

OFFICE OF THE MEDICARE OMBUDSMAN

Improving Medicare for Beneficiaries

2010 REPORT TO CONGRESS

Centers For Medicare & Medicaid Services



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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
ADLs	Activities of Daily Living
BCT	Beneficiary Contact Trend (Report)
CAO	Competitive Acquisition Ombudsman
CM	Center for Medicare
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
CSR	Customer Service Representative
CTM	Complaint Tracking Module
CWF	Common Working File
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
DSS	Department of Social Services
FCHCO	Federal Coordinated Health Care Office
FFS	Fee-for-Service
FY	Fiscal Year
GHP	Group Health Plan
HIPAA	Health Insurance Portability and Accountability Act
HSA	Health Savings Account
ICD	International Classification of Diseases
IEP	Initial Enrollment Period
IEQ	Initial Enrollment Questionnaire
IRMAA	Income-Related Monthly Adjustment Amount
IVR	Interactive Voice Response
LCD	Local Coverage Determination
LIS	Low-Income Subsidy
MA	Medicare Advantage

Acronym	Term
MAC	Medicare Administrative Contractor
MAISTRO	Medicare Administrative Issue Tracker and Reporting of Operations (System)
MA-PD	Medicare Advantage Prescription Drug (Plan)
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSP	Medicare Secondary Payer
NPI	National Provider Identifier
OEABS	Office of External Affairs and Beneficiary Services
OFM	Office of Financial Management
OIS	Office of Information Services
OL	Office of Legislation
OMO	Office of the Medicare Ombudsman
PDP	Prescription Drug Plan
QC	Quarters of Coverage
QMB	Qualified Medicare Beneficiary
RO	Regional Office
SAD	Self-Administered Drug
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SME	Subject-Matter Expert
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SSA	Social Security Administration
SSN	Social Security Number

MESSAGE FROM THE MEDICARE BENEFICIARY OMBUDSMAN



I am pleased to present the 2010 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 2010, is the primary opportunity for the OMO to inform Congress and the Secretary of the OMO's activities, systemic issues adversely affecting Medicare beneficiaries, and recommendations for addressing these issues.

Medicare beneficiaries do not always receive the coverage and care they need and are entitled to under Medicare in every case as it is intended. These gaps between beneficiaries' needs and the benefits received occur for a variety of reasons, including errors in the administration of Medicare benefits and beneficiary misunderstanding of Medicare policies. The OMO's role in helping to bridge this gap constitutes the key theme of the 2010 Report to Congress. For many beneficiaries, questions and issues related to their Medicare benefits may never arise or, if they do, they can be readily resolved by calling 1-800-MEDICARE or by contacting one of the many other Medicare-contracted entities, such as the Coordination of Benefits Contractor or other beneficiary assistance entities. In other cases, issues, particularly when they are systemic, are not so easily remedied. The OMO continues to assist Medicare beneficiaries after previous efforts by them, their families, and advocates have failed to resolve the issue.

In many instances since its establishment, the OMO has provided direct assistance to Medicare beneficiaries as the primary means for resolving individual beneficiary issues. Over the past 5 years, the OMO has worked to improve the efficiency and effectiveness of its responses to beneficiary inquiries and complaints. As a result of these efforts, in 2010, the OMO responded to more than 75 percent of complex cases within 10 business days and 93 percent in less than 30 business days. The OMO also implemented a rapid response process to expedite non-complex written inquiries, responding to most within 10 business days.

Although individualized casework is an integral element of the OMO's activities, the OMO's overarching goal is to improve service for beneficiaries by preventing issues from arising in the first place. To achieve this goal, the OMO identifies systemic issues that affect large segments of the Medicare population or that can adversely affect beneficiaries' well-being. It does so through an Issues Management process and through collaboration with beneficiary advocacy groups and other Centers for Medicare & Medicaid Services (CMS) components.

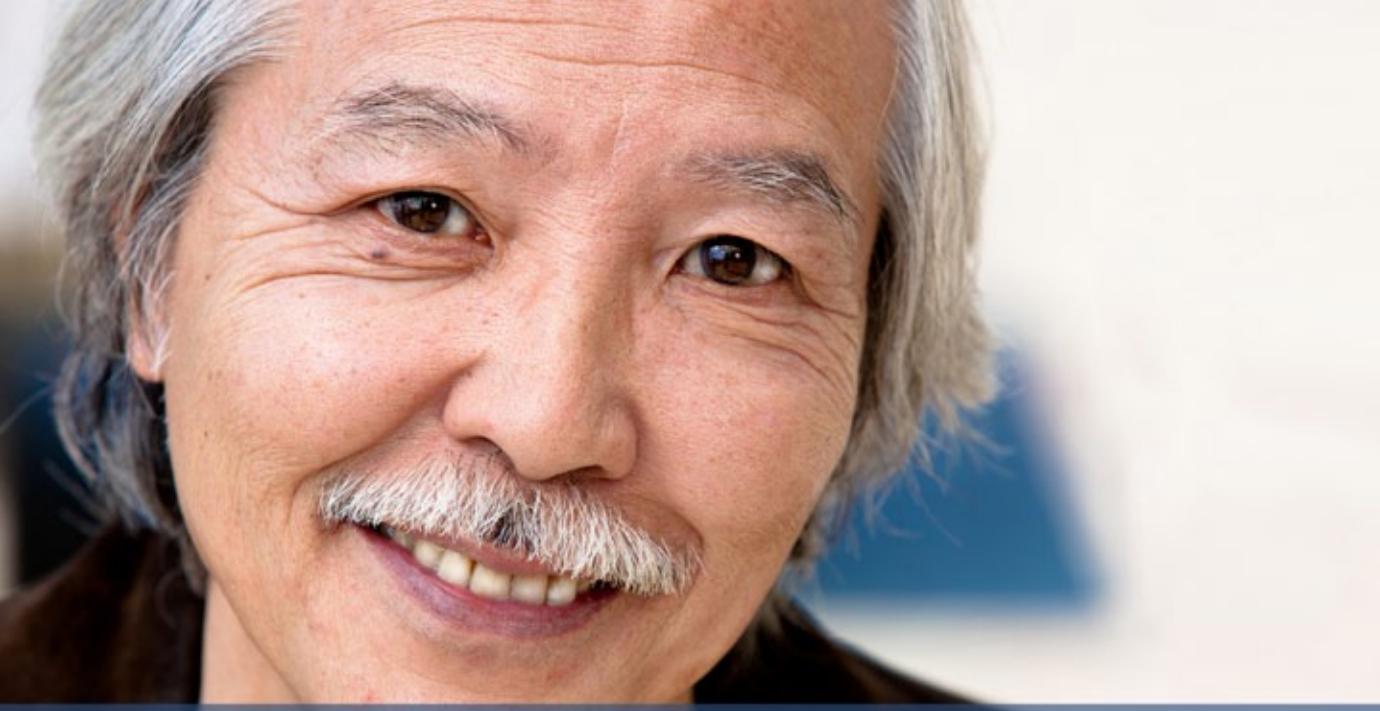
In 2010, the OMO completed several comprehensive studies designed to increase the organization's capacity to better identify the root causes of beneficiary issues and to develop specific, actionable recommendations. The use of comprehensive studies represents a shift toward a more evidence-based approach to understanding and resolving systemic beneficiary issues.

The OMO's 2010 Report to Congress presents in detail five issues that were the subject of comprehensive studies and the studies' recommendations. Coordination of benefits and balance billing of Medicare beneficiaries with Medicaid were initially presented in the 2009 Report to Congress. These two issues are revisited in this report, reflecting the completion of the comprehensive studies and including the recommendations the OMO made in 2010. Other issues discussed in the 2010 report include Medicare Part B enrollment decisions, the application of Medicare therapy benefits, and the use of observation services. The OMO has shared the recommendations from these studies with CMS Leadership and, where possible, has begun implementing them with the assistance of the appropriate CMS components. I look forward to reporting on the outcome of these efforts in future OMO Reports to Congress.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel J. Schreiner".

Daniel J. Schreiner
Medicare Beneficiary Ombudsman



The Office of the Medicare Ombudsman is a voice for beneficiaries, providing beneficiaries direct assistance with their inquiries, complaints, grievances, and appeals.

MISSION, VISION, AND ORGANIZATION

MISSION

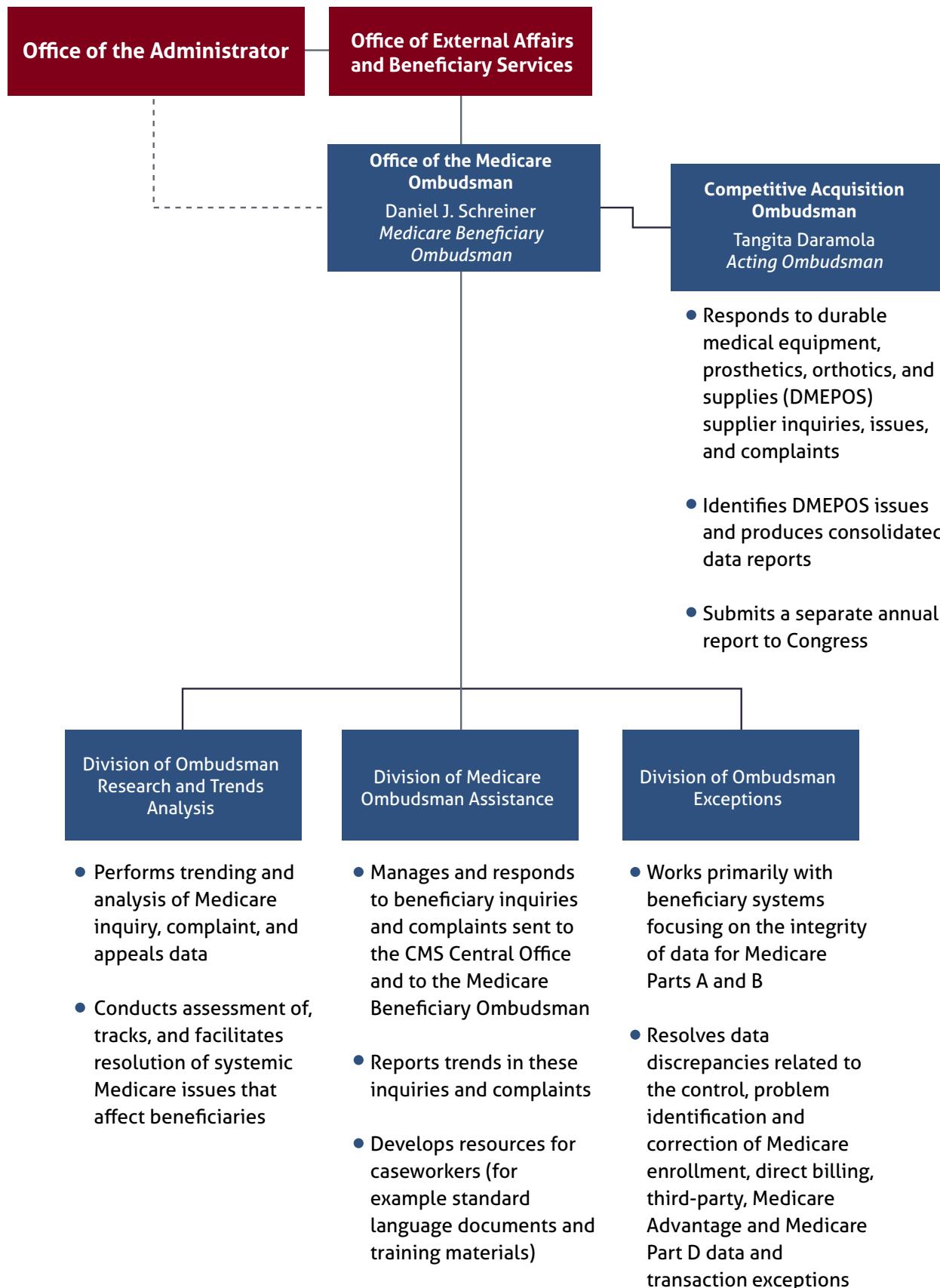
The Office of the Medicare Ombudsman (OMO) is a voice for beneficiaries, providing beneficiaries direct assistance with their inquiries, complaints, grievances, and appeals. The OMO works to improve Medicare through evaluating policies and procedures with internal and external partners and making recommendations to Congress and the Secretary of the U.S. Department of Health & Human Services.

VISION

The Centers for Medicare & Medicaid Services (CMS) Office of the Medicare Ombudsman is the beneficiary's advocate.

ORGANIZATION

The OMO is located within the CMS Office of External Affairs and Beneficiary Services and has direct access to the CMS Administrator to raise identified 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 provide direct assistance to beneficiaries through casework. Additionally, DOE works on data transaction issues. DORTA focuses on data reporting and trending, casework collaboration, and conducts an Issues Management process, which identifies and addresses systemic problems affecting Medicare and its beneficiaries. The Competitive Acquisition Ombudsman (CAO), within the OMO, responds to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier inquiries, issues, and complaints. The CAO also identifies DMEPOS issues, produces consolidated data reports, 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.





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.

EXECUTIVE SUMMARY

With over 46 million beneficiaries, Medicare is the largest health insurance program in the United States. The program serves individuals with a broad array of needs, including 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. To meet beneficiaries' varied needs, Medicare offers multiple coverage options, including enrolling in traditional Medicare or a Medicare-contracted health plan and enrolling in one of many Prescription Drug Plans.

Given Medicare's size and complexity, it is almost inevitable that some beneficiaries will have problems accessing the benefits to which they are entitled. The gap between beneficiaries' coverage and care needs and the benefits received occurs largely because of a lack of access to information, beneficiaries' and their caregivers' difficulties in fully understanding the available information, and unintended breakdowns in 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. The OMO completed several comprehensive studies in 2010 designed to increase the organization's understanding of systemic beneficiary issues and to develop specific, actionable recommendations. These studies represent a shift toward an evidence-based approach to understanding and resolving systemic beneficiary issues.

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 2010 to fulfill its mission:

Direct services to beneficiaries: The OMO managed 12,803 direct contacts to the Centers for Medicare & Medicaid Services (CMS)—from beneficiaries; their families, caregivers, and advocates; and from congressional offices. The OMO also handled 84,304 data issues and/or corrections to beneficiary enrollment and entitlement records.

30 quarters workload: The OMO trained the Regional Offices' (ROs') staff to assist with the manual processing of approximately 5,200 beneficiary records with incorrect Part A premium payments. The Division of Ombudsman Exceptions processed 835 complex refund cases, resulting in over \$5 million in excess Part A premium deductions refunded to beneficiaries.

Competitive Acquisition Ombudsman (CAO): During 2010, the acting CAO established customer service processing standards for CMS' response to durable medical equipment inquiries and complaints and facilitated the development of information regarding the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding program.

National Casework Calls: In 2010, the OMO facilitated 40 National Casework Calls, with 16 of the calls dedicated to Medicare Parts A and B topics and the remaining 24 calls dedicated to Medicare Parts C and D topics.

National caseworker training program: The OMO facilitated the national caseworker training program for CMS Central Office and ROs casework staff. To improve caseworker training opportunities further, the OMO refocused its training workgroup in 2010 to enhance training needs assessment, planning, and delivery for 2011.

Standard language letters: In 2010, the OMO developed 65 standard language letters that allowed CMS caseworkers to respond more accurately and

THE 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. Congress created this program to reduce Medicare costs for durable medical equipment (DME). In 2009, the Medicare Beneficiary Ombudsman named an acting CAO, within the Office of the Medicare Ombudsman (OMO). The acting CAO works with external partners and other Centers for Medicare & Medicaid Services (CMS) components to facilitate competitive bidding policy clarifications and changes and to identify and address regulatory issues that affect Medicare. The acting CAO submits an annual report to Congress in coordination with the OMO's Report to Congress.

During 2010, the acting CAO established customer service processing standards for responding to supplier and beneficiary inquiries and complaints about competitive bidding for DME. The acting CAO also led the development of information regarding the DMEPOS Competitive Bidding program; this information is available on www.cms.gov.

To ensure that caseworkers have the necessary training and access to information, the acting CAO developed and implemented agency-wide training and evaluation of caseworkers on competitive bidding. The acting CAO collaborated with contracted staff and CMS' Central Office and Regional Offices to implement a nationwide technical training program for caseworkers. The training featured scenarios and guidance on changes to the Medicare payment schedule amount resulting from the competitive bidding program and how to triage specific situations. The acting CAO also provided training to State Health Insurance Assistance Program counselors located in areas where the competitive bidding program will be implemented.

efficiently to inquiries on various Medicare topics, bringing the total number of letters to nearly 500 since the initiative began.

State Health Insurance Assistance Programs' (SHIPs') conversations with the Medicare Beneficiary

Ombudsman: The OMO initiated open conversations with SHIPs to develop stronger relationships with their directors and staff. In 2010, the Medicare Beneficiary Ombudsman visited several SHIP offices in Maryland, Virginia, Washington, Pennsylvania, and Washington, D.C.

Development of comprehensive studies: In 2009, in response to encountering increasingly complex issues that required in-depth evaluations and root-cause analyses, the OMO established a process for developing comprehensive studies. In 2010, the OMO completed four comprehensive studies and did substantial work on a fifth.

AREAS FOR IMPROVING BENEFICIARIES' EXPERIENCES WITH MEDICARE

In the 2010 Report to Congress, the OMO identifies five systemic issues adversely affecting beneficiaries; the OMO completed comprehensive studies on four of these issues, which resulted in specific recommendations to CMS for improving Medicare.

Coordination of Benefits

Coordination of benefits (COB) involves the coordination of beneficiaries' Medicare coverage with supplemental or other insurance policies. Most transactions requiring COB happen successfully and without any impact on the beneficiary. However, a small percentage of COB issues can affect a large number of Medicare beneficiaries because the vast majority of Medicare enrollees (approximately 87 percent in 2009) have at least one additional form of coverage. COB issues between Medicare, private group health plans (GHPs), and workers' compensation insurance have grown both in number and importance. COB-related issues may continue to grow because of the increasing number of individuals aged 65 and older remaining in the workforce and retaining insurance coverage through their employers.

In 2010, the OMO completed comprehensive studies on four issues, resulting in specific recommendations to CMS for improving Medicare.

Because of the number of scenarios that may arise from potentially multiple and overlapping coverage policies, the rules that govern COB issues are complex for Medicare beneficiaries, physicians, and insurers, particularly regarding the issue of primary payment responsibility (that is, who pays first), which is influenced by the source of the coverage. This complexity can result in miscommunication and delays in the payment of claims. For example, in the case of employer GHP coverage, the COB rules that determine primary and secondary coverage may depend on the employer's size.

Resolving COB issues may be time consuming and can create financial concerns for both beneficiaries and providers when medical bills are not paid on time and providers pursue payment from the beneficiaries.

