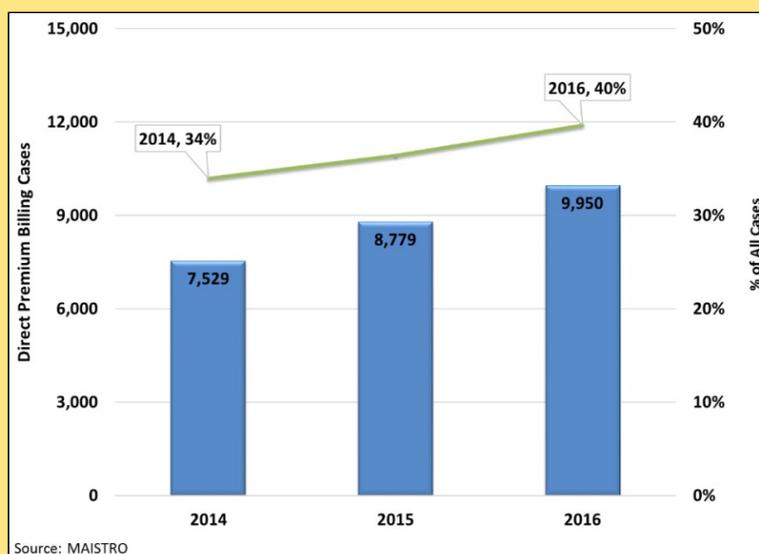
CMS convened a workgroup to identify potential improvements to the premium bill design and to update instructions in response to some of the most common

beneficiary questions, such as those about the calculation of late-enrollment penalties or Part D IRMAA and the application of previous months' payments. Because such an undertaking involved multiple systems and steps, many internal CMS components participated in the workgroup. Staff from external partners, including SSA, also provided feedback. Efforts to revise the layout of the premium bill and update instructions for payment that appear on its back page continued through FY 2016, including beneficiary focus groups, pilot tests of the revised bill, and updates to outreach materials. The revised bill was mailed to beneficiaries beginning in April 2017.

Additionally, beneficiaries have complained that the premium bill payment process is burdensome and outdated. For instance, a beneficiary cannot set up a recurring payment from a credit or debit card, pay by phone, or pay online through Medicare's Web site. Medicare Easy Pay allows for electronic funds transfer from a beneficiary's bank, but there is a delay between the Easy Pay enrollment and the start of the bank withdrawal, which can lead to confusion and missed payments.¹² A beneficiary also cannot check the status of a Medicare Easy Pay transfer online. CMS should consider continuing efforts to find ways to alleviate the undue burden on beneficiaries who are required to pay their premium bills directly and continue to strive toward a more modern bill-payment structure. Allowing beneficiaries to monitor and pay their bills online or over the phone would resolve many of these concerns. CMS is taking this into consideration as it continues to review additional premium-billing enhancements.

Data Highlight: Premium Billing Cases

"Direct Premium Billing" was the most common type of FFS case during the reporting period. As shown in the bar graph, which uses the left-hand scale, the volume of these cases increased each year. As a percentage of all cases, this category increased from 34 percent in FY 2014 to 40 percent in FY 2016, as shown by the line in the figure. The data represent cases from beneficiaries, beneficiary representatives, advocate groups, and congressional offices reported by CMS caseworkers.¹³



SIMPLIFYING THE TRANSITION FROM MARKETPLACE TO MEDICARE

Marketplace consumers may not understand why they should consider terminating their Marketplace qualified health plans (QHPs) and enroll in Medicare when they are first eligible for Medicare.

With the implementation of the Health Insurance Marketplace®, inquiries to CMS from Medicare beneficiaries and partner organizations indicated that transitioning from an Individual Marketplace QHP to Medicare was challenging.

