



CALENDAR YEAR 2021

Medicare Beneficiary Ombudsman

REPORT TO CONGRESS

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A MESSAGE FROM THE OMBUDSMAN

I am pleased to present this Medicare Beneficiary Ombudsman (MBO) Calendar Year (CY) 2021 Report to Congress and the Secretary of the U.S. Department of Health & Human Services. I'm honored to continue to support the mission of the Centers for Medicare & Medicaid Services (CMS) in making sure the needs of the population we serve are considered as the Agency develops, implements, and evaluates its programs and policies. As the MBO, my role is to recognize how Medicare beneficiaries experience the program and share their perspectives with policymakers, provide relevant information about how to file an appeal, and serve as an objective resource for stakeholders.

The year 2021 was challenging for so many as the COVID-19 public health emergency (PHE) continued to impact Medicare beneficiaries and their families, as well as the country as a whole. I share my deepest sympathy with all of the impacted Medicare beneficiaries, caregivers, stakeholders, and frontline staff who continued to face such extreme challenges. I am grateful to those who cared for Medicare beneficiaries during this extraordinary time.

This report highlights activities that staff within the CMS Offices of Hearings and Inquiries (OHI) conducted in support of the MBO's objectives and in close coordination with many other CMS components. Stakeholder engagement activities in 2021 remained virtual due to the COVID-19 PHE. Many partners were focused on how to serve their clients in new ways in order to keep themselves and the Medicare beneficiaries they serve safe. Activities undertaken during this reporting period included:

- Partnering with advocacy organizations to obtain feedback related to Medicare enrollment processes.
- Participating in the 2021 State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP) annual conference.
- Educating partners via the CMS Office of Communications National Training Program webinars.
- Engaging with internal CMS efforts, including the Advisory Council on Equity, Accountable Care Organization (ACO) Stakeholder Engagement, and the Rural Health Council.
- Assisting with complex inquiries received from beneficiaries and partners.

I am grateful to continue to serve Medicare beneficiaries in this role. Thank you to CMS leadership, my CMS colleagues, and external partners who are dedicated to supporting the Medicare Program and its beneficiaries.

Catherine A. Rippey

About the Ombudsman

In 2003, Congress established the Medicare Beneficiary Ombudsman (MBO) to assist Medicare beneficiaries with their inquiries, complaints, grievances, appeals, and requests for information, per Section 1808(c) of the Social Security Act.¹ This position is located in the Centers for Medicare & Medicaid Services (CMS) Offices of Hearings and Inquiries (OHI).

The MBO's day-to-day work includes supporting CMS customer service and administration efforts by receiving and responding to Medicare beneficiary and stakeholder inquiries and complaints, working with internal and external partners to provide outreach and education to beneficiaries and stakeholders, and providing recommendations for improving the administration of Medicare by evaluating beneficiary and partner experiences, reviewing trends, and identifying potential barriers.

Catherine Rippey brings a long history of customer service to the role of the MBO. Prior to accepting her current position, she spent ten years addressing stakeholder inquiries as a senior caseworker in the CMS Kansas City office. Ms. Rippey also worked as a senior coordinator for the University of Kansas School of Medicine, where she was a liaison for students, medical site directors, and physicians. Before that, she served as the recruitment coordinator for the West Central Missouri Area Health Education Center, collaborating with community organizations and counseling Medicare beneficiaries who had questions about the Medicare Drug Discount Card.

PARTNERSHIPS AND STAKEHOLDER ENGAGEMENTS

To fully understand how beneficiaries experience the Medicare program, it is imperative for the MBO to engage directly with partners, both internal and external to the Agency. In 2021, the MBO connected with a variety of stakeholders to gain a more comprehensive understanding of the issues beneficiaries were encountering. In addition to hearing from caseworkers and other customer-facing staff within CMS, the MBO met with advocacy groups such as the Medicare Rights Center, as well as fellow Health and Human Services (HHS) agencies like the Administration for Community Living (ACL), on a regular basis to help ensure the MBO was aware of trends occurring either on a national or local level. The MBO also assisted or referred partners to other resources if they encountered any barriers to their regular avenues of resolution.