Qualified Medicare Beneficiary Balance Billing

Qualified Medicare Beneficiary (QMB) balance billing refers to the prohibited practice of providers billing beneficiaries for the balance of charges not covered by Medicare and Medicaid. A QMB is an individual whose Medicare premiums, deductibles, co-insurance, and copays for Parts A and B are covered by Medicaid, under the provisions of the Medicare Catastrophic Coverage Act of 1988. Medicare providers serving QMBs must bill the state Medicaid agency to receive payment for Medicaid's contribution to the QMB cost of care. Section 1902(n)(2) of the Social Security Act provides that Medicare payments and Medicaid payments, if any, be considered payment in full to the provider for services rendered to a QMB. However, some providers do bill these beneficiaries for the balance of the charges, although this practice is prohibited.

QMB balance billing may cause hardships for QMBs who, although they are not required to pay these additional charges, often pay the balances anyway. The reasons they may do so are numerous, including fear of damaging their relationship with their doctor. Furthermore, QMBs may experience access to care issues. Because of a lack of understanding of their state's requirements for enrollment, providers may avoid accepting QMB patients out of concern that they may automatically be designated as Medicaid providers.

Medicare Part B Enrollment Decisions

The decision to enroll in Medicare Part B is often complex because enrolling may require payment of a premium, and this premium is dependent on individual circumstances, such as age at retirement, participation in other sources of health care coverage, health status, and financial resources. Although enrollment in Medicare Part B is voluntary, enrollment still requires individuals who become eligible for benefits to decide at the time of eligibility whether to enroll or defer enrollment to a later date.

Both the transition from current worker to retired worker and the transition from current worker under age 65 to current worker aged 65 years and older require the decision to either retain employer-provided health care coverage or enroll in Medicare. A source of confusion comes from the increase in the Social Security retirement age, which causes Medicare and Social Security benefits to no longer be synchronized and leads to uncertainty among beneficiaries as to the appropriate Medicare enrollment age. In order to make appropriate decisions about enrollment in Medicare Part B, beneficiaries must receive assistance from CMS, the Social Security Administration, or their employers so they can be well informed.

Medicare Rehabilitation Therapy Benefits

Medicare provides coverage for rehabilitation therapy services, which include physical and occupational therapy and speech/language pathology, for beneficiaries requiring the skills of a qualified therapist. These services are covered under Medicare Part A or Part B: the part of Medicare that covers therapy services depends on the treatment

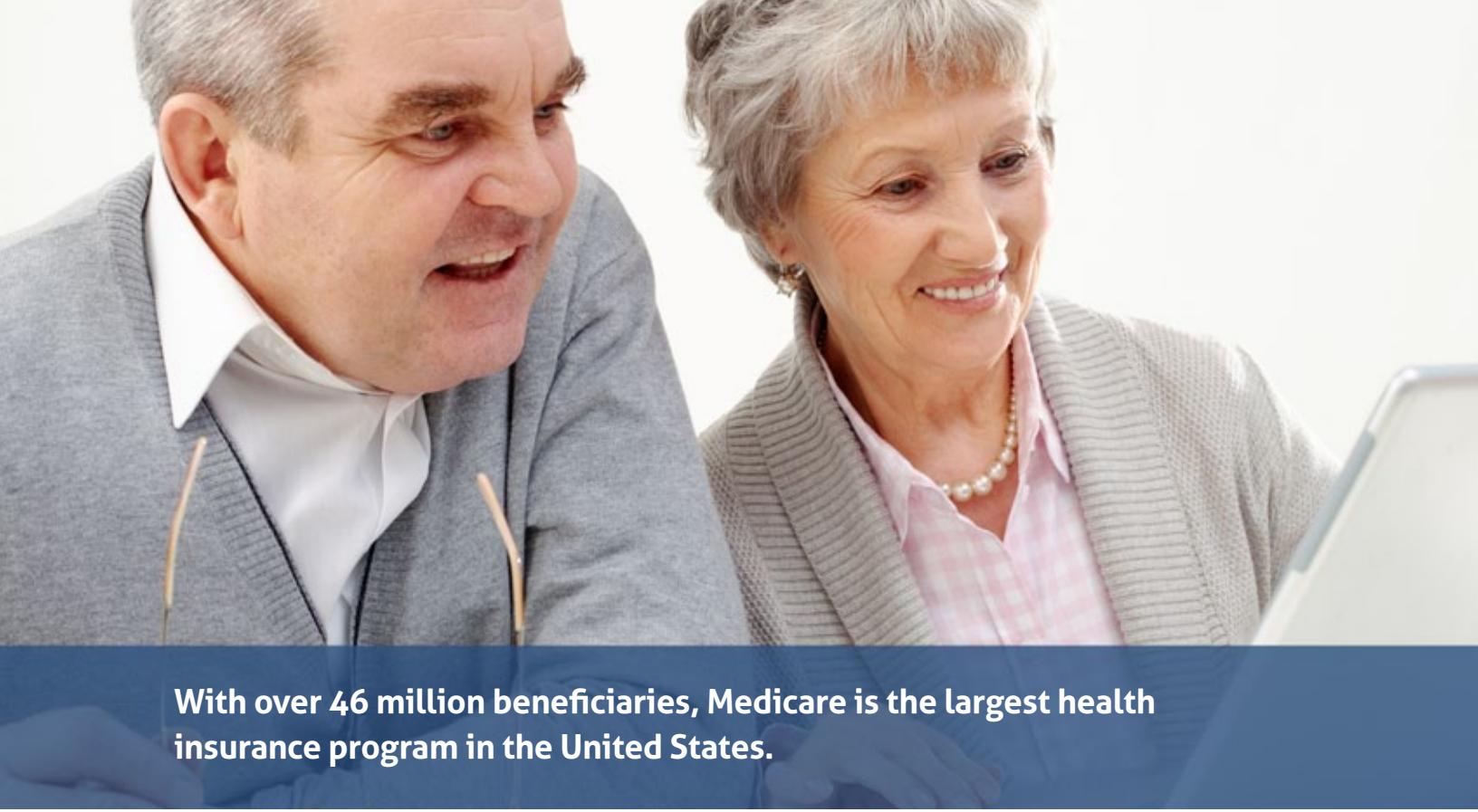
setting. The rules governing rehabilitation services can vary depending on the setting and the part of Medicare providing coverage. This variation can lead to confusion regarding how the benefit is applied. Additional complexity may arise with the application of the benefit when a beneficiary's condition has reached a "plateau" and is not expected to improve.

Although clarification concerning rehabilitation therapy benefits in the home health setting is included in the November 2010 release of the Home Health Prospective Payment System rule, the rules concerning rehabilitation therapy differ between care provided in a home health setting and a skilled nursing facility (SNF) setting. Consequently, the OMO has recommended further clarification by CMS on the rules to prevent misapplication and misunderstanding of rehabilitation therapy benefits by providers and beneficiaries.

Observation Services

The OMO has also been active in addressing the increase in both the frequency and duration of observation services because of the potential financial liabilities and coverage issues they may present for beneficiaries. Hospital observation services are outpatient services that include short-term treatment, assessment, and reassessment before a decision can be made regarding whether a beneficiary requires an inpatient stay or can be discharged. Because observation services are hospital outpatient services covered under Medicare Part B, greater use of observation services could increase beneficiaries' out-of-pocket spending, primarily for self-administered drugs, and potentially affect Medicare coverage for care provided at a SNF following the hospital care.

The OMO first presented this issue in the 2007-2008 OMO Report to Congress. The OMO is nearing completion of a comprehensive study on observation services, begun in 2010, which will include recommendations on how to address the issue. The study will be presented to CMS in 2011.



With over 46 million beneficiaries, Medicare is the largest health insurance program in the United States.

MEDICARE BENEFICIARY TRENDS IN COMPLAINTS AND INQUIRIES

SECTION HIGHLIGHTS

With over 46 million beneficiaries, Medicare is the largest health insurance program in the United States, serving a diverse population. The Centers for Medicare & Medicaid Services (CMS) uses contractors to help administer and regulate Medicare. Because of the intricate system within which CMS, its contractors, and health care providers operate, some beneficiaries need assistance to better understand and resolve their issues. The main points of this section are listed below:

- Medicare is increasingly complex as more coverage options and plan types become available.
- Beneficiaries have more varied needs than ever.
- Dual-eligible beneficiaries face complexities navigating both Medicare and Medicaid.
- Coordination of benefits is problematic, especially for working beneficiaries aged 65 and older regarding the primacy-of-payment responsibility.
- Part B-covered/noncovered services and Medicare secondary payer continue to be the topics about which beneficiaries most often request information through 1-800-MEDICARE.
- In 2010, similar to 2009, Medicare Part D was the most frequent reason for contacting the State Health Insurance Assistance Programs.

INTRODUCTION

With over 46 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. With its size, the diversity of its programs, and the beneficiaries it serves, Medicare is administratively complex. This administrative complexity results in a web of interactions among healthcare providers, Medicare beneficiaries, their family members and caregivers, and Centers for Medicare & Medicaid Services (CMS) contracted entities that help to administer Medicare.

To provide a context for the Office of the Medicare Ombudsman's (OMO's) work, this section describes key characteristics of Medicare and the increasingly diverse population it serves. The discussion in this section connects the characteristics of Medicare with the types of issues the OMO addressed in 2010. This section also identifies and reviews trends in common beneficiary complaints and inquiries.

MEDICARE: DIVERSE POPULATION WITH VARIED NEEDS

In 2011, the first generation of baby boomers¹ will reach the age of 65.² Although the number of Medicare beneficiaries grew by only two percent from 2009 to 2010, the upcoming milestone is expected to herald significant changes. As the baby boomer generation ages into the program, the Medicare population will become younger, but health statistics indicate that new beneficiaries will enter the program with more chronic conditions than prior generations.³ Beneficiaries also may enter Medicare with greater comfort and experience with choosing their providers than other cohorts, as private health insurers have increasingly offered high-deductible health plans with

Medicare beneficiaries in the labor force, those covered by Medicaid, and the disabled are examples of segments of the Medicare population who are at greater risk of experiencing issues related to their benefits.

health savings accounts⁴ and made available data concerning provider quality and price.⁵ As a result of being exposed to these options and consumer information, future Medicare beneficiaries entering the program may be savvier consumers. Still, these beneficiaries may need assistance selecting among the array of choices available within Medicare, whose options often exceed those available through employer-based coverage.

These seemingly contradictory trends are already appearing, and they point to a more diverse Medicare population. The OMO caseworkers have noted that Medicare beneficiaries seem to be more informed and have a deeper understanding of their issues. At the same time, the cases received by the OMO are frequently more complicated than those typically seen in prior years. These observations are anecdotal but suggest that beneficiaries generally are increasingly able to resolve less complex issues on their own and/or are increasingly knowledgeable about how to access and navigate the appropriate beneficiary assistance resources.

Given Medicare's size and complexity, it is almost inevitable that some beneficiaries will experience a gap between their care needs, the coverage to which they are entitled under Medicare, and the benefits they receive. These problems occur largely due to a lack of access to information, beneficiaries' inability to comprehend fully the information available to them,

¹ Population born during the Baby Boom period after World War II (1946 through 1964).

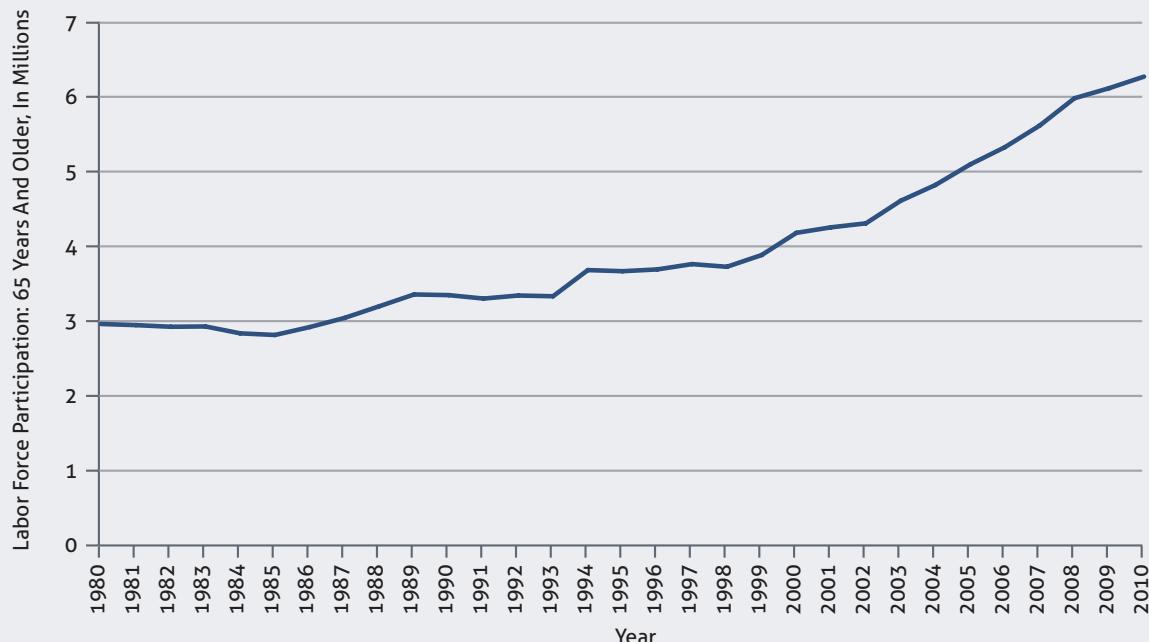
² U.S. Census Bureau. *Population Profile of the United States*. Retrieved on April 3, 2011, from <http://www.census.gov/population/www/pop-profile/natproj.html>.

³ Robert Wood Johnson Foundation. (2010). *Chronic Care: Making the Case for Ongoing Care*. Retrieved on April 3, 2011, from <http://www.rwjf.org/pr/product.jsp?id=56788>.

⁴ America's Health Insurance Plans: Center for Policy and Research. (May 2010). *January 2010 Census Shows 10 Million People Covered by HSA/High-Deductible Health Plans*. Retrieved on April 10, 2011, from <http://www.ahipresearch.org/pdfs/HSA2010.pdf>.

⁵ Tynan, A., Liehaber, A., and Ginsburg, P. (August 2008). *A Health Plan Work in Progress: Hospital-Physician Price and Quality Transparency*. Center of Studying Health System Change. Retrieved on April 10, 2011, from <http://www.hschange.com/CONTENT/1008/1008.pdf>.

Figure 1. Population aged 65 and over in the labor force, 1980-2010



Source: Bureau of Labor Statistics. Labor Force Statistics from the Current Population Survey. Washington, D.C.: U.S. Bureau of Labor Statistics. Retrieved April 10, 2011, from <http://data.bls.gov/pdq/SurveyOutputServlet>.

and/or unintended breakdowns in program operations. Medicare beneficiaries in the labor force, those covered by Medicaid, and the disabled are examples of segments of the Medicare population who are at greater risk of experiencing issues related to their benefits. The OMO has worked to improve the Medicare experience for these groups and all other beneficiaries through its activities. A brief review of some of the unique issues related to these three populations is provided below.

Medicare Beneficiaries in the Labor Force

Whether because of economic circumstances or personal preferences, more and more individuals aged 65 and over are choosing to stay in the workforce longer and to work more hours. Between 1990 and 2010, the number of individuals aged 65 and over in the labor force increased by 87 percent, from 3.3 million to 6.3 million (see figure 1).⁶ Projections indicate that by 2016, the number of Medicare-aged individuals in the labor force will be over 9 million.⁷

6 Bureau of Labor Statistics. Labor Force Statistics From the Current Population Survey, Washington, D.C.: U.S. Bureau of Labor Statistics. Retrieved April 10, 2011, from <http://www.data.bls.gov/pdq/SurveyOutputServlet>.

7 Toossi, M. (2007, November). Labor Force Participation to 2016: More Workers in

The increasing labor force participation of those aged 65 and over highlights the importance of efficient coordination of benefits (COB) when beneficiaries receive health care coverage from more than one source—an issue that the OMO has examined in depth. Medicare beneficiaries with full-time employment may also be covered by a group health plan (GHP) offered by an employer: in 2009, approximately 11.6 million Medicare beneficiaries were covered by a GHP through their own or their spouse's employer.⁸ It is not uncommon for Medicare to be a secondary payer to an employee's GHP. The OMO's research on the topic indicates that COB issues are most likely to arise when Medicare is the secondary payer.

Their Golden Years. *Monthly Labor Review*. U.S. Bureau of Labor Statistics.
 8 The Lewin Group. (2010, May). Draft Final Report for the Beneficiary Coordination of Benefits Study. Study prepared for the Office of the Medicare Ombudsman. Based on data from Coordination of Benefits Contractor, retrieved September 2, 2009.

In 2010, CMS established the Federal Coordinated Health Care Office to improve the coordination of care for dual-eligible beneficiaries.

Medicare Beneficiaries Covered by State Medicaid Programs

Dual-eligible beneficiaries, Medicare beneficiaries who also qualify for some level of Medicaid benefits, may face greater challenges than non-dual-eligible beneficiaries because they have to navigate two programs. Medicare and Medicaid have different benefits, billing systems, and enrollment, eligibility and appeals procedures.⁹ The need to ensure that Medicare works well for this vulnerable population becomes stronger yet when one considers that dual eligibles comprise approximately 21 percent of all Medicare beneficiaries and often require more medical services and coordination of care than non-dual eligibles (see figure 2).¹⁰

One issue the OMO has examined that is of particular concern is the practice of balance billing by physicians when a patient is covered by both Medicare and Medicaid. For most states, Medicaid reimbursement rates to providers are lower than those paid by Medicare, which can result in providers receiving less money for treating a dual eligible than if the beneficiary had Medicare only. Providers are prohibited by law from charging beneficiaries for the difference in payments, an action called balance billing. The OMO developed recommendations, presented later in this report, to reduce balance billing of dual eligibles and to improve in other ways the Medicare experience of beneficiaries who also have Medicaid.

In 2010, CMS established the Federal Coordinated Health Care Office (FCHCO), as required by the Affordable Care Act of 2010, to improve the

⁹ The Kaiser Family Foundation. (2011, January). *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid*. Retrieved April 1, 2011, from <http://www.kff.org/medicare/upload/8138.pdf>.

¹⁰ The Medicare Payment Advisory Commission. (2010, June). *Report to Congress: Aligning Incentives in Medicare*. Retrieved April 20, 2011, from http://www.medpac.gov/documents/Jun10_EntireReport.pdf.

coordination of care for dual-eligible beneficiaries. The OMO plans to collaborate with the FCHCO in the future.