Marketplace issuers (as well as off-Marketplace issuers of individual market coverage) are legally prohibited by Section 1882(d)(3) of the Social Security Act, known as the Anti-duplication provision, from selling individual market coverage, including an Individual Marketplace QHP, to beneficiaries who are already enrolled in Medicare, with knowledge of the enrollee's Medicare status when the coverage duplicates Medicare benefits. However, the Federally Facilitated Marketplace (FFM) system does not currently prevent the enrollment in an Individual Marketplace QHP of those beneficiaries already enrolled in Medicare, and some individuals may have coverage through the Marketplace prior to becoming eligible for Medicare. Under current law, those individuals may remain enrolled in their Marketplace QHPs when they become eligible for premium-free Medicare Part A, but they are not eligible to receive Marketplace premium and cost-sharing assistance, such as an advanced premium tax credit (APTC) or cost-sharing reductions. Some Medicare Part A beneficiaries may remain enrolled in Marketplace QHPs with APTC and may have to pay back all or some of the APTC received for the months when they were eligible for premium-free Part A.

In response to these concerns, CMS formed a multicomponent workgroup coordinated by the MBO that included CMS staff from the Center for Program Integrity, OC, CM, the Federal Coordinated Health Care Office (FCHCO), the Center for Consumer Information and Insurance Oversight (CCIIO), and the Consortium for Medicare Health Plans Operations (CMHPO). The workgroup, in close coordination with OC, initially focused on updating materials and messaging about the transition from Marketplace to Medicare. This effort included clarifying language on Web sites, updating presentations and frequently asked questions, and contributing feedback to the following initiatives.

Spotlight: Retroactive Part A Coverage

Despite the increase in the full retirement age for Social Security benefits, eligibility for those aging into Medicare still begins at age 65. For those who enroll in premium-free Medicare Part A after age 65, the Medicare coverage is retroactive for up to 6 months after the application date under current Medicare regulations.¹⁴ Historically, this has been a helpful beneficiary protection; however, the rule automatically providing retroactive Part A coverage may negatively affect some individuals due to shifts in the current health insurance landscape. For example, individuals with health savings accounts (HSAs) and their employers can contribute to their HSAs on a pretax basis and use those funds for qualified medical expenses. HSAs help offset the cost-sharing associated with the High-Deductible Health Plans with which HSAs are typically paired.¹⁵ However, Medicare enrollees are prohibited from contributing to HSAs, and tax penalties are imposed on those who contribute to HSAs while enrolled in Medicare. This “overlap” often occurs without the beneficiary's knowledge, despite CMS' recent education efforts on the topic of HSAs in recognition of the growth in employer-sponsored health plans that include them.^{16,17,18}

A tax penalty may also be imposed on individuals enrolled in Health Insurance Marketplace® QHPs who are receiving APTC, because individuals eligible for premium-free Part A or enrolled in Part A are not eligible for APTC. Tax penalties may occur if an individual age 65 or older delays Medicare in favor of remaining in his or her Marketplace QHP with APTC but later enrolls in Medicare and has retroactive enrollment applied.

To avoid the HSA tax penalty situation, CMS recommends that beneficiaries stop any HSA contributions at least 6 months before they apply for Medicare.¹⁹ CMS has also increased efforts to notify and encourage Medicare-eligible individuals to consider dropping their Marketplace QHP coverage and enroll in Medicare when they are first eligible. Due to the increased availability and popularity of HSAs, individuals working longer and delaying Medicare, and the tax implications for QHP enrollees, the MBO recommends that individuals carefully review how their current coverage intersects with Medicare eligibility when deciding whether to delay Medicare in favor of other coverage, or make HSA contributions.

In the summer of 2016, CCIIO identified individuals ages 65 and over who were inappropriately dually enrolled in Marketplace QHPs with APTC and in Medicare. Using that information, CMS sent notifications to these individuals, encouraging them to consider terminating their Marketplace coverage and providing detailed instructions for doing so.^{20,21} This initiative included concurrent training for multiple stakeholders in an effort to disseminate consistent information to individuals seeking assistance. CCIIO has since expanded its efforts to notify consumers ages 65 and over who are dually enrolled in Marketplace QHPs (with or without APTCs) and in Medicare. CMS has continued this initiative and has expanded the scope of this effort in subsequent notification rounds.