The MBO conducted multiple outreach activities in 2021, including a presentation at the annual SHIP and SMP conference hosted by ACL, a webinar hosted by the Office of Communication's Training Division on Medicare and the Marketplace, and education

provided to CMS and contracted staff who oversee the Beneficiary Family Centered Care-Quality Improvement Organizations (BFCC-QIO).

The MBO's staff also participated in the ACO Stakeholder Engagement initiative, which uses human-centered design to inform healthcare policymaking by understanding and visualizing the CMS customer experience, uncovering burden, and identifying opportunities for improvement. The objective of this initiative is to identify the human experience of ACO participants and other stakeholders by understanding barriers when reporting aggregate electronic Clinical Quality Measures (eCQMs) by interviewing engagement teams with a rich cross-section of experiences and barriers, such as ACOs, ACO members, and electronic health record vendors. The hope of this engagement is to identify areas that are within the MBO's cope of work that CMS could influence through statutory, regulatory, or sub-regulatory change.

As represented in Figure 1 below, these stakeholder activities help the MBO obtain a better understanding of the beneficiary perspective as it relates to the Medicare Program and share that feedback with policymakers.

Figure 1: MBO Stakeholder Engagement Activities



With legislation, such as the Consolidated Appropriations Act (CAA) of 2021, which updated Medicare enrollment policies, the MBO’s office increased the cadence of internal and external meetings and strengthened partnerships with internal CMS components to ensure that the MBO’s office is aware of upcoming program changes and can provide input and reflect upon how these changes may impact beneficiaries. Because the MBO’s partners, stakeholders, and ultimately the beneficiaries themselves will be impacted by new policies and requirements resulting from recent legislation, continuing to strengthen and expand these stakeholder relationships will remain a priority for the MBO.

IMPROVING THE CUSTOMER EXPERIENCE

In 2021, the MBO used findings gathered during stakeholder outreach activities to conduct research and develop programs and processes to help improve the Medicare beneficiary experience. Key efforts are highlighted below.

Improving staff resilience to better serve customers

The 2020 MBO Report to Congress outlined the office’s efforts to support the mental health and well-being of CMS staff by developing a program to enhance personal resilience so that staff can continue to deliver high-quality customer service in times of change. CMS customer-facing staff were tasked with resolving complex customer situations during stressful and unprecedented times created by the PHE. CMS representatives aim to provide outstanding service to customers despite the challenges they may experience doing this type of work. To provide high-quality customer service, the MBO recognized that CMS staff need self-care tools and employee support to perform their roles.

To address staff needs and promote key human resiliency concepts, OHI, in coordination with other CMS components, developed the CMS Human Resilience Training program, which consists of a combination of instructor-led coursework, breakout sessions, and recorded training modules to help attendees gain the knowledge they need to be more resilient, including the valuable practice of using real-life scenarios encountered by customer-facing staff. A cohort of CMS staff from various components became trainers for this material. These individuals continue to meet regularly to discuss training opportunities within CMS and to identify opportunities to share their knowledge and train other CMS staff on human resilience topics and techniques.

Building upon the work completed in 2020, the Human Resilience trainers created multiple 10 to 15-minute-long snippets of training materials that allow for shorter trainings to be completed over a longer period of time. These clips were presented during staff meetings over multiple months and received overwhelmingly positive feedback from staff.

Enhancing the beneficiary experience

The MBO continued to explore how to support CMS customer-facing staff who assist customers with particularly complex cases or concerns. In some cases, beneficiaries may need enhanced service from CMS. One initiative the MBO initiated to support staff was

establishing a cross-component workgroup to review customer service best practices across a variety of federal agencies and private companies to consider how CMS staff could enhance or improve the customer experience. The MBO also established a Community of Practice, which provides a space for external-facing CMS staff to meet with their colleagues to discuss complicated or challenging inquiries, receive training on topics such as developing self-care plans, and network with staff from multiple components across CMS. The Human Resilience trainers are invited to these quarterly meetings so they can contribute to the development of a supportive community for staff utilizing the knowledge they have gained to equip staff with resilience tools.

Based on feedback from participants, the human resilience program has improved job satisfaction, resilience, and the ability for staff to adapt and respond to customers' unique needs, ultimately improving the quality of customer experience with CMS staff. The team continues to find opportunities to share this training opportunity throughout CMS.