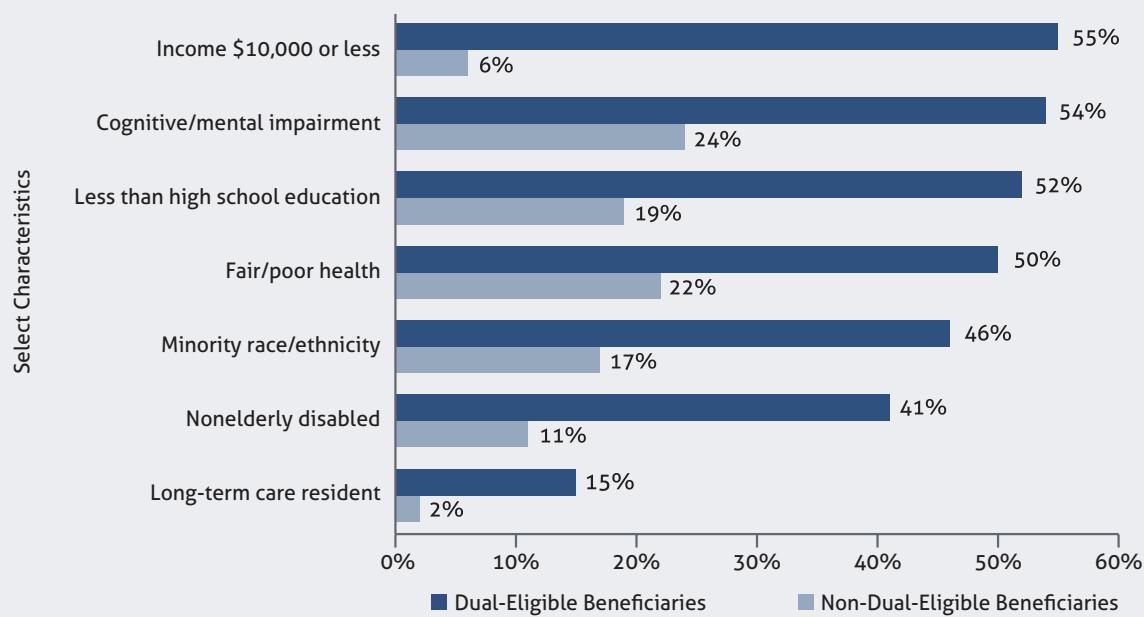
Other Vulnerable Populations

In addition to dual eligibles, other vulnerable Medicare populations include the disabled and the very elderly (defined as persons aged 84 and older). Beneficiaries who qualify for Medicare because of a disability differ from the traditional Medicare population in several ways. The disabled population is more likely to have limited incomes, often resulting from an inability to work; to be comprised of ethnic minorities; to have cognitive or mental impairments; to be in poor health; and to have more than one limitation in activities of daily living (ADLs)¹¹ (see figure 3). These characteristics translate into increased interactions with providers, Medicare Administrative Contractors, and various Medicare beneficiary assistance components. Consequently, beneficiaries potentially have more challenges navigating through the rules and regulations governing Medicare.

Because people are living longer, the number of Medicare beneficiaries aged 84 and over (the very elderly) has doubled since 1975 and continues to be a growing segment of the Medicare population. As with the disabled, the very elderly typically have greater health care needs than their younger Medicare counterparts and are more likely to reside in an institutional care setting. Consequently, the very elderly, their families, and their caregivers may have more interactions with providers and Medicare contractors. Thus, a greater opportunity for gaps exists between the benefits beneficiaries are entitled to and the services they receive. For example, an OMO assessment of observation services conducted in 2010 found that the very elderly may be at greater risk for receiving lengthy observation services in emergency departments. Observation services, which are provided to assess whether a patient should be hospitalized as an inpatient, have potential implications for increased beneficiary cost-sharing liability, particularly for self-administered drugs. The OMO's assessment findings on this issue are presented in the section entitled Recommendations Regarding Beneficiary Concerns.

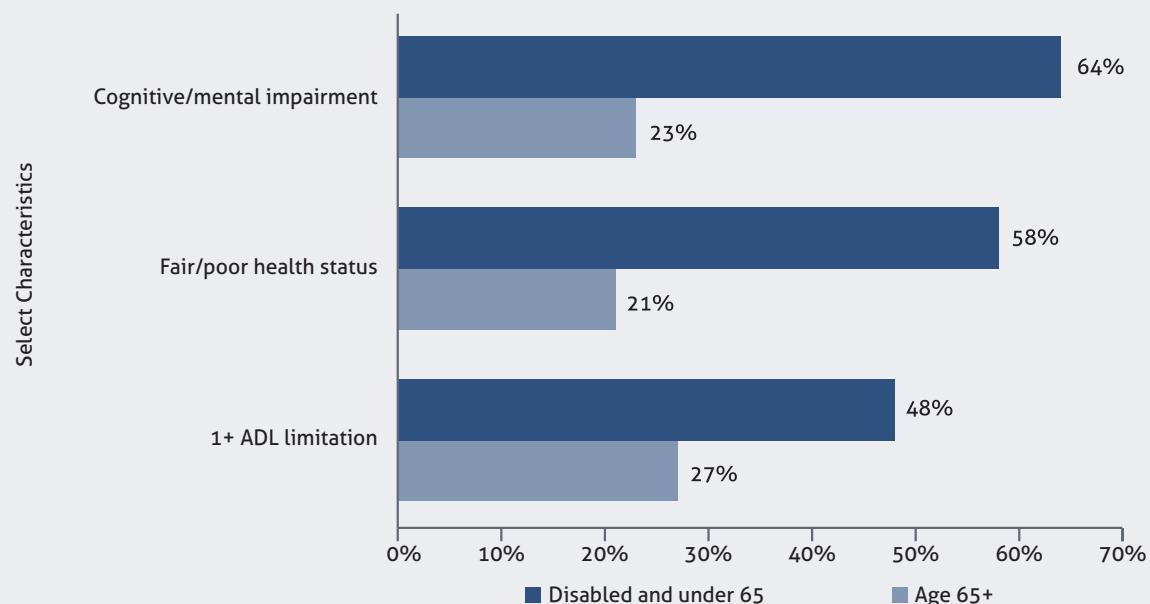
¹¹ ADLs refer to the routine activities that individuals tend to perform without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, walking, and continence.

Figure 2. Percentage of dual-eligible and non-dual-eligible Medicare beneficiaries with select characteristics, 2008



Source: Kaiser Family Foundation analysis of the Medicare Beneficiary Survey 2008 Access to Care File.
 Retrieved April 1, 2011 from <http://www.kff.org/medicaid/upload/4091-07.pdf>.

Figure 3. Comparison of Medicare beneficiaries aged 65 and over and nonelderly disabled Medicare beneficiaries, 2008



Source: Kaiser Family Foundation analysis of the Medicare Beneficiary Survey 2008 Access to Care File.
 Retrieved April 1, 2011 from <http://www.kff.org/medicaid/upload/4091-07.pdf>.

MEDICARE OFFERINGS AND ADMINISTRATION

The expansion of Medicare benefits in recent years has resulted in a wide range of coverage options and plan types for beneficiaries. Qualifying beneficiaries receive Part A (hospital insurance) and may choose to enroll in Part B (medical insurance) under original Medicare or elect for Part C coverage (Medicare Advantage [MA]) for both hospital and medical insurance. Beneficiaries may also elect to receive Part D coverage (prescription drug coverage) through either a stand-alone Prescription Drug Plan (PDP) or a MA Plan that includes a Prescription Drug Plan (MA-PD). Medicare Parts C and D coverage is provided through private insurance companies that contract with Medicare.

Although most Medicare beneficiaries are enrolled in traditional Medicare (Parts A and B), there has been an increase in the number of beneficiaries enrolling in MA Plans. MA enrollment increased from 6.1 million in 2006 to 11.1 million in 2010, accounting for approximately 24 percent of the Medicare population in 2010.¹² Most beneficiaries enrolled in an MA Plan receive their drug coverage through that plan. Medicare beneficiaries overall, however, are more likely to receive drug coverage from a stand-alone PDP. From the start of Part D in 2006 through 2010, the number of Medicare beneficiaries with prescription drug coverage through a PDP increased from 10.4 to 17.7 million.^{13,14} Over the same time period, the percentage of Medicare beneficiaries receiving prescription drug coverage through a PDP or a MA-PD rose from 53 to 60 percent.^{15,16}

Between 2009 and 2010, the number of PDPs and MA Plans decreased nationwide—even as the number of beneficiaries enrolled in these plans rose—creating some benefits and some disadvantages for beneficiaries who had to switch plans in response to discontinuations. The narrowed set of available

12 Kaiser Family Foundation. (2010, September). Medicare Advantage, Fact Sheet. Retrieved April 11, 2011, from <http://www.kff.org/medicare/2052.cfm>.

13 Kaiser Family Foundation. (2006, June). Fact Sheet: The Medicare Prescription Drug Benefit. Retrieved April 11, 2011, from <http://www.kff.org/medicare/upload/7044-04.pdf>.

14 Kaiser Family Foundation. (2010, October). Fact Sheet: The Medicare Prescription Drug Benefit. Retrieved April 11, 2011, from <http://www.kff.org/medicare/upload/7044-11.pdf>.

15 Kaiser Family Foundation. (2006).

16 Kaiser Family Foundation. (2010).

options may help beneficiaries to focus on more meaningful plan differences and reduce the confusion caused by having to choose among a wider array of often similar plans. More beneficiaries, however, will need to switch plans than otherwise would have, which could result in increased beneficiary contact with CMS. Inquiries and complaints related to MA and PDP enrollment—and more generally, Part D—are among the top reasons beneficiaries contacted 1-800-MEDICARE.

The expansion of Medicare benefits in recent years has resulted in a wide range of coverage options and plan types for beneficiaries.

Among other changes to Medicare, the Affordable Care Act authorized the gradual closing of the Part D coverage gap (commonly referred to as the “donut hole”), thus reducing beneficiaries’ out-of-pocket spending. Prior to this change, beneficiaries had to pay the full cost of their prescription drugs once they reached the initial coverage limit (\$2,830 in 2010) until reaching the out-of-pocket threshold (\$4,550 in 2010).¹⁷ The coverage gap began to be phased out with the implementation of the \$250 rebate check provided to beneficiaries who reached the Part D coverage gap in 2010 to help cover their prescription drug costs. In 2011, beneficiaries who reach the coverage gap will receive approximately a 50 percent discount on covered brand-name drugs, and savings are scheduled to increase until the coverage gap is closed by 2020. The OMO is involved in providing beneficiary assistance on Part D issues and has provided CMS caseworkers with guidance related to the \$250 rebate checks.

Because of the number of benefits offered and the special needs of certain Medicare beneficiaries, Medicare is a relatively complex program to administer and relies on multiple contracted entities to pay

17 Kaiser Family Foundation. (2009, November). Fact Sheet: The Medicare Prescription Drug Benefit. Retrieved April 11, 2011, from <http://www.kff.org/medicare/upload/7044-10.pdf>.

Figure 4. Entities that administer Medicare

Entity	Role and description
Provide assistance to beneficiaries	
Centers for Medicare & Medicaid Services (CMS) Central Office and Regional Offices	Provide assistance, outreach, and education to Medicare beneficiaries and other stakeholders (and administer Medicare)
1-800-MEDICARE	Provides 24-hour, 7-days-a-week assistance to English- and non-English-speaking callers on 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 Plans	Private companies approved by Medicare that provide beneficiaries with all of their Part A (hospital insurance) and Part B (medical insurance) coverage
Medicare Advantage Prescription Drug Plans	Medicare Advantage 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
Fee-for-Service Recovery Auditors	Identify and recover improper Medicare payments, including both underpayments and overpayments
Process appeals	
Medicare Administrative Contractors	Conduct first-level appeals for denial of a service or service payment in Medicare Parts A and B
Qualified Independent Contractors	Conduct second-level appeals for denial of a service or service payment in Medicare Parts A and B
Independent review entities	Conduct second-level appeals for denial of a service or service payment in Medicare Parts C and D
Ensure the quality and integrity of Medicare	
Program Safeguard Contractors	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

Medicare relies on multiple contracted entities to pay claims, regulate providers and health and drug plans, and assist beneficiaries with complaints and inquiries.

claims, regulate providers and health and drug plans, and assist beneficiaries with complaints and inquiries. Figure 4 lists examples of government entities and private contractors that help administer Medicare, although it should be noted that the numbers and types of Medicare contractors continue to change as new benefits are introduced and additional efforts are undertaken to improve customer service for Medicare beneficiaries.

MEDICARE BENEFICIARIES' INFORMATION SOURCES

Medicare beneficiaries have a variety of information sources, including the www.Medicare.gov and www.MyMedicare.gov websites, the 1-800-MEDICARE national telephone helpline, numerous Medicare health plans and PDPs, various Medicare contractors, multiple components within CMS (including the CMS Central Office [CO] and 10 Regional Offices [ROs]), State Health Insurance Assistance Programs (SHIPs), numerous CMS partner organizations, advocacy organizations, and other entities. However, because beneficiaries lack a single point of initial contact beyond the 1-800-MEDICARE helpline, which provides information and limited services to address issues and complaints, the process for dealing with issues can be convoluted and may result in missed opportunities for advocacy and for resolving issues. Multiple programs within CMS must coordinate to address beneficiary concerns successfully. The OMO serves as the voice of beneficiaries and represents their interests in working with these entities.

Tracking and Analyzing Beneficiary Contacts

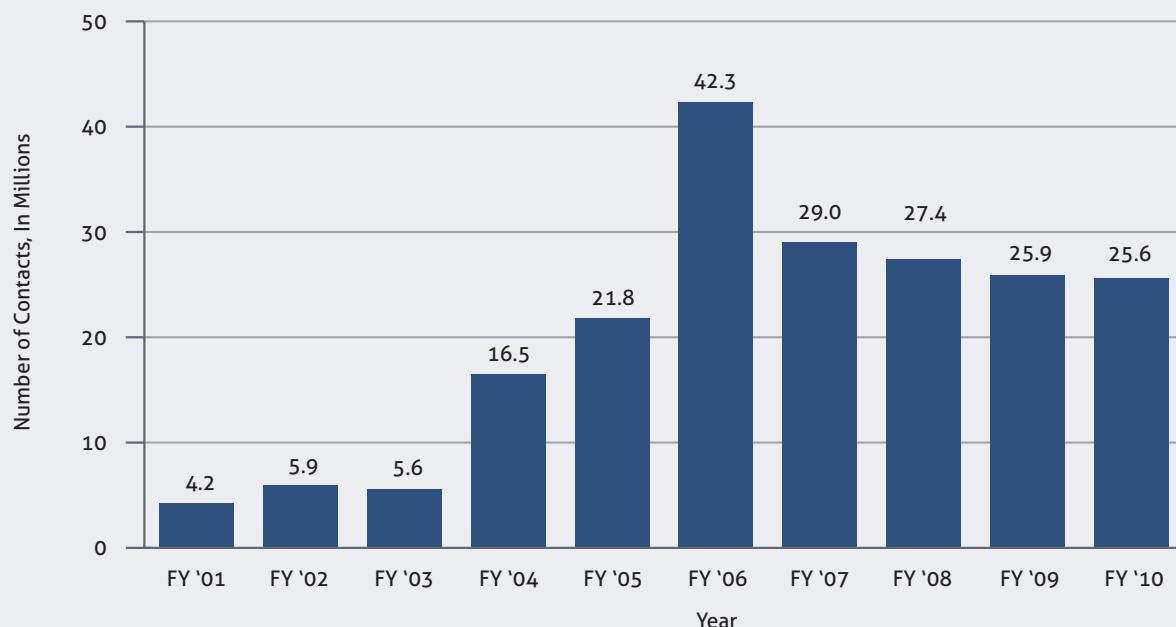
The OMO reviews and analyzes data from a variety of sources to assist in identifying potential systemic

beneficiary issues and to validate issues that have already been identified through the Issues Management process or by external partners. Presented in this subsection is 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. It should be noted that these systems were designed around business needs and operating purposes and that 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 readily used 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 such 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 recommendations for addressing them.

Beneficiary Contacts to 1-800-MEDICARE

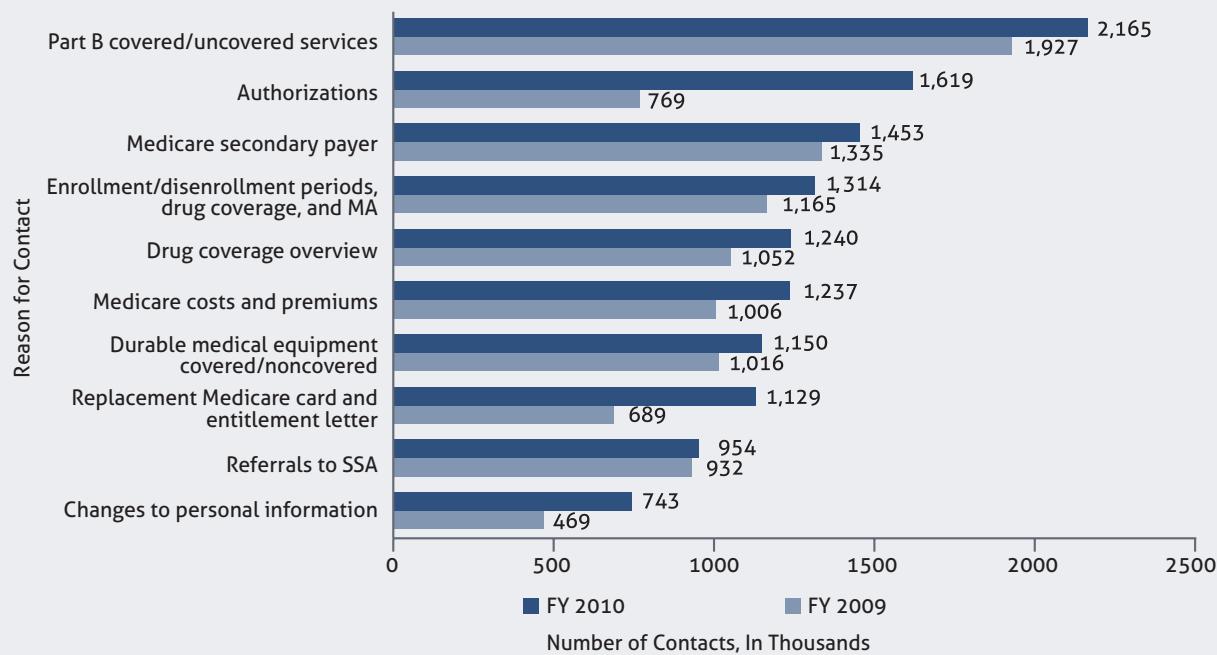
Medicare beneficiaries, their families, and other members of the public most often contact the 1-800-MEDICARE helpline as a first resource to find answers to their Medicare benefit inquiries. The helpline operates 24 hours a day, 7 days a week and provides assistance to English- and non-English-speaking 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.

The number of beneficiary contacts to 1-800-MEDICARE has varied significantly since its inception in 1999 (see figure 5), closely reflecting changes in legislation and the reorganization of the helpline's responsibilities. Between fiscal years (FYs) 2003 and 2006, beneficiary contacts increased by 655 percent, largely attributed to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA created Medicare Part D, effective January 1, 2006, and required that information about the new program be made available through 1-800-MEDICARE. The MMA also

Figure 5. Total number of contacts received by 1-800-MEDICARE, FYs 2001-2010

Note: these numbers do not indicate script hits.