CM provided equitable relief, in the form of a special enrollment period for Medicare Part B enrollment, to help beneficiaries with dual enrollment transition from Marketplace QHPs to Medicare. This opportunity provides eligible individuals with a chance to immediately enroll in Medicare Part B without penalty. It also provides an opportunity to request a reduction of the late-enrollment penalty for individuals who had been dually enrolled but were otherwise eligible for Part B and whose subsequent Part B enrollment included a late-enrollment penalty. The special enrollment period is available through September 30, 2019.

CMS will continue to seek feedback from Medicare and QHP enrollees, their representatives, and partners who assist with enrollment. The multicomponent workgroup will work to identify potential improvements to enrollment processes and systems and to enhance CMS notifications and outreach to reduce beneficiary exposure to dual-enrollment issues and to facilitate smooth transitions between these two programs.

REDUCING IMPROPER BILLING OF QUALIFIED MEDICARE BENEFICIARIES

The QMB Program covers Medicare cost-sharing payments for low-income beneficiaries through Medicaid.

Under the QMB Program, Medicare-enrolled beneficiaries with incomes under 100 percent of the federal poverty level and limited assets receive assistance with Medicare Parts A and B premiums and cost-sharing from Medicaid. The QMB program is one of the programs known collectively as the “Medicare Savings Programs.” In 2015, 7.2 million individuals—12

percent of people with Medicare—were enrolled in the QMB program. Under federal law, Medicare providers must accept payments from Medicare and Medicaid for services rendered to QMBs as payment in full.²² Although QMBs have no liability to pay providers for deductibles and co-insurance for services covered by Medicare Parts A and B, improper billing of QMBs persists. A 2015 CMS study assessing beneficiaries’ understanding of, and behavior related to, QMB billing confirmed that problems remain. It found that many QMBs mistakenly pay Medicare cost-sharing bills, unaware that such charges are not valid. The study also determined that improper billing of QMBs impacts access to health services.²³ Beneficiaries and their advocates have also identified erroneous billing of QMBs as an ongoing concern. Several factors can contribute to improper billing, including confusion about an individual’s QMB status, provider misunderstanding, and elections by many states to pay the lesser of the Medicare cost-sharing amount or the state’s Medicaid rate in their Medicaid State Plan.

To address these problems, CMS began an agency-wide, cross-component effort focused on improving beneficiary information and supports, promoting provider awareness, and modifying CMS systems to aid provider compliance.

In 2016, CMS revised the *Medicare & You* handbook and the Medicare.gov Web site to highlight billing protections for people in the QMB Program, and it updated internal casework systems to better track billing inquiries and complaints. CMS also improved the ability of 1-800-MEDICARE customer service representatives to identify callers’ QMB statuses and advise them about their billing rights. Additionally, Medicare Administrative Contractors will now send educational letters to providers whose QMB patients contact the 1-800-MEDICARE Call Center about persistent inappropriate billing despite the beneficiary’s efforts to resolve the issue with the provider.²⁴

CMS reminded providers about QMB billing prohibitions, clarified known areas of confusion, and specified consequences for noncompliance as part of the Calendar Year 2017 Physician Fee Schedule Rule and in updates to Medicare Learning Network® articles.^{25,26,27} CMS provided similar education and guidance to Medicare Advantage plans in the 2017 Call Letter and Medicare Managed Care Manual.^{28,29} Furthermore, CMHPO Account Managers engaged in strategic conversations with their plans to reiterate this guidance and identify

any needs for technical assistance to promote provider compliance.

In 2016, CMS began developing changes to the Medicare FFS claims processing systems to aid provider compliance with billing rules and promote greater awareness among beneficiaries. Rolled out in October 2017, these changes alerted providers about the QMB statuses of their patients and lack of liability for cost-sharing (through the Remittance Advice). System modifications will also inform beneficiaries that they are enrolled in the QMB Program and protected from Medicare cost-sharing (through the quarterly Medicare Summary Notice).³⁰

COLLABORATING WITH THE COMPETITIVE ACQUISITION OMBUDSMAN

The MBO participates in the response to certain concerns that the Competitive Acquisition Ombudsman (CAO) identifies.³¹ When inquiries and complaints presented to the CAO relate more generally to all durable medical equipment (DME) and not just to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program (the Program), the CAO collaborates with the MBO to communicate the information to the appropriate CMS officials. For example, documentation concerns related to standard power wheelchair repairs and continuous positive airway pressure (CPAP) devices fall under this category.