Enrollment challenges for formerly incarcerated individuals

Building on work started in 2020, the MBO continued to investigate Medicare enrollment challenges facing formerly incarcerated individuals. The number of re-entrants who are Medicare eligible is expected to continue to grow as the prison population ages. Enrolling in Medicare upon release can be challenging for many re-entrants due to missed enrollment periods and late enrollment penalties.

The MBO conducted an environmental scan of promising practices for Medicare and Medicaid enrollment for re-entrants at both the federal and state level to identify ways to help eligible individuals gain health care coverage upon release from prison. Key findings included:

- Individualized assistance programs, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Supplemental Security Income/Social Security Disability Income (SSI/SSDI) Outreach, Access, and Recovery program (SOAR) have improved Social Security enrollment among re-entrants.
- A 10-month Medicare enrollment pilot in Connecticut funded by the National Council on Aging offered benefits enrollment counseling to Medicare-eligible individuals who were scheduled for release from incarceration in Connecticut state prisons and helped identify barriers to reentry.
- Some states publish reentry guides which offer direction to re-entrants and their caseworkers on getting Medicare coverage reinstated upon release.
- Section 1115 Medicaid demonstrations give states additional flexibility to use Medicaid funding for innovative approaches to support reentry such as targeted case management, linkages to housing and employment support, and/or access to behavioral health services for recently released beneficiaries.

Looking ahead to 2022

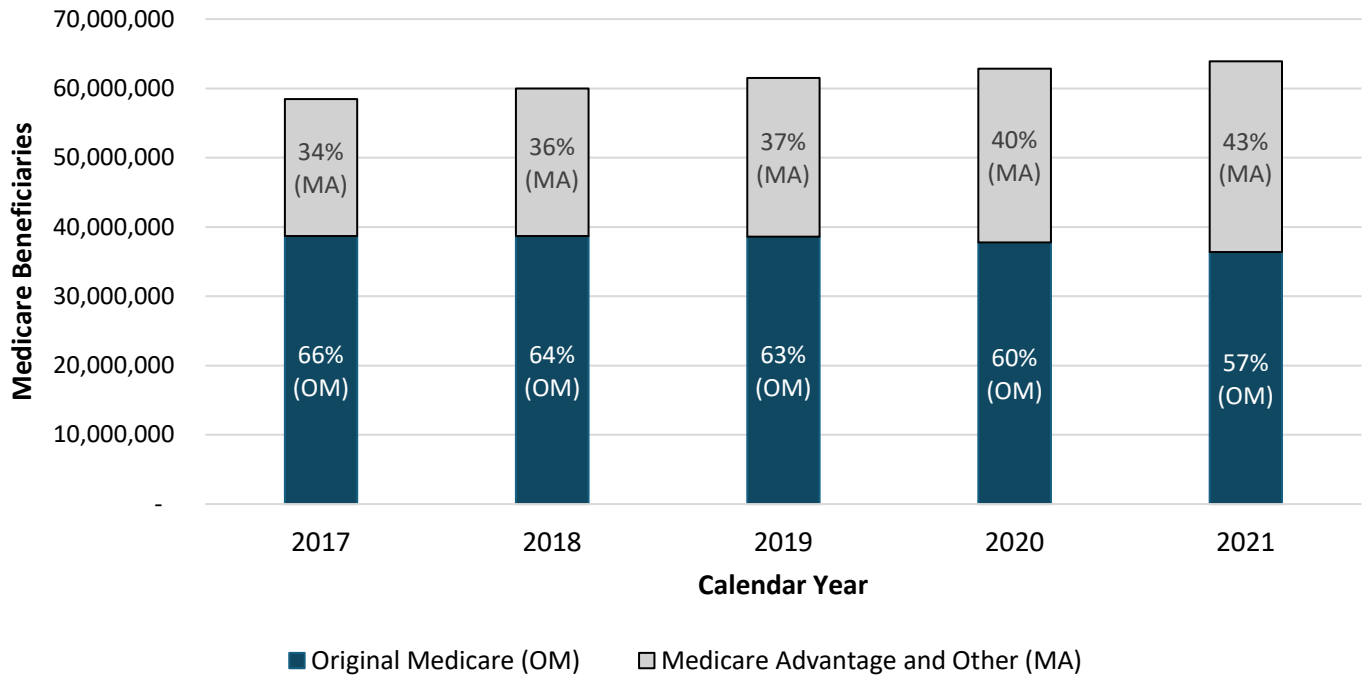
The MBO will continue to research beneficiary concerns, identify best practices, and work to improve the CMS customer and staff experience. These efforts will include continued work implementing activities related to recently passed legislation, addressing enrollment challenges for formerly incarcerated individuals, and developing and refining support programs for CMS customer-facing staff, including continuing the Community of Practice.