Source: 1-800-MEDICARE National Data Warehouse.

Figure 6. Comparison of FY 2010 and FY 2009 1-800-MEDICARE script hits

Source: 1-800-MEDICARE National Data Warehouse.

authorized the creation of the Medicare Beneficiary Ombudsman position, in part to address concerns arising from Part D. Additionally, the MMA transferred responsibility for information about Medicare Parts A and B claims calls, which were handled by a separate contractor, to 1-800-MEDICARE. This transition was completed at the end of FY 2006 and could account for some of the observed increase in call volume that occurred between the period before and after FY 2006. As noted in figure 5, calls to the helpline declined by 34.4 percent after 2006. Over the past few years, beneficiary contacts have continued to decline but at a slower rate, with only a 1.1 percent decline between FY 2009 (25.9 million) and FY 2010 (25.6 million). It is anticipated that call volume will increase over the next few years as more baby boomers become eligible for Medicare.

When beneficiaries or other members of the public contact 1-800-MEDICARE, they first receive assistance from an automated interactive voice response (IVR) system. If the IVR system cannot address the caller's inquiry or if the caller requests to speak with a person, the IVR system transfers the call to a customer service representative (CSR). The calls that are 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 claims¹⁸

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 6 provides the top 10 scripts accessed by CSRs in FY 2010 as well as the number of hits for the same category of scripts in FY 2009.

In FY 2010, the total number of CSR script hits was 25.6 million, matching the total number of contacts received by 1-800-MEDICARE. The similarity between

¹⁸ Government Accountability Office. (December 2008). Medicare: Callers Can Access 1-800-MEDICARE Services, but Responsibility Within CMS for Limited English Proficiency Plan Unclear. Retrieved on April 3, 2011, from <http://www.gao.gov/new.items/d09104.pdf>.

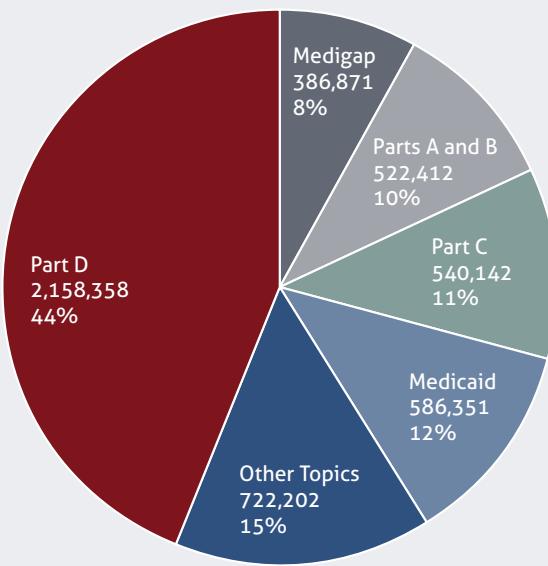
total contacts and script hits is coincidental, as not every contact to 1-800-MEDICARE requires accessing a script, and a single call may involve more than one script per contact. Between FY 2009 and FY 2010, the total number of CSR script hits increased by 4.8 million (or 23 percent). The top ten scripts accounted for half (50.8 percent) of all script hits in 2010. Issues related to Part B coverage of services continued to be the main reasons for beneficiary contact, with 2.2 million script hits (8.5 percent of all scripts hits) in 2010 and 1.9 million script hits (9.3 percent of all script hits) in 2009 (see figure 6). With approximately 42 million beneficiaries enrolled in Medicare Part B, the relative frequency of access to scripts regarding this topic is likely due to this topic being a broad category that includes all Part B-related coverage concerns.

Inquiries related to Medicare secondary payer issues, which include COB issues, continued to be a common reason for beneficiary contact in FY 2010.

Two of the top three script hits in 2010 were the same as in 2009: Part B-covered/non-covered services and Medicare secondary payer (MSP). Enrollment/disenrollment periods (for drug coverage and MA) were among the top three most accessed scripts in 2009, and authorization issues were among the top three most accessed scripts in 2010. CSRs use the authorization scripts to give permission for someone else (that is, a representative payee) to speak on behalf of a Medicare beneficiary. An analysis of calls for which the CSRs had to use the authorization script did not reveal a specific reason for the increase in authorization script hits from FY 2009 to FY 2010.

Inquiries related to MSP issues, which include COB issues, continued to be a common reason for beneficiary contact in FY 2010, accounting for a little over 1.4 million calls. Compared with the number of calls related to MSP in FY 2009, there was an 8.9 percent increase in this type of call in FY 2010, which may indicate a growing issue for Medicare beneficiaries.

Figure 7. Summary of SHIPs' total reasons for beneficiary contact, by type of reason for contact, FY 2010



Note: "Other topics" include long-term care, fraud and abuse, military health benefits, and employer health plan or Federal Employee Health Benefits Program.

Source: Kaiser Family Foundation analysis of the Medicare Beneficiary Survey 2008 Access to Care File. Retrieved April 1, 2011, from <http://www.kff.org/medicaid/upload/4091-07.pdf>.

The top reasons for contacting 1-800-MEDICARE are in line with the primary issues received and managed by the OMO. The OMO has examined the COB challenges that can arise when Medicare is the secondary payer, as well as Part D issues, some of which were addressed in the OMO 2009 Report to Congress. The OMO also works to ensure that scripts are developed to address beneficiaries' concerns as they come into 1-800-MEDICARE and to assist in routing complaints to the appropriate entity, whether it be a CMS contractor or an RO. The 1-800-MEDICARE helpline continues to be the focal point of beneficiary service, and the OMO has worked closely with the call center staff when needed to ensure that 1-800-MEDICARE has the necessary information to help beneficiaries with certain concerns.

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 collect and maintain complaints and complex inquiries related to fee-for-service (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 2010, a total of 42,321 complex inquiries and complaints related to FFS Medicare were captured in the MAISTRO System. The top Parts A and B complaints in the MAISTRO System concerned coverage and payment policy, with 7,353 complaints logged, which accounted for 17 percent of all reasons for contact. This reason for complaint was followed by premiums, with 7,121 contacts, and enrollment, entitlement, and eligibility issues, with 6,009 contacts. As with 1-800-MEDICARE, MSP constituted one of the top

reasons for beneficiary complaints in MAISTRO, with 4,891 contacts in 2010.

CTM recorded a total of 137,375 complaints in FY 2010: 66,827 Part C-related complaints and 70,548 Part D-related complaints. CTM complaints received in FY 2010 were 41.7 percent lower compared to complaints received in FY 2009 (235,607). In FY 2010, there were 32 percent fewer Part C-related complaints and 49 percent fewer Part D-related complaints compared to the previous year. The decrease in CTM complaints over the past year is largely attributed to the general maturation of Part D, which has led to fewer system issues and more efficient handling of complaints.

The top three reasons for complaints related to both Parts C and D in FY 2010 remained unchanged from FY 2009. Across both Parts C and D, the top complaints concerned issues related to enrollment and disenrollment, with 39,869 and 31,828 complaints, respectively. Some of the other reasons for Part C-related complaints included marketing, premium pricing and co-insurance, and benefits access. The reasons for Part D-related complaints were similar, although there were far more complaints related to premium pricing and co-insurance, with 20,066 complaints compared with 6,027 complaints for Part C for the same category, which reflects the larger number of beneficiaries enrolled in Part D than in Part C.

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, which authorized CMS to give grants to states to provide health insurance advisory services to Medicare beneficiaries through one-on-one counseling, public education presentations and programs, and media activities. Originally, SHIPs focused on addressing the confusion caused by the increase in Medigap¹⁹ choices. 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, mostly volunteers and staff.

SHIPs 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 2010, SHIP staff and volunteers responded to approximately two million contacts from Medicare beneficiaries, their families, and caregivers, an increase of 17.8 percent from FY 2009. Beneficiary inquiries related to the nationwide discontinuation of MA Plans and the implementation of the \$250 Part D rebate contributed to some of this increase. The total number of reasons for contact amounted to a little under five million, or about 2.4 reasons per contact, indicating that beneficiaries often seek assistance from the SHIPs for multiple reasons.

As in 2009, topics related to Part D presented the most frequent reason for contact in 2010, accounting for over two million reasons for contact (44 percent of all reasons—see figure 7). The reasons for Part D contact most often included issues related to plan eligibility and benefit comparisons, low-income subsidy eligibility and benefit comparisons, and enrollment and application assistance.

Other topics, such as long-term care, fraud and abuse, and military health benefits, presented the second most frequent reasons for contacting the SHIPs. Inquiries related to Medicaid, Medicare Part C, and Medicare Parts A and B accounted for one-third (33 percent) of all reasons for contact in 2010. Medigap-related reasons represented the smallest share of reasons for contact (8 percent).

¹⁹ A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in FFS Medicare plan coverage (Parts A and B).



In 2010, the OMO pursued new approaches to strengthen efforts to identify and address issues that affect beneficiaries.

FULFILLING ITS MISSION: HOW THE OMO IDENTIFIES AND MANAGES BENEFICIARY ISSUES

SECTION HIGHLIGHTS

The Office of the Medicare Ombudsman (OMO) improves beneficiaries' experience with Medicare by:

- Providing direct assistance to beneficiaries with inquiries, grievances, and complaints
- Collaborating with other Centers for Medicare & Medicaid Services (CMS) components and advocacy groups
- Developing recommendations for CMS regarding beneficiaries' issues
- Developing comprehensive studies to enhance the understanding of systemic issues

The OMO's activities are continuously evolving to meet the growing needs of the Medicare population by exploring new ways to resolve beneficiary issues.

INTRODUCTION

The Office of the Medicare Ombudsman's (OMO's) overarching goals are to improve Medicare for all beneficiaries and to be a voice for all beneficiaries. The OMO accomplishes these goals by providing direct assistance to Medicare beneficiaries with their inquiries, grievances, and complaints, often collaborating with advocacy groups and other components within the Centers for Medicare & Medicaid Services (CMS) to identify and address systemic issues that affect Medicare beneficiaries.

In 2010, the OMO pursued new approaches to strengthen efforts to identify and address issues that affect beneficiaries. The centerpiece of these approaches was a set of comprehensive studies designed to increase OMO's capacity to identify the root causes of beneficiary issues and, subsequently, to develop specific, actionable short-term and long-term recommendations to address these issues. These comprehensive studies represent a shift toward an evidence-based approach to understanding and addressing systemic beneficiary issues. Further, the OMO explored the value of tracking social media outlets for real-time information about beneficiary issues. In 2010, the OMO employed four primary activities to accomplish its mission:

Casework is the primary means through which the OMO resolves individual beneficiary complaints, often expediting the resolution of complex and urgent-need cases. The OMO also supports casework efforts by disseminating casework-related information and by providing technical assistance to its internal and external partners.

Partnership Initiatives with other CMS components and external entities play a key role in the OMO's efforts to identify and address beneficiary issues. The OMO develops and maintains these collaborative relationships to help identify and resolve beneficiary issues.

Issues Management is the process that the OMO uses to identify systemic issues that affect large segments of the Medicare population or that could have a profoundly negative effect on beneficiaries' well-being. As part of this activity, the OMO develops its

ORGANIZATION: OFFICE OF THE MEDICARE OMBUDSMAN DIVISIONS AND FUNCTIONS

The Office of the Medicare Ombudsman (OMO) serves as an advocate for Medicare beneficiaries. To fulfill its mission, the OMO directly assists beneficiaries, works closely with its internal and external partners, and monitors trends in inquiries, complaints, grievances, and appeals. The OMO has four distinct divisions to carry out its mission:

The Division of Medicare Ombudsman Assistance (DMOA) responds to, manages, and works to resolve beneficiary inquiries and complaints. DMOA's casework staff triage urgent-need beneficiary issues to facilitate the resolution of complex cases. DMOA collects and reports on trends in beneficiary contacts and casework.

The Division of Ombudsman Research and Trends Analysis (DORTA) performs trending and analysis of Medicare inquiry, complaint, and appeals data. DORTA also leads the Ombudsman's Issues Management process, which identifies and addresses systemic program and policy issues that affect Medicare beneficiaries. Additionally, it facilitates trainings for Medicare caseworkers.

The Division of Ombudsman Exceptions (DOE) resolves beneficiary data system anomalies and errors in data exchanges that may cause eligible Medicare beneficiaries to lose or have issues with coverage. DOE works with state and federal agencies (for example, the Social Security Administration and the Office of Personnel Management) and interacts directly with beneficiaries and data systems to identify system errors, make necessary corrections, and submit change requests for Medicare Parts A and B systems.

The Competitive Acquisition Ombudsman (CAO) responds to individual and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier inquiries, issues, and complaints. The CAO also identifies DMEPOS issues, consolidates data reporting, and develops an annual report to Congress.

Quarterly Issue report, which informs CMS Leadership about the issues facing Medicare beneficiaries.

Comprehensive Studies Development is the process the OMO uses to initiate extensive investigations and evaluations of the issues identified through the Issues Management process to determine the root causes of issues and to develop actionable recommendations for addressing the issues.

The OMO's activities are interconnected and designed to address individual beneficiary issues and issues affecting the Medicare population as a whole. These activities are important in facilitating Medicare beneficiary access to and/or navigation of benefits and services within Medicare. The following subsections provide detailed descriptions and examples that illustrate how the OMO assisted Medicare beneficiaries in 2010 through specific activities.

CASEWORK

The OMO handles beneficiary casework and leads the development of training and broad dissemination of information for Medicare caseworkers. The OMO's casework efforts regularly address complex and urgent-need cases that other entities have been unable to resolve to the beneficiary's satisfaction in some instances. The OMO's casework resolution strategy aims to analyze the caseload for trends that may indicate systemic issues. Although individualized casework is only one source among many the OMO uses to identify systemic issues, it is important because it offers direct assistance to beneficiaries who sometimes feel they have no other options in seeking resolution of their issues. Furthermore, casework provides an ongoing indication of trends in individual beneficiary concerns.

Volume of Direct Services to Beneficiaries

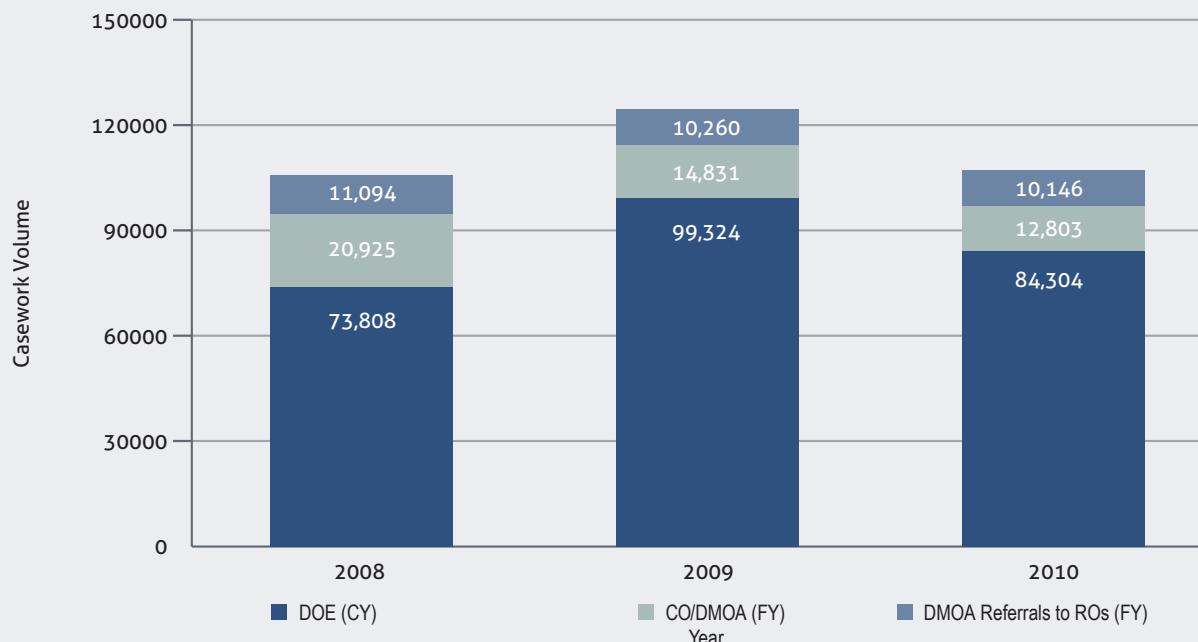
The OMO's individual casework responsibilities are shared between two divisions: the Division of Medicare Ombudsman Assistance (DMOA) and the Division of Ombudsman Exceptions (DOE). DMOA works directly with beneficiaries to resolve their inquiries and complaints, whereas DOE focuses on fixing data issues and making corrections to beneficiary enrollment and entitlement records.

EVOLUTION OF THE OFFICE OF THE MEDICARE OMBUDSMAN'S CASEWORK ACTIVITIES

Casework has been one of the Office of the Medicare Ombudsman's (OMO's) cornerstone activities since the office was established in 2005. Over the past 5 years, the OMO has worked to improve the efficiency and effectiveness of its responses to beneficiary inquiries and complaints, which has led to a decrease in the OMO's correspondence response time to 10 business days or less for more than 75 percent of correspondence received and fewer than 30 business days for 93 percent of correspondence received. Previously, 20 percent of all correspondence was not handled within 30 business days. The OMO has also been able to decrease the amount of time it takes for correspondence to reach a caseworker from the time it is received by CMS from 3 to 4 weeks to approximately 1 week. Lastly, by establishing a process called rapid response, the OMO has reduced the overall response time for non-complex inquiries, such as assisting beneficiaries with verifying their enrollment in a plan or their premium payment, from as many as 30 business days to an average of 10 business days.

Over the past 2 years, OMO caseworkers have noted that beneficiaries appear to be increasingly informed and have a deeper understanding of their issues when contacting the OMO, which may explain why the OMO's casework has decreased over the past 2 years. However, cases have become more complex, due to ongoing changes to Medicare. As Affordable Care Act of 2010 provisions pertaining to Medicare continue to be implemented over the next few years, the OMO expects that the type and number of beneficiary inquiries will fluctuate. As with previous changes to the program, caseworker training will begin before the new policy is implemented in order to facilitate the timely resolution of beneficiary inquiries and complaints.

Figure 8. Office of the Medicare Ombudsman casework volume, 2008 through 2010



Note: DOE data cover calendar year (CY) periods (January 1 to December 31), while all other sources cover fiscal year (FY) periods (October 1 to September 30).

Source: OMO Casework Reports.

Figure 8 summarizes the OMO's casework volume over the past 3 years, from 2008 through 2010. The OMO received the highest volume of cases in 2009 (124,415). In 2010, OMO's total casework volume decreased to 107,253 cases, which represented a 14 percent decline from the number of cases received in 2009. Of the total casework volume in 2010, DMOA received through the CMS Central Office (CO) 12,803 cases and DOE received 84,304 cases; DMOA referred the remaining 10,146 cases to the CMS Regional Offices (ROs). The share of cases referred to the ROs has remained fairly stable during the last few years. The OMO works closely with the ROs to respond to beneficiary inquiries and complaints. ROs play a key role in representing CMS and delivering key messages locally. Moreover, ROs work more directly than the OMO does with health plans, Prescription Drug Plans, and Medicare Administrative Contractors within their given regions.