Case Example: Standard Power Wheelchair Repairs

The CAO received inquiries and complaints in FY 2014 from contract suppliers and beneficiary advocates in competitive bidding areas about some suppliers' reluctance to repair beneficiary-owned equipment due to a CMS medical review policy that requires verification that the provision of the original item was reasonable and necessary. CMS reminded suppliers of wheelchair repair and replacement rules.³² Also in FY 2014, a large national wheelchair supplier did not become a grandfathered or contract supplier under the Program, which meant that beneficiaries who had previously been served by this supplier had to transition to new contract suppliers within a short period of time and medical necessity documentation was not readily available from the former supplier. In response to this issue, CMS implemented the Medicare Policy Manual Change

Request 8952 (CR 8952) in November 2014, which directs suppliers and contractors to review the DME repair claims to confirm the continued medical necessity of the DME product within the previous 12 months, in addition to the medical necessity of the repair itself, for equipment still within the capped rental period.³³ This addressed the issue of unavailable documentation of medical need for the original base equipment; however, some stakeholders were unaware of the new requirements resulting from the policy change. CMS caseworkers worked with individual beneficiaries to assist them in finding suppliers to make repairs to the beneficiary-owned equipment and to obtain necessary documentation. The CAO shared the change request information with stakeholders and communicated feedback to the CMS Program staff regarding the need for provider education on the topic.

Case Example: CPAP Device Medical Necessity Documentation

CMS medical review criteria require several supporting documents for Medicare coverage of CPAP devices, which are typically generated by beneficiaries' treating physicians and sleep-study labs. When a beneficiary transitions to any new supplier—not just those under the Program—these documents must be obtained by the new supplier and kept on file to support claims reimbursement. However, contract suppliers under the Program may experience times when a larger number of beneficiaries than usual are transitioning to their services because of Program implementation cycles.

Contract suppliers reported that collecting the required medical necessity documentation was often difficult due to a lack of collaborative document sharing between original and new suppliers and the timing of initial sleep studies. Thus, contract suppliers requested more time to gather the required medical necessity documents. The CAO provided supplier and beneficiary advocate feedback to CMS staff, including the MBO. Due to this feedback, contract suppliers were granted a 120-day grace period (July 1, 2013–October 31, 2013) to obtain written CPAP/respiratory assist device orders for certain beneficiaries and documentation to support medical necessity for accessories. CMS and the supplier community collaborated to raise awareness of this policy change by disseminating information through e-mail lists, online forums, Open Door Forums, Web applications, and CMS and supplier Web sites.

CMS Accessibility & Nondiscrimination for Individuals with Disabilities Notice

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

CMS Accessible Communications

CMS provides free auxiliary aids and services including information in accessible formats like Braille, large print, data/audio files, relay services and TTY communications.

To request Medicare or Marketplace information in an accessible format you can:

Call us:

For Medicare: 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048

For the Health Insurance Marketplace®: (1-800-318-2596). TTY: 1-855-889-4325

Email us: altformatrequest@cms.hhs.gov

Send us a fax: 1-844-530-3676

Send us a letter:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1-13-25
Baltimore, MD 21244-1850
Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known) and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Prescription Drug Plan, contact your plan to request their information in an accessible format. For Medicaid, contact your State or local Medicaid office.

How to File a Complaint:

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online (the link will take you directly to: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>)

By phone: Call 1-800-368-1019. TTY users can call 1-800-537-7697.