DATA HIGHLIGHT: BENEFICIARY SNAPSHOT

Understanding the Medicare beneficiary population and recent enrollment trends can help the MBO and her partners better serve the Medicare population. From 2017-2021, an increasing number of Medicare beneficiaries enrolled in Medicare Advantage (MA) plans, also known as Part C.ⁱⁱ The total number of

Medicare beneficiaries increased by 9% from 2017 to 2021, with an increase in Medicare Advantage enrollees accounting for all the program growth. Original Medicare has over 2 million fewer total beneficiaries in 2021 than it did in 2017. As a result, the percentage of total Medicare beneficiaries in MA or other programs (cost plans, pilot demonstrations, etc.) grew from 34% in 2017 to 43% in 2021, while the percentage of Original Medicare beneficiaries has decreased from 66% to 57% over the same period (Figure 2).

Figure 2: Beneficiaries Enrolled in Original Medicare vs. Medicare Advantage (MA) and Other Plans, 2017-2021

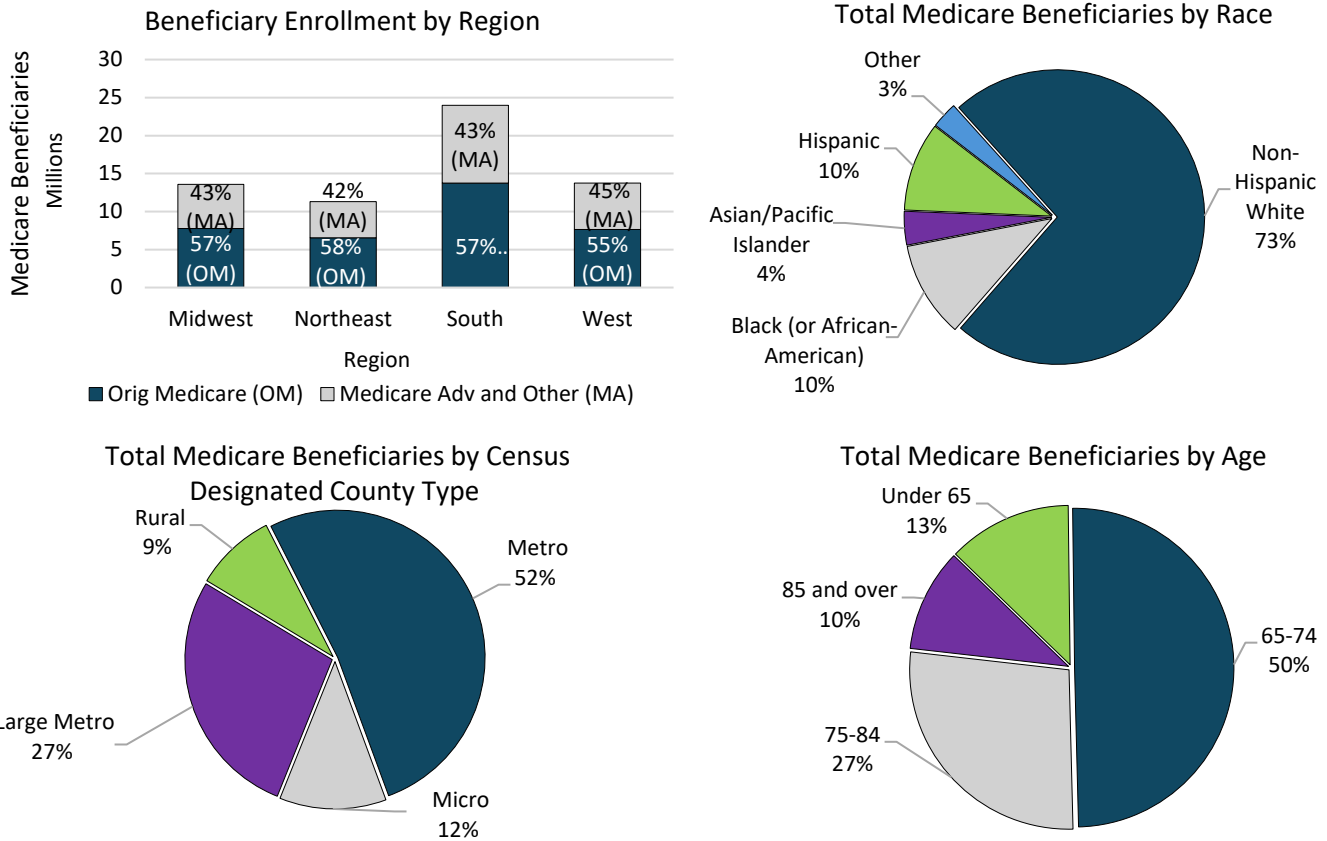


Source: Data.cms.gov. Medicare Monthly Enrollment Table, 2021.

Figure 3 displays other key characteristics and demographic information for the Medicare population as of 2021. About half of all Medicare beneficiaries in 2021 were between the ages of 65 and 74 years old, and another 27% were between ages 75 and 84 years old. The majority of