In FY 2010, CO/DMOA received 22,949 inquiries and complaints, some of which were referred to the

ROs, from the following sources: beneficiaries; their families, caregivers, and advocates; and legislators. DMOA applies several criteria when deciding which cases will be handled in CMS' CO and which will be referred to the ROs. In general, inquiries consisting of general public mail and previous RO casework are referred to the ROs. Inquiries remain in the CO if they fall into one of the following categories: priority mail, e-mail, telephone calls, inquiries addressed to the Medicare Beneficiary Ombudsman, dire-need inquiries, other foreign language correspondence, and inquiries from high-priority sources, such as Congress.

Over the past 3 years, CO/DMOA's casework volume was lowest in 2010 with 22,949 cases, representing a decline from FY 2009 (25,091) and FY 2008 (32,019). The trend of decreasing inquiries and complaints received by the OMO likely reflects important changes to Medicare as a whole, such as the maturation of Medicare Part D. The OMO began receiving inquiries and complaints in 2006, during the first year of Medicare Part D establishment. Over time, CMS,

beneficiaries, and Part D plans have gained more experience with the program. To reduce beneficiary issues with Part D, CMS has instituted various improvements that help reduce operational issues and increase beneficiary understanding of Part D. For instance, in 2007, CMS uncovered and addressed a marketing misrepresentation issue showing that in some cases Medicare beneficiaries were misled by insurance agents about enrollment in Medicare Part D. Also as the program matured, fewer issues have been noted concerning premium withholdings from Social Security benefits. Furthermore, CMS has refined the enrollment process and extended outreach and education associated with auto enrolling certain beneficiaries into plans.

The three most common topics for the contacts received by DMOA in 2010 concerned premiums, Medicare eligibility/enrollment, and coordination of benefits (COB), which together accounted for 57 percent of all inquiries and complaints received by the OMO (see figure 9). The same areas were the top reasons for contacting DMOA in 2009.

Contacts pertaining to questions and issues about Medicare premiums accounted for 40 percent of all contacts in 2010, more than any other issue topic. Inquiries and complaints associated with Medicare premiums also comprised the highest volume of contacts in 2009 (7,105) and 2008 (9,204) (not shown in figure 9).

CASE EXAMPLE

OMO and RO Collaboration to Resolve Complex Beneficiary Issues

This case example demonstrates how the joint efforts by the Office of the Medicare Ombudsman (OMO) and the Centers for Medicare & Medicaid Services' (CMS') Regional Offices (ROs) can address complex beneficiary issues. A female beneficiary contacted her local Social Security Administration (SSA) office in January 2010 to enroll in Medicare Part A and made a request for state "buy-in" assistance to pay the Medicare Part A premium, which she qualified for due to her limited financial resources. The beneficiary did not receive any response on the status of her application, and when the effective enrollment date of July 1, 2010 passed, the beneficiary contacted the OMO. The OMO's investigation confirmed that the beneficiary was entitled to enroll in Part A under a special condition, Conditional Qualified Medicare Beneficiary (QMB) Enrollment, whereby the state pays the QMB's monthly Part A premium.

The OMO caseworker requested intervention from the CMS RO, asked the state Department of Social Services (DSS) about the history of the beneficiary's application, and continued to monitor the status of the case. The DSS office indicated that the request had been mistakenly denied because the beneficiary had failed to provide proof of residency. Further review of the state's eligibility database showed that the beneficiary's record reflected proper evidence of residency; the DSS, therefore, reopened the case for redetermination. The OMO caseworker received notice from the RO that the beneficiary's request for Part A state buy-in assistance was approved. In conjunction with the state buy-in assistance approval, the beneficiary was granted equitable relief (that is, no penalty for delayed enrollment) by SSA for Medicare Part A enrollment. The OMO checked the beneficiary's record to confirm that the system correctly reflected updates for Medicare enrollment and QMB state assistance and contacted the beneficiary to inform her of the final outcome. The case, which required federal, state, and local agency communication and systems transactions, was resolved within several weeks of the beneficiary contacting the OMO.

Some of the reasons for the prevalence of inquiries related to Medicare premiums during FY 2009 and FY 2010 included questions and complaints regarding anticipated annual Part B premium increases; issues regarding credit card payments; nonreceipt of bills; Part B income-related monthly adjustment amount (IRMAA) discrepancies; and payments that had not been applied to beneficiary accounts or that had been erroneously applied to beneficiary accounts.

DOE's casework consists of resolving issues with multiple entitlement records for the same beneficiary and correcting records from various internal and external systems that contain inconsistencies or incorrect (or missing) information. Direct billing assistance involves responding to inquiries and dealing with payment issues related to direct billing of Part A or Part B premiums. Third-party premium billing casework is similar to entitlement casework but also includes adjustments of Part A and Part B premiums. Third parties include entities such as states, private payers, local governments, and the Office of Personnel Management. In 2010, DOE's casework was almost equally split between resolving entitlement cases and

third-party premium billing cases, receiving slightly more than 39,000 cases in both categories.

National Casework Calls and Training Programs

The goal of the National Casework Calls is to ensure that caseworkers have the necessary information to assist beneficiaries with their complaints and inquiries and to address policy and systemic issues that affect casework and Medicare beneficiaries. These calls complement the OMO's casework activities by ensuring that CMS staff members can provide beneficiaries with timely and consistent information. The National Casework Calls serve as a forum for discussing Medicare updates and changes, disseminating related casework-specific information, and addressing casework issues with RO caseworkers across the country. Participants also include representatives from other CMS components, including the Office of External Affairs and Beneficiary Services (OEABS), the Center for Medicare (CM), and the Office of Financial Management (OFM).

Figure 9. Comparison of FY 2010 and FY 2009 DMOA beneficiary contacts

Reason for contact	Contacts, FY 2010	Percentage of all contacts, FY 2010	Contacts, FY 2009	Percentage of all contacts, FY 2009
Premiums	9,142	40%	7,105	28%
Medicare Eligibility/ Enrollment	2,164	9%	2,059	8%
Coordination of Benefits	1,797	8%	1,403	6%
Medicare Coverage	1,121	5%	865	3%
Medicare Advantage	1,018	4%	797	3%
Inquiries not Medicare/Medicaid Specific	834	4%	969	4%
Low-Income Subsidy	601	3%	743	3%
Claims Inquiries/ Complaints	516	2%	602	2%
Health Insurance Replacement Cards	244	1%	208	1%
Disenrollment/ Enrollment/ Withdrawal	152	1%	644	3%

Source: OMO Casework Reports.

In 2010, the OMO facilitated 40 National Casework Calls, with 16 of the calls dedicated to Medicare Parts A and B topics and the remaining 24 dedicated to Medicare Parts C and D topics. Some of the topics discussed during the Parts A and B calls included implementation of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding program and updates to the Medicare Administrative Issue Tracker and Reporting of Operations system, which CMS uses to track, manage, report, and trend inquiries, complaints, and issues related to fee-for-service Medicare.

The topics discussed during the Parts C and D calls included annual enrollment guidance and changes, Part D premium IRMAA, eligibility for the Part D low-income subsidy (LIS), and late enrollment penalty guidance.

Along with facilitating the National Casework Calls, the OMO also manages the national caseworker training program, which facilitates CO and RO casework staff training. Caseworkers attend regular training sessions to obtain the skills and resources needed to resolve

beneficiary issues. This program aims to ensure that caseworkers are well informed and equipped to handle the various—and often complex—questions and concerns they receive from Medicare beneficiaries and those working on their behalf. The OMO facilitated a total of eight caseworker training sessions in 2010 for CMS CO and RO caseworkers.

To further improve caseworker training opportunities, the OMO refocused its training workgroup in 2010 to better assess, plan, and enhance the delivery of caseworker training for 2011. This initiative analyzed beneficiary inquiry trends and individual caseworker responses on training needs surveys; the training needs survey instrument was also updated to improve response rates.

Highlighted Accomplishments

Standard Language Letters

In 2010, the OMO developed 65 standard language letters that allowed CMS caseworkers to respond more accurately and efficiently to inquiries about various

CASE EXAMPLE

Resolving Complex Beneficiary Cases

The Division of Medicare Ombudsman Assistance caseworkers and Division of Ombudsman Exceptions (DOE) staff members work closely together to resolve complex problems that have a serious impact on beneficiaries' medical insurance coverage and financial stability. In one case, a male beneficiary contacted the Office of the Medicare Ombudsman (OMO) regarding an issue that had remained unresolved for 1 full year. The beneficiary's Social Security number (SSN) had been incorrectly associated in the Social Security Administration (SSA) system with another beneficiary with a similar name, and charges for this other person were appearing on his record. Additionally, his premium payments had been credited to the other person's account as a result of the error. Previous attempts by the beneficiary to correct the issue with SSA had been unsuccessful.

The OMO caseworker provided the beneficiary with instructions for filing a name change with SSA and sent the necessary forms to SSA's Payment Service Center to update the beneficiary's account. The beneficiary was also told how to ensure that SSA applied his payments correctly. Further, the caseworker referred the case to DOE and requested that it review the beneficiary's record to ensure he was credited with all the payments he had made. With the OMO's assistance, the beneficiary's SSN was applied to his account only, and payments made by both beneficiaries were properly applied to their respective accounts. With the assistance of the OMO caseworker, the beneficiary's issue was resolved within approximately 5 weeks.

aspects of Medicare. These letters were designed to provide consistent and uniform responses to beneficiary inquiries on topics such as telemarketing fraud, identity theft, and LIS standard benefits. Since the OMO's establishment in 2005, it has developed 478 standard language letters, all of which have been cleared by CMS' subject-matter experts (SMEs) for clarity and content.

The results from the most recent Standard Language Survey, which was sent to over 50 respondents, including RO caseworkers, Standard Language Workshop members, and DMOA staff, indicated that 90 percent of respondents found the letters useful. Survey respondents commented that the standard language letters are very useful as a resource on most topics and that the letters create efficiencies in responding to inquiries. When asked whether it is easy to find a specific letter, the majority of respondents agreed that the letters can be easily located.

30 Quarters Workload Summary

DOE led an effort to analyze and categorize approximately 7,000 cases of incorrect Part A premium payments, some dating back to 1994, which resulted in refunds to beneficiaries. Individuals who have paid into the Medicare system through payroll deductions for 40 or more quarters of coverage (QCs) qualify for premium-free Part A coverage. Individuals who have paid into the Medicare system through payroll deductions for 30-39 quarters, but who otherwise qualify for Medicare, are responsible for a portion of their Part A premium but are eligible for a reduction of the premium amount. The Social Security Administration (SSA) is responsible for determining the number of QCs an individual has accumulated and classifying the individual's premium status as premium-free, full Part A premium, or reduced premium. Once SSA makes this determination, the information is sent to CMS, which bills the individual or the third-party payer directly based on SSA's premium classification.

CASE EXAMPLE

The Office of the Medicare Ombudsman and Regional Offices Collaboration

In some cases, the actions required to resolve a beneficiary's issue call for a close collaboration and delineation of activities between the Office of the Medicare Ombudsman (OMO) and Centers for Medicare & Medicaid Services' (CMS') Regional Offices (ROs). In one such instance referred to the OMO, a female beneficiary sought assistance after paying her surgeon for a medical procedure that was determined not to be covered by Medicare. Prior to contacting the OMO, the beneficiary submitted documentation to the incorrect Medicare Administrative Contractor (MAC), who then did not forward the information to the appropriate MAC. Thus the beneficiary was unable to obtain reimbursement despite her attempts to resolve the issue, which also included contacting Medicare representatives to establish whether the submitted documentation was adequate. Following multiple unsuccessful attempts to resolve the problem on her own, the beneficiary decided to contact the OMO to investigate the issue.

After a careful assessment of the case, the OMO communicated the issue to CMS' RO in Boston, MA, requesting that local caseworkers assist the beneficiary in preparing the required documentation package. The OMO caseworker also requested a policy exception and a waiver of the penalty for the untimely claim submission, since the beneficiary and provider were not at fault for the delay. With the OMO's assistance, the RO caseworker helped the beneficiary through the process for obtaining reimbursement. As a result of the OMO and RO caseworkers' collaborative efforts, the beneficiary was reimbursed for the full costs of her surgical procedure.

Following the identification of incorrect Part A premium payments, SSA provided CMS with approximately 7,000 records that had to be processed manually. DOE led this effort and developed specifications for a program that would sort and categorize by the record type and priority. The system determined that 835 of the total records were due large refunds; these records were given priority processing status. The cases that DOE processed were complex and time consuming, many of them retroactive to 1994 and requiring adjustments and refunds.

Overall, DOE processed 835 complex refund cases, which resulted in significant refunds to Medicare beneficiaries. In addition, DOE developed a targeted training package for the ROs to process required system adjustments, which were different from the premium refunds that DOE processed, as beneficiaries had not made any remittances. As a result of this collaboration, the ROs processed a total of 5,200 adjustment cases.

PARTNERSHIP INITIATIVES

Along with assisting individual beneficiaries through casework, the OMO seeks to identify, address, and/or develop recommendations for systemic beneficiary issues through its internal and external partnership initiatives. The OMO collaborates with other CMS components and external organizations that are in direct contact with the Medicare population to listen attentively to beneficiaries' concerns. This collaboration results in the identification of beneficiary issues not captured through calls to 1-800-MEDICARE, casework, or CMS data systems.

The OMO first validates the issues raised through external partners and then works with the appropriate CMS component to address them.

Internal Partnerships

The main objective of internal partnerships is to work with the appropriate CMS components to resolve beneficiary issues identified by external partners or

CASE EXAMPLE

30 Quarters Refund

The Division of Ombudsman Exceptions (DOE) and the Social Security Administration (SSA) collaboratively led an effort to correct over 7,000 inaccurate Part A premium determinations; these efforts resulted in significant refunds for beneficiaries. In one case, a male beneficiary did not have enough quarters of coverage to qualify for premium-free Part A coverage, so he opted to pay the monthly required premium in order to receive Part A coverage. When the beneficiary's wife took an early retirement and qualified for a free Part A premium, SSA did not inform her that her husband also qualified for premium-free Part A coverage under her policy. When the beneficiary became aware of this policy, he filed for a refund of the \$3,847 in Part A premiums that he had paid during the time when his coverage should have been free under his wife's policy.

DOE and SSA staff members investigated the issue and were able to confirm that the beneficiary was entitled to free Part A coverage under his wife's policy. Additionally, the investigation revealed that the amount of the refund was significantly higher than what the beneficiary had requested: the beneficiary had qualified for a reduced Part A premium but had been charged the full premium for 7 years. Once the corrections were made in the Medicare system, the beneficiary was issued a refund of \$21,067.60, a direct result of DOE's and SSA's collaboration efforts.

casework. The OMO uses its partnerships with other CMS components to address issues by elevating them to the appropriate CMS component or by assisting in implementing solutions to systemic problems. Additionally, the OMO serves as an intermediary or facilitator when issues involve input, actions, and agreement from multiple CMS components. In these instances, the OMO uses various methods, such as quarterly reports, National Caseworker Calls, and ad hoc workgroups, to communicate across CMS components. In 2010, the OMO continued to maintain its strategic relationships with the ROs, CM, the Office of Information Services (OIS), OEABS, OFM, and others (see figure 10). The OMO's efforts with 1-800-MEDICARE to address an increasing number of questions regarding Medicare coverage of chiropractic services provide an example of its internal collaborations. The Medicare Rights Center alerted the OMO that some Medicare beneficiaries were experiencing billing issues upon receiving chiropractic

services because they were unaware of Medicare's coverage policies for this type of care.

According to the advocacy group, Medicare beneficiaries were misled to believe that Medicare would cover all of the costs associated with the services they received. To address this beneficiary issue, the OMO suggested that information be added to CMS' 2012 *Medicare & You* handbook specifically relating to common chiropractic services that beneficiaries believe or are told are covered, but are not. The OMO then coordinated with 1-800-MEDICARE to add a "chiropractic services" qualifier to the existing script for Part B covered and noncovered services. This script will allow the OMO to monitor the number of complaints regarding this issue, starting in 2011.

The OMO, which has already addressed several issues regarding dual-eligible and high-need populations,

Figure 10. Examples of how the OMO works with other CMS components

Partner	Strategic relationship
Office of the Administrator	The Office of the Administrator and the Office of the Medicare Ombudsman (OMO) work collaboratively to ensure timely resolution of high-impact and potentially high-profile Medicare issues.
Regional Offices (ROs)	CMS ROs operate in conjunction with the OMO to identify and resolve systemic issues and to develop standard casework 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. The CM collaborates with the OMO to assess and address issues regarding traditional Medicare (Parts A and B), including existing payment policy and concerns or problems involving Medicare fee-for-service contractors.
Office of External Affairs and Beneficiary Services (OEABS)	The OMO collaborates with OEABS to identify systemic program issues and to develop effective communication strategies to resolve them. The OEABS' Partner Relations Group facilitates the OMO's collaboration with external partners. OEABS also identifies trends in calls to 1-800-MEDICARE that could indicate systemic program issues and coordinates with the OMO to resolve a small percentage of highly complex beneficiary cases.
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 Legislation (OL)	OL assists the OMO in communicating with lawmakers to identify or resolve issues that affect their respective constituencies.
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.

aims to improve the provision of health care for these populations. To achieve this objective, the OMO strives to maintain its relationships with its current internal partners and plans to establish relationships with the two newly created CMS offices: the Federal Coordinated Health Care Office and the Center for Medicare and Medicaid Innovation.

Collaboration With Beneficiary Support Organizations

Along with its internal relationships with CMS components, the OMO has cultivated lasting, collaborative relationships with national, state, and local organizations that work with Medicare beneficiaries. The OMO communicates with its external partners through four established forums:

- Medicare Ombudsman partner and beneficiary advocate meetings
- National conference support
- State Health Insurance Assistance Programs' (SHIPs') conversations with the Medicare Beneficiary Ombudsman
- The Annual SHIP Directors' Conference

The OMO established the Medicare Ombudsman partner and beneficiary advocate meetings in 2009 to provide advocacy organizations—including the National Council on Aging, the Alzheimer's Association, Families USA, the Center for Medicare Advocacy, the National Council on Disability, Medicare Access for Patients-Rx, the United Spinal Association, the Legal Aid Society of the District of Columbia, AARP, the American Society of Consultant Pharmacists, the National Alliance on Mental Illness, the Multiple Sclerosis Association of America, the National Organization for Rare Disorders, the Neighborhood Legal Services Program, and the Medicare Rights Center—with the opportunity to share beneficiary problems with the OMO. The meetings enable the OMO to learn about high-level issues from organizations that have daily and direct contact with beneficiaries. In 2010, the OMO held three partner and beneficiary advocate meetings and discussed topics such as observation services, Qualified Medicare Beneficiary (QMB) balance billing, Part D outreach, equitable relief

SHIPS' CONVERSATIONS WITH THE MEDICARE BENEFICIARY OMBUDSMAN

In 2010, the Office of the Medicare Ombudsman (OMO) initiated conversations with State Health Insurance Assistance Programs (SHIPs) to develop stronger and more personal relationships with their directors and staff. These meetings were open discussions between the SHIP staff and the Medicare Beneficiary Ombudsman. To guide the conversation, the Medicare Beneficiary Ombudsman sought input on topics such as the accessibility and availability of SHIP services, training, volunteer recruitment, the SHIPs' communication with Centers for Medicare & Medicaid Services (CMS), and the types of technical assistance needed from the OMO.