In writing: Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

CMS Accessibility & Compliance with Section 508

CMS is committed to making its electronic and information technologies accessible to people with disabilities. If you can't access content or use features on this website due to a disability, contact our Section 508 Team at 508Feedback@cms.hhs.gov. To help us better serve you, upload the material in question and/or include the URL if possible and let us know the specific problems you're having.

Appendix:



FY 2014–2016 Online Complaint Data

INTRODUCTION

Among other customer service tasks, the Centers for Medicare & Medicaid Services (CMS) utilizes the Complaint Tracking Module (CTM), for managing complaints about Medicare Advantage, Cost, Demonstration, and Prescription Drug Plans and PACE Organizations. Complaints may be submitted by beneficiaries, their caregivers, and other parties orally, in writing, or electronically. An electronic complaint form relating to Part D drug plans must be displayed in a prominent location on the Medicare.gov and Medicare Beneficiary Ombudsman (MBO) Web sites.^{34,35} This electronic complaint form was made available in December 2010 and is found at <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. CMS is subsequently required to include an analysis of the complaints registered through this system in an annual Report to Congress.³⁶ CMS is complying with this requirement via this fiscal year (FY) 2014–2016 MBO Report to Congress.

Because the online complaint form is widely accessible to all Medicare providers, beneficiaries, and their caregivers, various types of matters are received. 1-800-MEDICARE customer service representatives review each submission, addressing questions and inquiries whenever possible. Those determined to require casework handling are logged into CTM. In other words, not all entries through the online complaint form, will be recorded in CMS' systems as a complaint. Beneficiaries with urgent issues are directed to not use the online form in order to receive more rapid resolution. CMS requires Medicare Advantage and Prescription Drug Plans to address and resolve CTM complaints assigned to them, and to provide information on the time frame in which they notified beneficiaries regarding the status and resolution of their complaints.³⁷ This requirement allows CMS to determine whether sponsors are closing complaints in a timely manner. CMS routinely monitors the status of all complaints assigned to plans for program compliance.