Medicare beneficiaries identified as Non-Hispanic White (73%) with about 10% of beneficiaries identifying as Black or African-American, or Hispanic, respectively. Fewer than 5% of Medicare beneficiaries identified as Asian or Pacific Islander, and the remaining 3% identified as other or unknown.

The South is the region where most Medicare beneficiaries resided, with nearly 25 million total Medicare beneficiaries. When analyzing beneficiary residence by county type, about 79% of beneficiaries resided in either a census-designated “Large Metro” or “Metro” counties and only 9% of beneficiaries resided in a “Rural” county.

Figure 3: Demographics of Medicare Beneficiaries, 2021

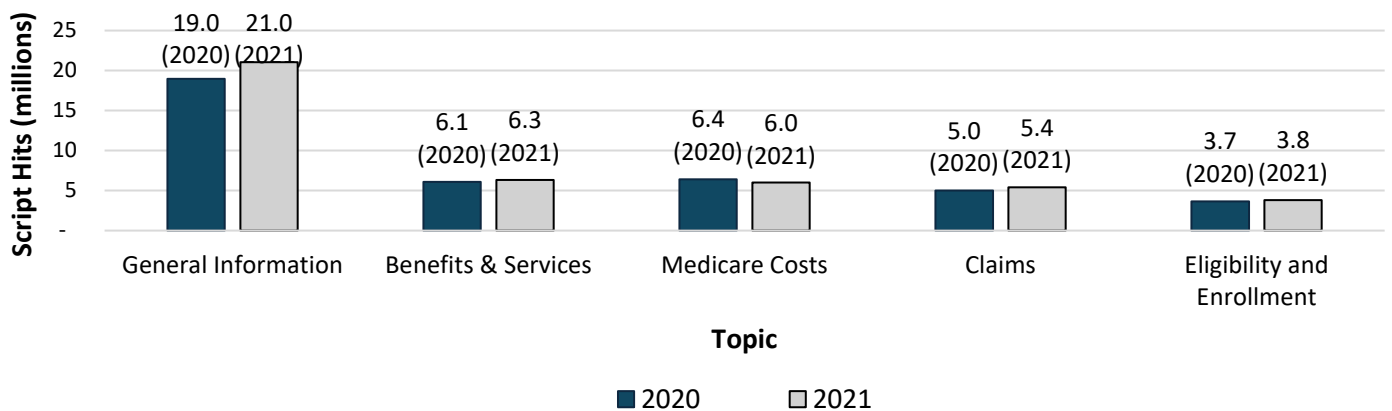


Source: Data.cms.gov, Total Medicare Enrollment Table, 2021.

1-800-MEDICARE contacts

To get answers to their Medicare questions, beneficiaries, their families, and other members of the public are directed to 1-800-MEDICARE. When beneficiaries speak to a customer service representative, the representative responds using a defined script based on keywords related to the caller’s issue. CMS tracks the number of times a script is read, known as “Script Hits.” As seen in Figure 4, the total count of script hits increased slightly between 2020 and 2021, but the five most common script topics remained the same in both years.