The issues that SHIPs raised varied from a special enrollment period for disabled beneficiaries to broader concerns—such as the challenges facing SHIPs in assisting Medicare beneficiaries and in recruiting volunteers. Following these visits, the OMO met with the appropriate CMS components to discuss the findings from SHIP meetings and to consider possible solutions for addressing identified problems.

The Medicare Beneficiary Ombudsman visited several SHIP offices, including those located in Maryland, Virginia, Washington, Pennsylvania, and Washington, D.C. In 2011, the Medicare Beneficiary Ombudsman will continue to meet with SHIP staff, as opportunities arise, to gain a better understanding of the issues these organizations face and the support that they will need to continue to assist Medicare beneficiaries.

The OMO established the Medicare Ombudsman partner and beneficiary advocate meetings in 2009 to provide advocacy organizations with the opportunity to share beneficiary problems with the OMO.

appeals, Part B enrollment decisions, Special Needs Plans' (SNPs') models of care, concierge services, and Medicare coverage of chiropractic services.

At the outset of each partner and beneficiary meeting, the Medicare Beneficiary Ombudsman provides updates on the issues raised at previous meetings. For instance, the OMO updates its partners on the status of comprehensive studies or provides information that the partners can share with beneficiaries when problems occur.

As part of the national conference support partnership activity, in 2010, the OMO staff supported CMS' presence at conferences throughout the nation, including the National Alliance of Mental Illness Conference, the SHIP Directors' Conference, the National Association for the Advancement of Colored People Conference, AARP's Annual Conference, and the American Health Lawyers Association Conference.

In addition to obtaining information about beneficiary issues, the OMO also provided direct assistance to Medicare beneficiaries during the conferences and reviewed concerns that indicated possible system or policy issues.

The OMO collaborates with SHIPs to identify issues that affect Medicare beneficiaries and to gain an understanding of SHIP issues related to providing assistance to Medicare beneficiaries. SHIPs are federally funded state programs that provide free, local one-on-one health insurance counseling for Medicare beneficiaries, making them important OMO partners. The OMO attended the 2010 SHIP Directors'

Conference, where the issues discussed fell into several categories: marketing surveillance, Medicare fraud, Medicare and employer-based health coverage, COB, beneficiary information enhancements, the new healthcare landscape, and Medicare initiatives. The OMO responded to the issues raised at the conference by ensuring that any concerns raised during the breakout sessions were directed to the appropriate CMS component. The OMO later followed up with CMS components to ensure that the issues would be investigated and/or resolved.

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 casework trends or trends in CMS' inquiry and complaint data systems. The Division of Ombudsman Research and Trends Analysis facilitates the Issues Management process, which consists of the following:

- Hosting monthly internal issue review meetings
- Performing issue validation and tracking
- Developing Quarterly Issue reports
- Issuing the Beneficiary Contact Trend (BCT) Report, which summarizes beneficiary inquiries, complaints, and appeals from several CMS data sources (see figure 11)

The Issues Management review meetings give the 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 enabling a centralized overview of the entire effort for each issue, including detailed background information, assigned lead analyst and SME, the status of the OMO's interventions, and recommendations to resolve the issue. The OMO uses the information it tracks to develop Quarterly Issue reports, which document the OMO's progress toward resolving beneficiary- and system-related concerns. The Medicare Beneficiary Ombudsman regularly shares the Quarterly Issue reports, which include BCT Report data, with senior CMS Leadership (see figure 11).

The OMO uses both qualitative and quantitative methods to identify issues affecting the Medicare population. For instance, the OMO analyzes data from the Complaint Tracking Module, the CMS system used to track complaints regarding Medicare Parts C and D, to identify outliers or trends that might indicate systemic problems.

The OMO also relies on qualitative information, such as that provided by beneficiary advocates or by caseworkers who notice patterns in their caseload. After an issue has been identified, analysts validate the issue by discussing its impact on beneficiaries' well-being and whether it warrants further assessment, tracking, and resolution via the Issues Management process. Once the issue is validated, it is assigned to an analyst to perform a root-cause analysis. When necessary, the analyst performing the root-cause analysis solicits feedback from other members of the OMO and CMS SMEs.

The issues entering into the Issues Management process typically fall into one of three categories: insufficient beneficiary education and outreach regarding a given topic, systemic issues, and policy issues. The OMO addresses the first category by working with other CMS components to develop and implement beneficiary-focused education and

outreach materials, 1-800-MEDICARE scripts, and changes to the *Medicare & You* handbook. The OMO also communicates with beneficiary advocates who can provide the information directly to beneficiaries. To address the latter two categories (systemic issues and policy issues), the OMO either collaborates with CMS components to resolve the issue quickly or provides short-term and long-term recommendations in the Quarterly Issue reports and in the annual Report to Congress. The section entitled Recommendations Regarding Beneficiary Concerns provides a detailed overview of systemic and policy issues and interventions employed to address them.

To address the issue of insufficient beneficiary education, the OMO collaborated throughout 2010 with other CMS components to facilitate updates to existing publications or to develop new publications. These publications included:

- *Are You a Hospital Inpatient or Outpatient? If You have Medicare – Ask!*
- *Information Caregivers Can Use on: Speaking With a Friend or Family Member's Doctor During an Office Visit*
- *Programs that Can Help You Pay Your Medical Expenses*

Figure 11. 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 contract volume
State Health Insurance Assistance Programs (SHIPs)	<ul style="list-style-type: none"> • SHIP contact volume • Reasons for contact (that is, 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 CMS Central Office (CO)
Components that report complaints in the Complaints Tracking Module: <ul style="list-style-type: none"> • 1-800-MEDICARE • CMS CO and Regional Offices 	<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 volume of Level I appeals • Volume of inquiries
Qualified Independent Contractors	<ul style="list-style-type: none"> • Parts A, B, C, and D total volume of Level II appeals • Volume by type of appeals

In 2010, the OMO also coordinated with 1-800-MEDICARE to develop call scripts, including one to assist beneficiaries who have questions about Medicare coverage of chiropractic services and another to assist beneficiaries who are uncertain about the Equitable Relief Appeals process. In response to unclear or insufficient information in the *Medicare & You* handbook, the OMO suggested the addition of clarifying language about chiropractic service coverage and the difference between SNPs and other MA Plans as well as clarification in the "Doctor Services" section to make beneficiaries aware that Medicare does not cover the extra fees that physicians charge for concierge services.

In 2010, the OMO coordinated with 1-800-MEDICARE to develop call scripts to assist beneficiaries with their questions.

The OMO strives to develop new approaches to identify beneficiary issues and concerns. For example, in 2010, the OMO developed a pilot project to scan and review social media outlets for issues, concerns, and complaints expressed by Medicare beneficiaries. This pilot project was an effort to respond to the changing way in which beneficiaries communicate their Medicare concerns. The environmental scan searched 100 million Internet forums such as blogs, news sites, social networking sites (for example, Facebook and Twitter), and social forums for conversations and posts of high importance to Medicare beneficiaries and stakeholders. The OMO is evaluating whether this pilot project is a useful approach for identifying beneficiary issues in their infancy.

COMPREHENSIVE STUDIES DEVELOPMENT

In response to encountering increasingly complex issues that require in-depth evaluations and root-cause analyses, in 2009, the OMO established a process for developing comprehensive studies.

The issues selected for the development of comprehensive studies often emerge from the Issues Management process and require thorough and sometimes lengthy investigation. The overarching methodology for each comprehensive study includes the following elements:

- Interviews with different stakeholders, such as beneficiaries, CMS contractors, CMS SMEs, and insurance companies
- Reviews of Medicare contractor manuals, policies, and regulations
- Analyses of data from CMS data sources and external sources

Once the information from these elements is collected, the OMO looks for patterns and common problems across all areas in order to understand the factors that underlie a beneficiary issue. Having an in-depth understanding of the root causes of these issues allows the OMO to develop actionable short-term and long-term recommendations for CMS that aim to alleviate the problems and improve beneficiaries' experiences with Medicare. The OMO presents these studies to the CMS Administrator, emphasizing its recommendations.

During 2010, the OMO completed four comprehensive studies and did substantial work on a fifth study. The study topics included:

- Coordination of benefits
- Qualified Medicare Beneficiary balance billing
- Medicare rehabilitation therapy benefits
- Medicare Part B enrollment
- Observation services

The COB and QMB studies were introduced in the 2009 Report to Congress; however, at that time, the studies were not finalized. In addition, the observation services issue was first discussed in the 2007-2008 OMO Report to Congress. This report reintroduces these three issues and provides the final set of findings and recommendations for the COB and QMB studies. All of the studies are discussed in detail in the Recommendations Regarding Beneficiary Concerns section.

AFFORDABLE CARE ACT ACTIVITIES

CMS' role in implementing a large number of Affordable Care Act provisions enabled the OMO to participate in the development of program processes, inter- and intra-agency collaboration, and beneficiary outreach campaigns, in addition to its regular activities. The OMO's involvement with two Affordable Care Act implementation initiatives—Part D IRMAA and the Part D Beneficiary Drug Rebate—is described in the following sections.

Part D Income-Related Monthly Adjustment Amount

Section 3308 of the Affordable Care Act, *Reducing Part D Premium Subsidy for High-Income Beneficiaries*, decreases the amount of the Part D coverage premium that the federal government subsidizes for beneficiaries who meet certain income thresholds. As a result, starting January 1, 2011, higher-income beneficiaries will pay higher prescription drug premiums based on their income as reported to the Internal Revenue Service. The extra premium amount is called the income-related monthly adjustment amount or IRMAA. The implementation of this provision required coordination between CMS and SSA.

In an effort to contribute to the implementation of Part D IRMAA, the OMO assumed leadership of the Part D IRMAA Communications Workgroup, a subgroup of the larger Part D IRMAA Oversight Workgroup, which included SMEs from each CMS component. To ensure that beneficiaries and their caregivers would receive appropriate and timely information on the subject, one of the primary goals of the workgroup was to coordinate all Part D IRMAA communication efforts with SSA, the Office of Personnel Management, and the Railroad Retirement Board. The workgroup, led by the OMO, contributed to the following:

- Development of internal responses and 1-800-MEDICARE call scripts to address potential beneficiary questions
- Development of an SSA IRMAA publication with CMS' feedback, which is posted on www.ssa.gov
- Development of a Part D IRMAA informational brochure that was included in the December 2010 premium bill for direct-billed beneficiaries

SSA AND CMS PART D IRMAA RESPONSIBILITIES

To many beneficiaries, it may appear that only one government agency is responsible for administering Medicare Part D. Administration of the prescription drug program, however, is shared between the Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA). Although each agency has a unique role and specific responsibilities, CMS and SSA must coordinate their activities to ensure the seamless administration of the prescription drug program for Medicare beneficiaries.

Coordination and communication between the two agencies were necessary during the implementation of the Part D income-related monthly adjustment amount (IRMAA) in 2010. SSA published the regulations governing Part D IRMAA and requested the tax data needed to make Part D IRMAA determinations from the Internal Revenue Service. SSA, with CMS' feedback, developed an IRMAA-related publication, which was made available to the public on www.ssa.gov.

Although SSA has the primary responsibility for Part D IRMAA outreach activities, CMS, with the assistance of the Office of the Medicare Ombudsman, also contributed to this effort. To ensure the accurate and timely dissemination of information, CMS communicated SSA's responsibilities regarding Part D IRMAA to 1-800-MEDICARE, the Regional Offices, state Medicaid agencies, State Health Insurance Assistance Programs, and other partners. The two agencies also collaborated to develop the Part D IRMAA call scripts for 1-800-MEDICARE to avoid transferring beneficiaries' calls between CMS and SSA.

The OMO also plays an ongoing role in discussions about the handling of Medicare Part D premium refunds, nonreceipt of refunds, returned refund checks, and the impact of these matters on beneficiaries.

Part D Beneficiary Drug Rebate

The Affordable Care Act provided a one-time \$250 rebate check in 2010 to Medicare Part D beneficiaries who reach the coverage gap (also known as the "donut hole"). CMS began mailing the first rebate payments to beneficiaries in June 2010 and continued to do so every 2 months throughout the year. Overall, 3.8 million Medicare beneficiaries received a rebate check. A number of checks were initially returned to CMS undelivered because of incorrect beneficiary mailing addresses or for other reasons. The OMO developed a process and issued instructions for handling inquiries and complaints regarding undelivered rebate checks.

Efforts included:

- Developing instructions—with input from the CMS Center for Medicare, the Consortium for Medicare Health Plans Operations, and 1-800-MEDICARE—about how to handle beneficiary inquiries and complaints. The OMO provided these instructions to the caseworkers.
- Providing updates regarding check mailings and processing to enable caseworkers to provide timely and accurate responses to inquiries and complaints regarding the status of beneficiaries' rebate checks.



This section discusses key beneficiary issues and associated recommendations, including those from four comprehensive studies completed in 2010.

RECOMMENDATIONS REGARDING BENEFICIARY CONCERNS

SECTION HIGHLIGHTS

In fiscal year 2010, the Office of the Medicare Ombudsman's research activities included developing comprehensive studies with recommendations addressing five issues:

- Coordination of benefits
- Balance billing of Qualified Medicare Beneficiaries
- Medicare Part B enrollment concerns
- Medicare rehabilitation therapy benefits application
- Use of observation services

Recommendations on the observation services issue, which was first discussed in the 2007-2008 Report to Congress, will be completed in 2011. The Office of the Medicare Ombudsman developed detailed recommendations outlined in the comprehensive studies. One common theme among the recommendations was to improve beneficiaries' and providers' access to timely information through:

- A single source of information to improve access to existing documents
- More effective placement of documents on the www.Medicare.gov website
- Frequent and regular updating of shared information to ensure data accuracy

The Office of the Medicare Ombudsman also reviewed other issues related to Fee-for-Service Recovery Auditors, Special Needs Plans, form CMS-1490S, and Medicare Administrative Contractors.

INTRODUCTION

The annual Report to Congress is the Office of the Medicare Ombudsman's (OMO's) primary opportunity to inform Congress and the Secretary of the U.S. Department of Health & Human Services of systemic issues affecting Medicare beneficiaries and of steps that could be taken to either solve or lessen adverse impacts. To encourage the improvement of beneficiaries' experiences with Medicare, the OMO regularly shares its findings and recommendations with the Centers for Medicare & Medicaid Services (CMS) Leadership through its Quarterly Issue reports and briefings.

This section discusses the key beneficiary issues and associated recommendations the OMO presented to CMS Leadership in 2010. It also places the OMO's recommendations within a detailed context of the select issues that the OMO identified as complex or systemic concerns or which offered opportunities to improve beneficiaries' experiences with Medicare through the adoption of actionable recommendations. The discussion focuses mainly on the issues examined through the comprehensive studies.

DETAILED REVIEW OF SELECT ISSUES

The OMO developed comprehensive studies on systemic issues affecting Medicare beneficiaries to identify the root causes and to develop recommendations. These five issues were as follows:

- Coordination of benefits (COB)
- Balance billing for services provided to Qualified Medicare Beneficiaries (QMBs)
- Concerns related to the decision to enroll in Medicare Part B
- The application of Medicare rehabilitation therapy benefits
- The use of observation services²⁰

The following subsections provide an in-depth review of these five issues along with the findings and recommendations from OMO's comprehensive studies. The OMO first outlined the COB and balance billing for QMB issues in its 2009 Report to Congress. In 2010,

²⁰ The observation services study will be completed in 2011.

the OMO completed comprehensive studies on these issues and finalized recommendations, which it has shared with CMS Leadership. Four additional issue areas on which the OMO took action and/or is investigating further are also reviewed later in the final subsection.

Coordination of Benefits

COB involves the coordination of beneficiaries' Medicare coverage with supplemental or other insurance policies. Often in instances where there are problems, the primacy-of-payment responsibilities (that is, which insurance entity pays first) are not always well understood by Medicare beneficiaries, who then may not be able to convey accurate information to their health care providers regarding Medicare and other insurance coverage. Most Medicare beneficiaries have additional insurance coverage that supplements their Medicare coverage. In 2009, approximately 87 percent of Medicare enrollees had at least one additional form of coverage.²¹ The most common types of additional insurance included Medigap plans (30.6 percent of Medicare beneficiaries who have other coverage), private group health plans (GHPs) (29.2 percent), Medicaid (19.6 percent), and other coverage sources (20.6 percent, combined) including workers' compensation, liability insurance, or governmental programs such as TRICARE.

In certain situations, the coordination of Medicare benefits is well understood. For example, with individual market supplemental insurance programs such as Medigap, which wraps around Medicare, Medicare is always the primary payer. It is not always known, however, if Medicare is the primary or secondary payer to insurance plans and programs in the following scenarios:

- For beneficiaries (aged 65 years and older) who are covered under GHP coverage through either their own or their spouse's policy as active workers.
- For disabled beneficiaries who are covered through current employment of a family member, including dependents or domestic partners.
- For beneficiaries with end-stage renal disease who have GHP coverage through the beneficiary or as a spouse or dependent child of an active worker.

²¹ The Lewin Group. (2010, May). Draft Final Report for the Beneficiary Coordination of Benefits Study. Study prepared for the Office of the Medicare Ombudsman. Based on data from Coordination of Benefits Contractor, September 2, 2009.

- In matters concerning auto and other liability insurance.
- Where no-fault insurance applies.
- In workers' compensation situations.

When a beneficiary is covered by more than one health plan or there are instances of injuries where liability insurance, no-fault insurance, or workers' compensation coverage becomes the primary payer, effective administration of coverage requires COB among Medicare and other sources of coverage. Most COB efforts occur without difficulty and, as a result, are invisible to the beneficiary. However, because of the large number of COB transactions, even a small percentage of problems represents difficulties for many beneficiaries. Resolving COB issues can be time consuming and can create financial concerns both for beneficiaries and providers because medical bills are not paid on time and providers pursue payment from the beneficiaries.