FY 2014–2016 Data Analysis and Results

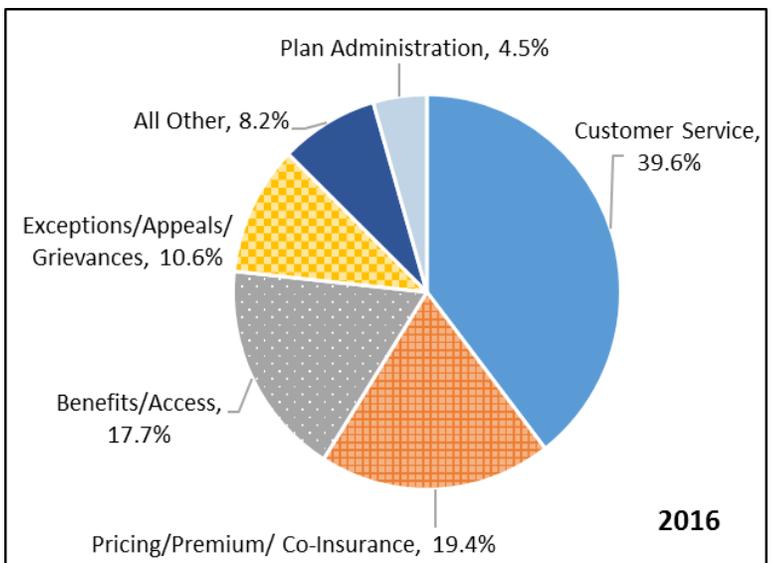
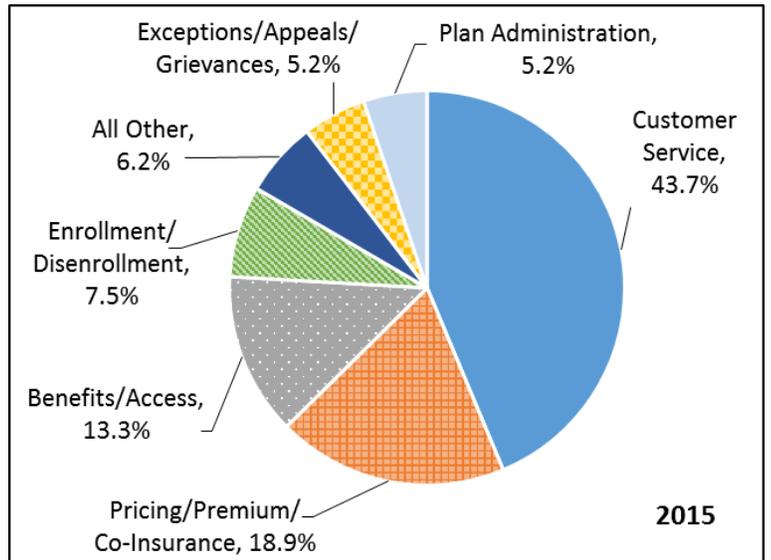
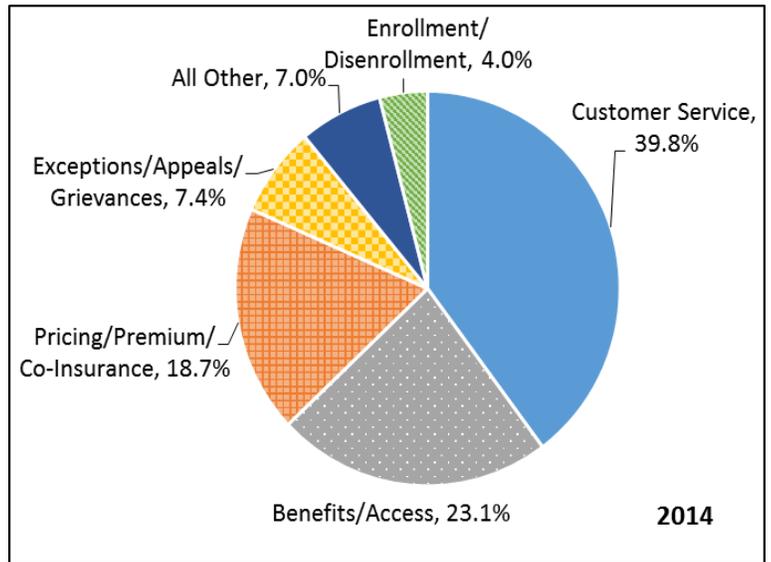
During FYs 2014–2016 (October 1, 2013–September 30, 2016), 88,017 complaints were received in FY 2014; 100,792 in FY 2015; and 73,382 in FY 2016 for an overall total of 262,191. Of these, 9,911 online submissions were received, and 2,133, or 22 percent, were complaints related to Medicare health and/or drug plan coverage. These 2,133 online complaints represented less than one percent of all CTM complaints received during the reporting period.

Complaints are categorized in CTM for casework and resolution. Most online complaints reported during FYs 2014–2016 related to (1) problems with customer service; (2) pricing concerns, such as copays and co-insurance; (3) benefits and access; (4) appeals concerns, such as exceptions and grievances; (5) enrollment and disenrollment concerns; and (6) concerns about plan administration.

The ranking, percentage, and categories of the top five complaints slightly varied during each fiscal year, as shown in the figures. In FY 2015, concerns about exceptions and grievances and issues with plan administration were tied for the fifth most reported complaint. During FY 2016, problems with plan administration were the fifth most reported complaint category. Concerns regarding enrollment and disenrollment came in sixth.

The top five groupings of complaints made up more than 90 percent of all complaints received during each fiscal year reported, as shown in the figures. Remaining complaints are captured under "All Other" in the figures and included concerns about marketing, payments and claims, contractor and partner performance, confidentiality and privacy, good cause equitable relief, acquisition of Medicaid eligibility information, and the Medicare Part D Coverage Gap Discount Program.