The OMO undertook a comprehensive study of COB issues beginning in 2009 and provided a description of the issue and initial recommendations in the 2009 Report to Congress. The comprehensive study was completed in 2010, and final recommendations were developed. The length of the effort underscores the importance and complexity of the COB issue. The rules that govern COB issues are complex for Medicare beneficiaries, physicians, and insurers, particularly regarding the primacy-of-payment responsibility, which is influenced by the source of the coverage. This complexity can result in miscommunication and delays in payment of claims. For example, in the case of employer GHP coverage, the COB rules that determine primary and secondary coverage depend on employer size. For an elderly Medicare-eligible individual who is covered by an employer GHP either as an active worker or as the spouse of an active worker, Medicare is a secondary payer and the GHP is primary if the employer has 20 or more employees. The opposite would be true for a worker whose employer has fewer than 20 employees. In contrast, for a disabled Medicare beneficiary, primacy of payment is based on whether or not an employer has 100 or more employees. Once the active worker (either the beneficiary or his or her spouse) retires, then Medicare becomes primary.

Complex COB issues can occur in situations when a workers' compensation company becomes the primary payer instead of Medicare.

Although COB issues arise with many of the sources of coverage, the most complex issues were reported to arise in situations when a beneficiary is involved in an accident, injury, or work-related illness, and the liability insurance, no-fault insurance, or workers' compensation company becomes the primary payer instead of Medicare. These COB situations are particularly complicated because, for example, the company providing the workers' compensation insurance is only responsible for those health care conditions arising from the specific accident, injury, or work-related illness. While the Coordination of Benefits Contractor (COBC) flags the beneficiary's Common Working File (CWF) record to indicate the presence of a Medicare secondary payer (MSP) and thereby alerts the system to either pay conditionally or deny payment on future claims submitted for MSP-related care, the beneficiary is likely to obtain other non-MSP-related health care. Paying conditionally or denying payment for the one MSP situation while concurrently allowing payment for all other conditions is complex and can be a source of confusion for beneficiaries and for providers.

The OMO also noted a further complication in coordinating benefits in cases involving liability insurance, no-fault insurance, and workers' compensation: although treating physicians and other providers do have access to some beneficiary information available in the CWF system, they do not have access to the CWF's MSP screens that would enable them to know the coverage responsibilities for one condition or another. Further, because of rules set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding beneficiary privacy, providers and COBC staff are sometimes reluctant to query each other on the issues of payment responsibility for various health care conditions without involvement of the beneficiary, which can be confusing for the beneficiary. However, the HIPAA privacy rules do

allow for the sharing of individuals' health information for the purposes of treatment, payment (including coordination of benefits), and operations.

The 2009 OMO Report to Congress discussed COB issues, and on the basis of feedback received from various stakeholders, the OMO listed actions that could be undertaken to rectify COB challenges. This set of recommendations has been expanded since 2009, providing additional guidelines to address COB issues, particularly issues that are related to workers' compensation and third-party liability insurance. Listed below are several recommendations that were included in the 2009 OMO Report to Congress, along with those developed in 2010.

Recommendations about the accessibility of existing materials:

- Provide a more visible placement for the *Who Pays First* guide on www.Medicare.gov (2009 OMO Report to Congress).
- Expand the coverage types discussed in the *Who Pays First* guide to include, for example, Medicaid coverage situations.
- Provide the contact information for the COBC more prominently, such as on the cover of the *Who Pays First* guide.
- Improve the accessibility of the provider COB fact sheets so that they are accessible from any web page that discusses COB. Rather than having each fact sheet on a different web page, all the fact sheet links for providers should appear on a single web page (2009 OMO Report to Congress).
- Replace links and language that are in English on the Spanish version of www.Medicare.gov (2009 OMO Report to Congress).

CASE EXAMPLE

Coordination of Benefits: Workers' Compensation Case

In workers' compensation cases, occasionally Medicare denies claims for treatment of unrelated conditions rather than just those claims with codes that are specific to a course of treatment matching the condition covered by the workers' compensation policy. The Office of the Medicare Ombudsman (OMO) assisted a Medicare beneficiary who had received notices that his Medicare claims had been denied because of the existence of an open workers' compensation record in the Common Working File (CWF).

The CWF is a single data source for fiscal intermediaries and carriers to verify beneficiary eligibility and conduct prepayment review and approval of claims from a national perspective. The Medicare Administrative Contractor (MAC) verifies the beneficiary's coverage in the CWF prior to making payment for a claim. In the case of the Medicare beneficiary who reached out to the OMO, it was determined that the MAC had checked the CWF and found that an open workers' compensation case existed. The MAC, therefore, denied payment for the beneficiary's Medicare claim.

The OMO investigated the incident and learned that the beneficiary had been denied payment of his Medicare claims because a trauma diagnosis code associated with his workers' compensation was listed on the beneficiary's claim, causing a code error. The OMO informed the beneficiary that the provider could appeal the denied claim by indicating that the service was not related to the workers' compensation health condition. As a result of the OMO's intervention, the claims were properly filed, and the case was settled within 16 days, including the reconciliation of the appropriate payments.

Recommendations about communication and development of new materials:

- Develop COB materials specifically focused on more esoteric situations, such as liability insurance, no-fault insurance, and workers' compensation.
- Provide additional guidance about the HIPAA rules to clarify that the exchange of information related to treatment, payment, or operations is permitted when providers and claims processors are dealing with COB.
- Develop and provide more materials and tools for providers to use to facilitate discussions with beneficiaries and to facilitate the administration of provider intake questionnaires for beneficiaries.
- Provide guidance and communication tools to encourage employers to emphasize the importance of completing the Initial Enrollment Questionnaire (IEQ) and to assist with the completion of the questionnaire.

Recommendations about system changes:

- Work with stakeholders to identify opportunities to reduce CWF overwrite incidents in which updated information is replaced by old information in the system (2009 OMO Report to Congress).
- Administer the IEQ at the time of Social Security eligibility in addition to during initial enrollment into Medicare.
- Promote the adoption of voluntary industry standard explanation-of-benefits codes and messaging (2009 OMO Report to Congress).
- Provide access to the diagnostic information within the CWF MSP screens to physician offices (and other entities billing Medicare) so that physician offices and other providers know which diagnosis code(s) are involved in workers' compensation, liability insurance, or no-fault insurance cases.

Qualified Medicare Beneficiary Balance Billing

Under the provisions of the Medicare Catastrophic Coverage Act of 1988, low-income Medicare beneficiaries are eligible to receive Medicaid premium and cost-sharing subsidies through the QMB program. Eligible beneficiaries are entitled to Medicare Part A and are eligible for Medicare Part B, which is optional. Under this Act, states are required to participate in Medicare cost sharing for dual-eligible enrollees who are entitled to varying levels of benefits. These benefits range from assistance with Medicare cost sharing to the same set of services available to Medicaid beneficiaries. Medicaid pays Medicare premiums, deductibles, co-insurance, and copays for Parts A and B on behalf of QMB beneficiaries. Medicare providers serving QMB beneficiaries must bill the state Medicaid agency to receive payment for Medicaid's contribution to the QMB cost of care.

Section 1902(n)(2) of the Social Security Act prohibits Medicare providers from balance billing QMBs for services. Specifically, the statute provides that Medicare payments and Medicaid payments, if any, be considered payment in full to the provider for services rendered to a QMB. Section 1902(n)(2) supersedes Section 3490.14 of the State Medicaid Manual, which previously stipulated that a provider can accept a patient as a "...private pay only or QMB only..." and if a provider does not accept Medicare assignment, he or she may, in certain circumstances, bill a QMB directly for the difference between his/her rate and the Medicare rate. These provisions in the State Medicaid Manual are no longer applicable, and under current law, Medicare providers cannot balance bill a QMB. CMS has provided guidance to help clear up any confusion on this issue.²²

Nevertheless, balance billing occurs. There are a number of reasons a provider might balance bill a QMB. Providers may not be aware that they are not allowed to balance bill QMBs. A survey of communications to Medicare providers found that there has not been any recent, direct communication on the issue of balance billing QMBs.

²² Centers for Medicare & Medicaid Services. (2008). Medicare Cost-Sharing for Medicaid Beneficiaries. Retrieved from http://medicareadvocacy.org/InfoByTopic/MedicareSavingsPrograms/MedSavProg_08_04.24.ARACostShare.pdf.

Providers often do not have a clear understanding about the requirements and responsibilities of becoming a registered Medicaid provider.

Providers might also be dissatisfied with the level of compensation they receive from state Medicaid agencies for QMBs. Medicaid reimbursement rates to providers are frequently set below Medicare rates, meaning that providers may receive less than their usual payment for services provided to QMBs. For example, a recent study found that Medicaid reimbursements for office-based medical care in 2008 were lower than Medicare in 40 states, with Medicaid rates 28 percent lower than Medicare on average.²³

Additionally, providers might have concerns about what would be required of them if they enroll as a Medicaid provider in order to bill a state for a QMB or other dual-eligible beneficiary. Rather than billing Medicaid appropriately, some providers inappropriately bill the QMB beneficiary. Providers often do not have a clear understanding about the requirements and responsibilities of becoming a registered Medicaid provider. Providers may avoid accepting QMB patients because they are concerned that the act of billing Medicaid for care provided to a QMB may automatically designate them as a Medicaid provider, even though there is evidence that most states do not allow QMB providers to be enrolled simply by billing the Medicaid agency. This lack of understanding has the potential to affect QMB access to care.

In the 2009 Report to Congress, the OMO discussed the issue of balance billing and made a number of recommendations to address the issue. A comprehensive study commissioned by the OMO on QMBs and balance billing was completed in 2010 with expanded recommendations regarding the balance billing issue that QMBs and QMB providers face.

²³ Zuckerman, S., Williams, A., and Stockley K. (2009, April). Trends In Medicaid Physician Fees, 2003-2008. *Health Tracking*.

Recommendations about communication:

- Develop a joint communication between Medicaid and Medicare officials for state Medicaid directors and Medicare providers that focuses specifically on the balance billing issue as well as on increasing awareness that QMB beneficiaries with certain questions should be directed to 1-800-MEDICARE.
- Clarify advocacy groups' misconceptions regarding claims submissions constituting a method for Medicaid provider enrollment.
- Clarify the governing rules that determine whether a physician may refuse to accept a Medicare or Medicaid patient.

Recommendations about informational and educational materials for beneficiaries and providers:

- Communicate to state Medicaid agencies the importance of making information on the provider registration process available.
- Encourage states to include QMB balance billing prohibitions in their provider education materials, as mandated by Section 1902(n)(2) of the Social Security Act.
- Ensure the development of additional scripts for 1-800-MEDICARE that address specific QMB questions posed by beneficiaries and by providers.
- Develop additional educational materials to assist Medicare providers with registration and claims submission processes with specific references to QMB-related situations.

Recommendations about system changes:

- Encourage Medicare providers to obtain information about state Medicaid program provider registration practices, including the process for obtaining payment from the state Medicaid program.
- Provide guidance and technical assistance using examples of systems or best practices to assist states in facilitating QMB provider enrollment.
- Identify internal process improvements related to dual-eligible issues within CMS, including

the Center for Medicaid, CHIP and Survey & Certification, and the Center for Medicare (CM), to help mitigate challenges for beneficiaries and providers.

- Encourage states that do not use QMB ID cards to implement the practice so that QMB beneficiaries can be properly identified when seeking care from providers.

Part B Enrollment

Enrollment in Medicare Part B is voluntary, and individuals who become eligible for benefits must decide at the time of eligibility whether to enroll or defer enrollment to a later date. However, the decision to enroll in Medicare Part B is complex, not only because enrolling requires payment of a premium that will vary according to an individual's income and resources, but because other factors such as age at retirement; existence of other health care coverage; health status; and financial resources may be considerations when a beneficiary is deciding whether or not to defer Medicare Part B enrollment.

The Social Security Amendments of 1972 mandate that beneficiaries receiving Social Security benefits at the time of Medicare eligibility be automatically enrolled in Part B at the time of entitlement to Part A.²⁴ Those individuals not receiving retirement benefits must actively request enrollment in Medicare through the Social Security Administration (SSA) or the Railroad Retirement Board. Individuals may also choose to defer or opt out of Part B enrollment; however, premium penalties may be incurred for enrollment in Part B after an individual's initial enrollment period (IEP).²⁵ Beneficiaries who defer enrollment in Medicare 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 initial eligibility, unless they qualify for a special enrollment period (SEP). The most common SEP is available if the individual can establish evidence that he or she was covered under health insurance provided through active employment of the individual or his or her spouse. In that situation, the individual is entitled to an SEP.

²⁴ This rule does not apply to beneficiaries residing in Puerto Rico.

²⁵ The initial enrollment period is the 7-month period that begins 3 months before the month an individual first meets eligibility requirements and ends 3 months after that first month of eligibility.

Making the correct decision about enrollment in Medicare Part B requires that beneficiaries be well informed about the enrollment process and that they receive appropriate assistance from CMS, SSA, or their employers. A 2010 OMO assessment of the subject listed the following issues associated with beneficiary confusion concerning Part B enrollment:

- The changing retirement age
- Group health coverage
- TRICARE coverage
- Veterans Affairs and Civilian Health and Medical Program of the Department of Veterans Affairs health benefits
- Federal employees' Health Benefits Program
- Medicare Supplement Insurance (Medigap) open enrollment
- Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Making the correct decision about enrollment in Medicare Part B requires that beneficiaries be well informed and that they receive appropriate assistance.

The OMO identified that some beneficiaries are confused regarding their need to submit an application to enroll in Medicare to obtain Part B benefit coverage. This confusion is likely caused by increases in the Social Security retirement age, which mean that some people reach Medicare age before receiving Social Security benefits. Additionally, the transitions from current worker to retired worker and from current worker under age 65 to current worker aged 65 years and older require a decision to either retain employer-provided health care coverage or enroll in Medicare.

Employers play a critical role in assisting individuals with understanding their Part B enrollment options and responsibilities. Nonetheless, the OMO found that employers are often unable to answer Part B enrollment

questions, which may have the consequence of late enrollment penalties for employees/beneficiaries. Because of their role as a trusted resource, it is important that employers be familiar with Medicare policies and requirements related to Part B enrollment and that they be able to provide necessary guidance to their employees. Consequently, the OMO made the following recommendations for improving employers' ability to take an active role in assisting individuals in understanding the Part B enrollment process:

- Create a direct line of contact between CMS and employers, perhaps as a specialized helpline through 1-800-MEDICARE.
- Add an "Employers" section to www.cms.gov and/or www.Medicare.gov with fact sheets and other information that can improve employers' ability to inform their employees about Part B enrollment decisions.
- Educate employers about the availability of State Health Insurance Assistance Programs as a resource to enhance employers' and beneficiaries' understanding of the Part B enrollment process.

Providing clear guidance to individuals approaching age 65 about the Medicare Part B enrollment process may help beneficiaries who are eligible for additional

coverage through an employer make informed decisions. Some employer health plans require retirees who become eligible for Medicare to enroll in Part B in order to remain eligible for the employer's health benefits. In another example, an employed individual with a health savings account (HSA) who also enrolls in Medicare may only withdraw funds from an HSA and can no longer contribute to an HSA.

The decision to enroll in Medicare Part B may also be problematic when a beneficiary must consider other supplemental coverage, including Medigap, which is sold by private insurers to assist Medicare beneficiaries with their cost-sharing liability. An individual has a 6-month Medigap open enrollment period that begins when he or she is aged 65 or older and is enrolled in Medicare Part B. During the Medigap open enrollment period, a Medigap insurer is required by law to offer an individual a Medigap insurance policy regardless of the individual's health. For individuals who are covered through an employer health plan based on current employment, the employer coverage is primary to Medicare, and as noted above, it is possible to delay enrolling in Part B without penalty. However, when the employee retires and the employer plan is secondary, the employer may require the individual to enroll in Part B, which starts the Medigap open enrollment period. Once the 6 months has passed, the individual may

CASE EXAMPLE

Part B: Special Enrollment Period

The rules that define conditions under which Medicare beneficiaries qualify for a special enrollment period (SEP) to enroll in Medicare Part B are complex. The Office of the Medicare Ombudsman (OMO) assisted a Medicare beneficiary who contacted the OMO because she was denied enrollment in Medicare Part B during the initial enrollment period. Instead, the Social Security Administration (SSA) instructed her to wait to enroll during the general enrollment period. The OMO's investigation determined that the beneficiary was eligible to enroll in Parts A and B through the Medicare buy-in program. Under the buy-in program, states assist beneficiaries with paying for their Medicare premiums, and in some instances, deductibles and copayments if they meet certain income guidelines. These individuals also qualify for an SEP. To assist the beneficiary with the issue, the OMO contacted SSA on the beneficiary's behalf to explain the rules associated with beneficiaries who are enrolled in the Medicare buy-in program. As a result of the OMO's efforts, the case was resolved within 3 days, and the beneficiary was able to enroll in Medicare Part B through the SEP.

have fewer options for buying a policy once Medigap insurers can start to use medical underwriting. In order to take advantage of the open enrollment period, these individuals would potentially be required to pay separate premiums for group health coverage, Medicare Part B coverage, and Medigap coverage.

In addition to the specific employer-related recommendations noted above, the 2010 OMO study outlined a number of recommendations to assist CMS in improving the existing beneficiary information that guides the decision to enroll in Medicare Part B. The recommendations encompassed six overarching areas related to content and dissemination of information, which demonstrated the need for the following:

- A single, comprehensive source of information about the Medicare Part B enrollment process
- Automatic notification to adults turning 65 of their Medicare eligibility, regardless of retirement status
- The timely delivery of current resources to help beneficiaries understand Part B enrollment and to be informed of options and the process before the enrollment decision must be made
- An expanded online Medicare enrollment tool to facilitate the Medicare Part B enrollment process for Medicare enrollees
- A decision support tool or checklist—including specific scenarios related to Part B enrollment—to address the intimidating amount of information needed to make informed decisions

CASE EXAMPLE

Part B: Initial Enrollment Period

The potential complications facing beneficiaries when they enroll in Medicare Part B are exemplified in the case example of a Medicare beneficiary who missed the initial enrollment period because she had received inadequate information about the Medicare enrollment policy. Upon turning 65, the beneficiary had been assured by 1-800-MEDICARE and the Social Security Administration that because she was enrolled in an employer group plan with a health savings account (HSA), she could enroll in Medicare at any time. Several months later, she was informed by her employer that her employer group Prescription Drug Plan was not a creditable drug plan (a plan is considered creditable if the actuarial value of the coverage equals or exceeds the actuarial value of the standard Medicare prescription drug benefit). When the beneficiary tried to enroll in Part D, she was informed that she was ineligible to enroll because she had not enrolled in Part B and had missed the initial enrollment period, during which she also would have needed to enroll in Medicare Part A. She was informed that her enrollment date in Medicare Part A was retroactively set to an earlier period, meaning that she would have to be concurrently enrolled in an HSA and Medicare.