Top Five Categories for Online Complaints, by Fiscal Year



REFERENCES

- 1 CMS.gov. (2015). *Medicare & Medicaid 50th Anniversary*. Retrieved on April 6, 2016 from <https://www.cms.gov/outreach-and-education/look-up-topics/50th-anniversary/medicare-and-medicare-50th-anniversary.html>.
- 2 Social Security Act § 1808(c), 42 U.S.C. 1395b-9.
- 3 Individuals may also choose to defer or opt out of Part B enrollment; however, premium penalties may be incurred for enrolling in Part B after an individual's initial enrollment period (IEP). Beneficiaries who defer enrollment in Part B until after the IEP has passed are generally subject to a penalty of 10 percent of the Part B premium for each 12-month period that has passed since their initial eligibility, unless they qualify for a special enrollment period.
- 4 CMS.gov. (n.d.). *Office of the Medicare Ombudsman 2010 Report to Congress*. Retrieved on February 26, 2016 from <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/downloads/2010OmbudsmanReporttoCongress022212.pdf>.
- 5 Medicare.gov. (2015). *What You Need to Know First About Enrolling in Medicare*. Retrieved on February 26, 2016 from <http://blog.medicare.gov/2015/07/13/enrolling-in-medicare/>.
- 6 Medicare.gov. (2015). *Medicare & You 2016*. CMS Product No. 10050. Retrieved on February 26, 2016 from <https://www.medicare.gov/Pubs/pdf/10050.pdf>.
- 7 Medicare.gov. (2012). *Enrolling in Medicare Part A and Part B*. CMS Product No. 11036. Retrieved on February 26, 2016 from <https://www.medicare.gov/Pubs/pdf/11036-Enrolling-Medicare-Part-A-Part-B.pdf>.
- 8 CMS.gov. (2015). *Employer Community Webpage*. Retrieved on February 26, 2016 from <https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers/Employer-Community.html>.
- 9 CMS.gov. (n.d.). *Office of the Medicare Ombudsman 2012 Report to Congress*. Retrieved on February 26, 2016 from <https://www.cms.gov/Center/Special-Topic/Ombudsman/2012-Ombudsman-Report-to-Congress.pdf>.
- 10 Data were obtained from the Medicare Administrative Issue Tracker and Reporting of Operations (MAISTRO) system, where caseworkers record FFS case details, on April 6 and 7, 2017. Date was generated based on "Component Received Date." Inquirer types other than beneficiaries, beneficiary representatives, advocate groups, and Congressional offices were excluded. Total case volume for the inquirer types represented was 22,181 in FY 2014, 24,118 in FY 2015, and 25,083 in FY 2016.
- 11 Medicare.gov. (n.d.). *Ways to Pay Part A & Part B Premiums*. Retrieved on May 31, 2016 from <https://www.medicare.gov/your-medicare-costs/paying-parts-a-and-b/pay-parts-a-and-b-premiums.html>.
- 12 Medicare.gov. (n.d.). *Medicare Easy Pay*. Retrieved on May 23, 2017 from <https://www.medicare.gov/your-medicare-costs/paying-parts-a-and-b/medicare-easy-pay.html>.
- 13 Data were obtained from the MAISTRO system, where caseworkers record FFS case details, on April 6 and 7, 2017. Date was generated based on "Component Received Date." Inquirer types other than beneficiaries, beneficiary representatives, advocate groups, and Congressional offices were excluded. Total case volume for the inquirer types represented was 22,181 in FY 2014, 24,118 in FY 2015, and 25,083 in FY 2016.
- 14 Gpo.gov. (1997). *42 CFR 406.6 - Application or Enrollment for Hospital Insurance*. Retrieved on October 25, 2016 from <https://www.gpo.gov/fdsys/granule/CFR-1997-title42-vol2/CFR-1997-title42-vol2-sec406-6>.
- 15 Ibid.
- 16 Pwc.com. (2015). *Medical Cost Trend: Behind the Numbers 2015*. Retrieved on October 18, 2016 from <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/pwc-hri-medical-cost-trend-2015.pdf>.
- 17 Ebri.org. (2015). *Health Savings Account Balances, Contributions, Distributions, and Other Vital Statistics, 2014: Estimates From the EBRI HSA Database*. Retrieved on October 26, 2016 from https://www.ebri.org/pdf/briefspdf/EBRI_IB_416.July15.HSAs.pdf.
- 18 Devenir.com. (2016). *2015 Year-End HSA Market Statistics & Trends*. Retrieved on September 22, 2016 from <http://www.devenir.com/devenirWP/wp-content/uploads/2015-Year-End-Devenir-HSA-Market-Research-Report-Executive-Summary.pdf>.
- 19 Medicare.gov. (n.d.). *Signing Up for Medicare: Special Conditions*. Retrieved on April 6, 2017 from <https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/special-conditions/special-conditions.html#collapse-5132>.
- 20 CMS.gov. (2016). *Medicare Periodic Data Matching (PDM): Identifying and Notifying Consumers Who Are Dually Enrolled in FFM Coverage With Financial Assistance and MEC Medicare*. Retrieved on November 4, 2016 from <https://marketplace.cms.gov/technical-assistance-resources/medicare-periodic-data-matching.pdf>.
- 21 CMS.gov. (n.d.). *Overview*. Retrieved on November 4, 2016 from <https://marketplace.cms.gov/applications-and-forms/medicare-pdm-notice.pdf>.
- 22 CMS.gov. (2016). *Prohibition on Balancing Billing Dually Eligible Individuals Enrolled in the Qualified Beneficiary (QMB) Program*. MLN Matters®: SE1128. Retrieved on June 2, 2016 from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1128.pdf>.
- 23 CMS.gov. (2015). *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)*. Retrieved on April 10, 2017 from http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.
- 24 CMS.gov. (2016). *Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs) for Medicare Cost-Sharing*. MLN Matters®: MM9817. Retrieved on April 24, 2017 from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf>.
- 25 CMS.gov. (2016). *CY 2017 Physician Fee Schedule: CMS-1654-F*. Retrieved on April 24, 2017 from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-f.html>.
- 26 CMS.gov. (2016). *Prohibition on Balancing Billing Dually Eligible Individuals Enrolled in the Qualified Beneficiary (QMB) Program*. MLN Matters®: SE1128. Retrieved on June 2, 2016 from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1128.pdf>.
- 27 CMS.gov. (2016). *Dual-Eligible Beneficiaries Under Medicare and Medicaid*. MLN® ICN 006977. Retrieved on April 24, 2017 from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.
- 28 CMS.gov. (2016). *Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*. Retrieved on October 12, 2018 from <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>.
- 29 CMS.gov. (2017). *Medicare Managed Care Manual Chapter 2 - Medicare Advantage Enrollment and Disenrollment*. Retrieved on October 12, 2018 from <https://www.cms.gov/Medicare/Eligibility-and->

Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2018_MA_Enrollment_and_Disenrollment_Guidance_6-15-17.pdf
30 CMS.gov. (2017). *CMS Manual System Change Request 9911: Qualified Medicare Beneficiary Indicator in the Medicare Fee-for-Service Claims Processing System*. Retrieved on March 23, 2017 from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3715CP.pdf>.
31 Social Security Act § 1847(f), 42 U.S.C. 1395w–3(f).
32 CMS.gov. (2015). *The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program*. MLN® ICN 905283. Retrieved on December 11, 2015 from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DME_Repair_Replacement_Factsheet_ICN_905283.pdf.
33 CMS.gov. (2014). *CMS Manual System Change Request 8952*. Retrieved on August 8, 2017 from <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R546PI.pdf>.
34 §42 USC § 1395w-154(a).
35 §42 USC § 1395w-154(b).
36 §42 USC § 1395w-154(c).
37 42 CFR §§ 422.504(a)(15), 423.505(a)(22).

The website links provided were accessible at the time this report was developed. Please contact us if a reference website is now inactive and you would like to request a copy of the referenced material.

Please contact:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1-13-25
Baltimore, MD 21244-1850

Your request should include:

- Your name, phone number, and the mailing address where we should send the materials.
- The endnote/footnote number and title of the reference materials you request.
- The format you need, like original publication, Braille, large print, or data/audio CD.