The beneficiary contacted the Office of the Medicare Ombudsman (OMO) asking to be considered for a postponed enrollment period because her HSA would charge significant penalties during the months she would be enrolled in both Medicare and the HSA—a situation that had resulted despite her timely request for appropriate information on enrollment policies. The OMO caseworker contacted the Social Security Southeastern Program Service Center, requesting equitable relief in order to grant the beneficiary a special enrollment period because of the incorrect information she had previously received. The OMO's advocacy on behalf of the beneficiary resulted in a positive outcome for the beneficiary, whose enrollment period was postponed until later in the year, helping her to avoid penalties associated with being concurrently enrolled in an HSA and in Medicare. The beneficiary was able to receive Medicare Part A and Part D benefits.

- Frequent and regular updating of shared information between CMS and SSA to ensure that information provided is accurate and comprehensive

Medicare Rehabilitation Therapy Benefits

Medicare provides coverage for rehabilitation therapy services for beneficiaries requiring the skills of a qualified therapist to restore a level of functioning. Rehabilitation therapy services include physical and occupational therapy and speech/language pathology. Although therapy to maintain a level of functioning generally does not require the skills of a qualified therapist to deliver such services, Medicare will cover the design of a safe and effective maintenance program for patients' specific illnesses or injuries.

Clarification concerning rehabilitation therapy benefits in the home health setting is included in the November 2010 release of the Home Health Prospective Payment System rule. However, as the Medicare coverage rules around rehabilitation therapy differ between care provided in a home health setting and a skilled nursing facility (SNF) setting, further clarification is desirable.

Rehabilitation therapy services are covered under Medicare Part A or Part B: the part of Medicare that covers therapy services depends on the treatment setting. Medicare Part A pays for qualifying rehabilitation therapy services in a SNF when the beneficiary is within a Medicare Part A-covered SNF stay. A Part A-covered SNF stay is subject to a limit on the number of covered days; consequently, Part A-covered SNF therapy services also are subject to that limit.

Medicare Part B can also pay for qualifying therapy services. Beneficiaries who are residents of nursing homes (not covered by a Part A stay) can receive coverage for therapy services under Medicare Part B. In addition, Part B provides coverage for therapy services in ambulatory/outpatient settings. However, Medicare Part B outpatient therapy has caps that apply in certain settings. For example, in 2010, Medicare Part B in most cases capped incurred expenses for physical therapy and speech language pathology services at \$1,860 for the calendar year. The outpatient therapy cap, however,

does not apply to therapy services delivered in an outpatient hospital setting.

Depending on the circumstances, Medicare Part A or Part B pays for therapy services delivered to beneficiaries eligible under the home health benefit. Within the context of home health services, a qualified therapist is required to reassess and document the beneficiary's continued need for the skilled therapy services at set intervals; day or dollar coverage limitations are not specified.

The OMO conducted a comprehensive study of Medicare rehabilitation therapy benefits after beneficiary advocacy groups raised concerns about payment denials for needed services, in particular, regarding maintenance therapy services delivered under the home health benefit. The comprehensive study included a review of related statutes, regulations, local coverage determinations (LCDs), and other guidance documents. The study also included discussions with CMS program experts and beneficiary advocates. The study identified several issues that may be contributing to the concern regarding Medicare rehabilitation therapy benefits. For example, an examination of LCDs revealed that Medicare claims processing contractors are not interpreting policies related to therapy services in a consistent manner, thereby supporting the need for clarity on this issue.

Due, in part, to the Medicare Payment Advisory Commission's March 2010 report, CMS was prompted to issue a regulatory clarification concerning rehabilitation therapy benefits in the home health setting: the clarification was published in November 2010 in the Home Health Prospective Payment System rule. The rule is expected to decrease some of the confusion that may result from the complex rules governing rehabilitation therapy. However, as the Medicare coverage rules regarding rehabilitation therapy differ among care provided in a home health setting, in a Part A-covered SNF stay, and in various settings under Part B, further clarification may prove helpful to mitigate concerns and problems.

The OMO's report from the comprehensive study made the following recommendations on how to alleviate confusion about applying rehabilitation therapy benefits:

- Create a single, comprehensive Medicare publication dedicated to therapy services and limitations across various settings of care.
- Restructure the language in the Medicare Benefit Policy Manual to present reasonable and necessary governing principles for maintenance therapy in the initial general policy sections about skilled therapy services. Ensure consistency of these principles throughout the manual.
- Provide a stakeholder document outlining therapy benefits and limits across settings of care.
- Clarify policy distinctions between coverage of “skilled nursing” versus “skilled therapy” services in all materials related to the subject.
- Provide guidance and education to Medicare contractors, focusing particularly on reasonable and necessary use and coverage of therapy services across different settings of care, specifically for maintenance therapy services. Also, provide guidance and education about limitations on therapy services and maintenance therapy across various settings of care.

Observation Services

Advocacy groups have raised concerns to the OMO regarding hospital observation services covered by Medicare. The OMO discussed this issue initially in the 2007-2008 OMO Report to Congress. Subsequently, in 2010, the OMO began a more comprehensive assessment of this issue. Substantial work was completed on this study during 2010, and the OMO will release the study with recommendations to CMS in 2011.

Observation services include short-term treatment, assessment, and reassessment before a decision can be made regarding whether a beneficiary requires inpatient hospitalization or can be discharged. The number of these services has increased over the last few years. Although the expectation is that a beneficiary will be placed in observation for less than 48 hours, with most admission decisions occurring within 24 hours, an internal analysis by CMS revealed increases in the duration of hospital observation services.

Observation services are hospital outpatient services and are covered under Medicare Part B. Because they

are Part B services, the increase in both the frequency and duration of these services is generating potential financial liabilities and post-acute coverage issues for beneficiaries. Self-administered drugs²⁶ (SADs), which many beneficiaries are taking, are not covered under the Part B benefit; hence, beneficiaries being cared for through hospital observation who do not bring their own SADs (which is often prohibited) to the hospital are at financial risk for the reimbursement of these drugs to the hospital that dispenses them.²⁷ Beneficiaries with Part D coverage do have the option of submitting their hospital SAD bill to their Part D plan; however, they are still at risk for the substantial variance between what the Part D plan might reimburse and what the hospital charges. Had the beneficiary been in an inpatient setting, these drugs would have been covered under the Part A benefit.

A second area of concern that the OMO is investigating further in 2011 involves the coverage (or lack thereof) of SNF services after observation services have been furnished. Observation services are not counted toward the 3-day inpatient hospital “qualifying stay” for Medicare SNF coverage. Only the inpatient hospital care is counted toward the qualifying inpatient hospital stay. That is, if a patient was admitted as an inpatient for a 2-day hospital stay after receiving observation services for 2 days, the admission to a SNF would not be covered because the inpatient stay was shorter than 3 days. The OMO has found that this issue of SNF coverage eligibility following observation services is an access issue for Medicare beneficiaries.

²⁶ Self-administered drugs are drugs individuals would take on their own. CMS. (2011, February) *How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings* Retrieved June 17, 2011, from <http://www.medicare.gov/Publications/Pubs/pdf/11333.pdf>.

²⁷ CMS has noted and is considering the recommendation cited in the 2007-2008 Report to Congress that hospital pharmacies become Part D participating pharmacies.

Because of increased scrutiny by Medicare and other payers of the appropriateness of shortstay inpatient admissions, hospitals may be approaching inpatient admissions more cautiously.

A third area of concern that has been raised is that beneficiary cost sharing associated with the Part B observation services might exceed the cost sharing that beneficiaries would have been subject to had they been admitted as inpatients and covered under Part A. However, the OMO has done preliminary research into this concern and has found that most beneficiaries who received observation services did not incur total Part B expenses that exceeded the inpatient Part A hospital deductible.

The OMO has already made efforts to inform beneficiaries of the potential impact of observation services on them. As an initial step to address beneficiary issues associated with the use of observation services, the OMO developed the beneficiary education brochure, *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!*²⁸ The document informs beneficiaries about the importance of obtaining information regarding whether they are an inpatient or an outpatient when they have been in the hospital for more than a few hours. To better understand the reasons for growth in these services, the OMO prepared a white paper on observation services in 2009. Furthermore, as a follow-up, the OMO conducted the comprehensive study to further understand the nature and scope of the use of observation services, what may be contributing to the escalating use of this type of care, and its impact on beneficiaries.

Although the study is ongoing, the preliminary findings from the comprehensive study suggest the following potential reasons for the increasing use and duration of observation services:

- Because of increased scrutiny by Medicare and other payers of the appropriateness of short-stay inpatient admissions, hospitals may be approaching inpatient admissions more cautiously, and as a result, “borderline” patients may receive observation services rather than being admitted as hospital inpatients.
- Older Medicare beneficiaries tend to have longer periods of observation services than do younger beneficiaries, and the number of patients aged 80 and over has grown rapidly in the last few years.
- The use of observation services may benefit hospitals by decreasing the length of inpatient stay, freeing up inpatient and emergency department beds, and reducing claims denials.

The OMO expects to complete the comprehensive study on observation services and to develop recommendations for the 2011 OMO Report to Congress.

OTHER ISSUES ADDRESSED BY THE OMO

The OMO investigated other issues brought to its attention by casework and internal and external partnerships that could have a significant effect on beneficiaries' well-being or affect a large portion of the Medicare population. The OMO's investigation revealed related issues and the need for further study of the Fee-for-Service (FFS) Recovery Audit Program and the dissemination of information to beneficiaries regarding Special Needs Plans (SNPs). The OMO also worked with several CMS components to address inconsistencies in processing request for payment forms submitted by beneficiaries, and it continues to monitor the issue of Medicare Administrative Contractors' (MACs') performance.

Fee-for-Service Recovery Auditors

In June 2010, a concern regarding incorrect billing for related outpatient and inpatient services by hospitals and the potential ineffectiveness of FFS Recovery Auditors to identify these billing issues was brought to the OMO's attention at the American Health Lawyers Association Conference. The FFS Recovery Auditors responsibilities include investigating and recovering

²⁸ CMS. *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* Retrieved June 15, 2011, from <http://www.medicare.gov/publications/pubs/pdf/11435.pdf>.

overpayments from improper billing on FFS claims as outlined in their scope of work. Section 1886(a)(4) of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1990, states that inpatient hospital services include ("bundle") diagnostic services or other services related to the patient's hospital admission during the 3 calendar days preceding the date of the hospital admission. According to the law, the term "other services" applies to outpatient nondiagnostic services, which must be bundled on the inpatient (Part A) bill only when the services are related to the beneficiary's admission. Additionally, nondiagnostic services could be bundled on the inpatient bill only when the principal diagnosis codes for the outpatient encounter and the inpatient admission match exactly. This requirement, as one of the beneficiary advocates pointed out, was too restrictive, as it increased out-of-pocket costs for beneficiaries in the form of copayments and deductibles.

While the OMO was investigating this issue, Congress passed the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, which clarified the term "other services" related to admission to include all outpatient services that are not diagnostic services on the date of the beneficiary's inpatient admission or during the 3 days preceding the date of admission. Further, in order for hospitals to bill the outpatient nondiagnostic services separately, they must demonstrate that the services provided on the day of or up to 3 days prior to the admission were not related to the admission.

The OMO reviewed the 2010 law and determined that to a large extent it will address the issues raised at the American Health Lawyers Association Conference. However, the OMO's investigation of the Part A bundling issue revealed other underlying FFS Recovery Auditors issues requiring further investigation. Therefore, the OMO initiated a comprehensive FSS Recovery Auditor study, which will be completed in FY 2011. The findings, along with the recommendations from this study, will be presented in the 2011 Report to Congress.

Medicare Special Needs Plans were created to give certain groups of beneficiaries better access to Medicare, with plans designed to meet their unique needs through improved coordination of care.

Informing Beneficiaries About Special Needs Plans

Through the OMO's network of internal partnerships, the Center for Medicare Advocacy raised the issue of whether beneficiaries have sufficient knowledge about the potential benefits of SNPs to make informed enrollment choices. The advocacy group noted that eligible beneficiaries are not choosing to enroll in SNPs because they are uncertain how SNPs differ from other Medicare Advantage (MA) Plans. Beneficiary advocacy groups suggested that beneficiaries are unable to make informed decisions about SNPs because MA sponsors do not make the models of care for these plans publicly available.

As authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), SNPs are allowed to target enrollment to one or more of the following types of beneficiaries: individuals with certain types of chronic or disabling conditions, individuals in institutions, and dual-eligible beneficiaries. SNPs provide their members with all hospital (Part A), medical (Part B), and prescription drug (Part D) coverage. Medicare SNPs were created to give certain groups of beneficiaries better access to Medicare, with plans designed to meet their unique needs through improved coordination of care.

The OMO's investigation concerning the availability of information to beneficiaries about SNPs—and through what media—revealed the existence of a 1-800-MEDICARE call script for SNPs that assists beneficiaries with questions such as:

- Are prescription drugs covered?
- Do I need to choose a primary care doctor?
- What else do I need to know about this type of plan?

In addition to the SNP script, a CMS publication titled *Your Guide to Medicare Special Needs Plans (SNPs)* provides information about how SNPs are different from other MA plans and about how to join or switch SNPs.

The OMO also met with representatives from CM to determine whether publicizing information about the SNPs' models of care would help beneficiaries make informed decisions about these plans. The OMO determined that the models of care are highly technical documents, most of which are unlikely to assist beneficiaries in their decision making. However, a few sections in the models of care documents contain information that may be useful to advocates and beneficiaries, such as the section, "Care Management for the Most Vulnerable Subpopulations," which requires SNPs to do the following:

- Describe how they identify their most vulnerable populations.
- Describe the add-on services and benefits they deliver to their most vulnerable beneficiaries.

In FY 2011, the OMO will continue to work with CM to determine the most effective way to make the above information available to advocates and beneficiaries. The OMO has also recommended several enhancements to the Medicare Plan Finder that are expected to become effective in 2011. Furthermore, to increase beneficiary understanding of SNPs, the OMO recommended several changes to the 2012 *Medicare & You* handbook, including a section explaining that SNPs are designed to develop and provide individual care plans.

CMS Contractor Processing of Patient Request for Medical Payment Forms

Inconsistencies in how contractors process Patient Request for Medical Payment forms (form CMS-1490S) affect whether beneficiaries are reimbursed by Medicare. Beneficiaries use form CMS-1490S to file a Medicare claim for covered services and supplies

received from a nonparticipating physician, provider, or supplier who does not file the claim on behalf of the beneficiary.²⁹ Unless beneficiaries file the form, Medicare cannot reimburse beneficiaries for its share of the bill.

The most common reasons identified by the OMO in 2010 for inconsistencies in processing the form CMS-1490S included:

- Beneficiaries did not indicate on the form that the provider had not submitted the claim.
- Beneficiaries did not include a National Provider Identifier (NPI) number on the form.
- The MAC denied receipt of the claim for which the form was filed.

To resolve these issues, the OMO collaborated with several CMS components: the Office of Information Services (OIS), CM, the Office of Financial Management, the Office of External Affairs, and the Consortium for Financial Management and Fee-for-Service Operations. These collaborations resulted in CMS issuing a memorandum to all contractors requiring them to use the NPI registry to locate the supplier's or provider's NPI when beneficiaries do not provide this information. The OMO also worked with the OIS and the Center for Medicare Management to review discrepancies between the contractor manual and instructions for filling out the form CMS-1490S.

In some cases, beneficiaries may not be aware that they can submit a request for payment directly to Medicare if their providers did not submit a claim. Through its partnership network, the OMO informed Medicare beneficiary advocates of available resources, such as the *Medicare & You* handbook and the 1-800-MEDICARE helpline, that address the issue of inconsistencies with how contractors process the request for payment form. Additionally, the OMO provided references to these available resources to inform beneficiaries how to submit claims when a provider will not submit a claim on the beneficiary's behalf.

²⁹ Participating doctors, providers, and suppliers are those who have signed an agreement with Medicare to accept the Medicare-approved amount as full payment for covered services. Nonparticipating providers accept Medicare but choose whether they will accept the Medicare-approved amount on a claim-by-claim basis. Even when providers choose not to accept the Medicare-approved amount, they are supposed to submit the claim to Medicare on behalf of the beneficiary so that the beneficiary may be reimbursed for the Medicare-covered portion of the service.

Furthermore, the OMO also reviewed the claims processing procedures for services performed by providers who "opt out" of Medicare.³⁰ Beneficiaries automatically receive a one-time reimbursement if they receive services from a physician who opts out of Medicare, provided that the beneficiary or the physician submits form CMS-1490S. Beneficiaries also receive a message in their quarterly Medicare Summary Notice explaining that Medicare does not reimburse for Medicare-covered services provided by physicians who opted-out following the one-time reimbursement.

Timeliness of Medicare Administrative Contractors' Responses to Beneficiary Inquiries

COB issues and extended delays in obtaining information from entities contracted by Medicare to administer claim payments may negatively affect beneficiaries' experience with Medicare. In 2010, the OMO received beneficiary complaints regarding the timeliness of MAC responses to beneficiary inquiries. CMS has a process in place to elevate issues regarding the responsiveness of MACs. The OMO initially investigated and reported findings about this issue in the 2007-2008 OMO Report to Congress.

As mandated under MMA, Medicare contracting reform requires that fiscal intermediaries and carriers be replaced with MACs to streamline the resolution of complex claim inquiries. Despite this statutory requirement, some beneficiaries experience significant delays in receiving responses to their inquiries from these contractors.

Contractually, CMS mandated that MACs respond to beneficiary inquiries within 45 days. However, ROs have worked with the MACs to establish a maximum response time to Congressional inquiries of 10 business days and a reduction of the escalation response time to 30 days from the previously prescribed 45 days. Therefore, some inquiries may be addressed sooner than the statutory requirement, depending on the nature of the beneficiary's inquiry. Furthermore, CMS requires underperforming MACs to explain the reason for failure to meet their objectives and to develop an action item plan to improve their performance. Given the methods available to beneficiaries to improve the response time for urgent inquiries and the existing CMS policies to address MACs' underperformance, the OMO did not take further action but will continue to monitor related calls to 1-800-MEDICARE.

³⁰ Physicians who opt out of Medicare are not subject to any limits on what they may charge their Medicare patients; Medicare does not cover services provided by physicians who opt out.

CASE EXAMPLE

Medicare Beneficiaries' Experiences With Medicare Administrative Contractors

The Office of the Medicare Ombudsman (OMO) works to resolve cases involving Medicare beneficiaries' experiences with delays in processing payments by Medicare Administrative Contractors (MACs) who are contracted by the Centers for Medicare & Medicaid Services to pay Parts A and B claims. In one such example, a Medicare beneficiary experienced delays in resolving his claim because the MAC could not match the beneficiary's information in its system with the information on the claim his physician submitted. After numerous unsuccessful attempts by the physician to obtain payment and 13 months of denied claims, the Medicare beneficiary sought assistance from the OMO to investigate the cause of the claim denial. The OMO reviewed the data in the MAC's system and found that the beneficiary's information was incorrect and, therefore, did not match the data his physician had submitted. The OMO assisted the Medicare beneficiary in determining the reasons for the payment delay and correcting the problems, resulting in payment of the claim. The OMO resolved the case within approximately 10 weeks.



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