Figure 4: Top 1-800-MEDICARE Script Hits by Topic, 2020-2021

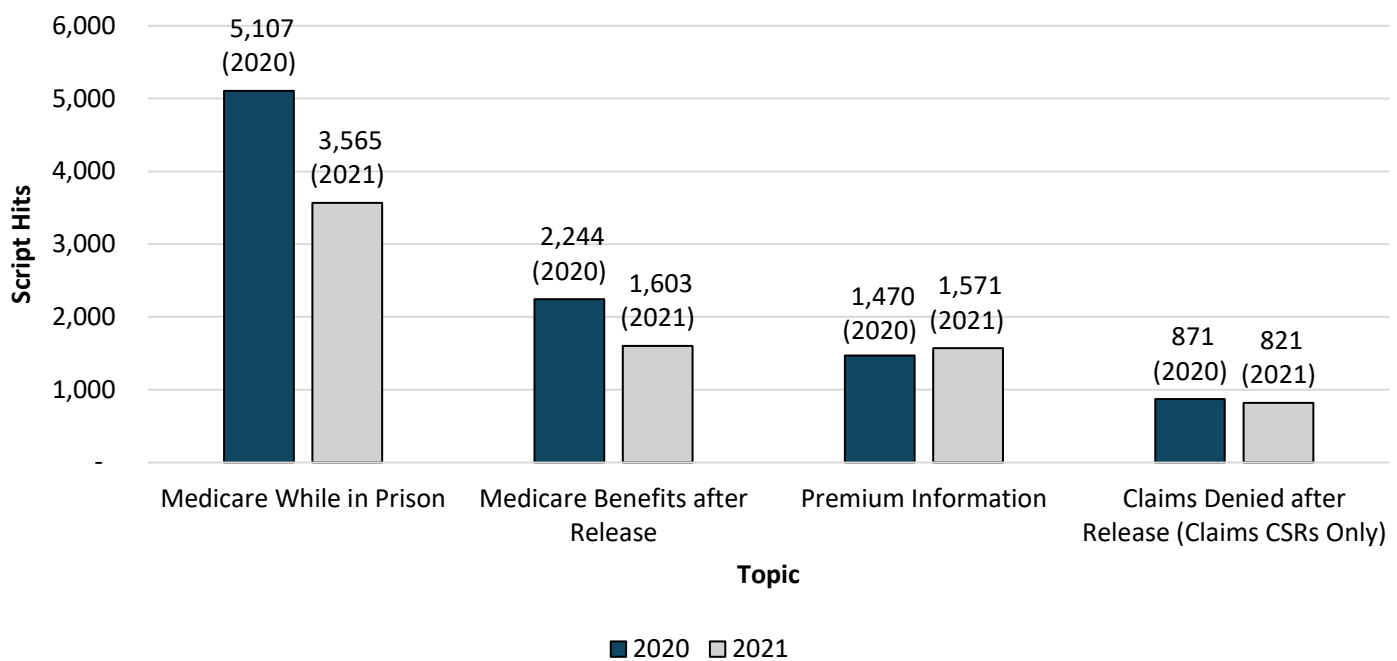


Source: NDW, 1-800-MEDICARE Script Hits 2020-2021.

Looking more closely at script hits related to Eligibility and Enrollment, which include many of the most relevant issues for the MBO, the number of script hits for this topic increased slightly from 3.7 million in 2020 to 3.8 million in 2021 (Figure 4). Eligibility and Enrollment script hits are classified into three subtopics: Enrollment Periods, General Information, and Medicare Eligibility. Enrollment Periods represented 97% of the Eligibility and Enrollment script hits in both 2020 and 2021, indicating beneficiaries and their families have many questions about the Medicare enrollment process each year.

As noted earlier, one area of particular interest to the MBO is the Medicare enrollment challenges facing formerly incarcerated individuals. Script hits for prison-related topics are captured under the Medicare Eligibility Sub-Topic (Figure 5). The most common prison-related topics are Medicare While in Prison, Medicare Benefits After Release, Premium Information, and Claims Denied After Release. From 2020 to 2021, overall script hits for prison-related topics decreased from 9,692 to 7,560, with a slight increase in script hits related to Premium Information. Premium Information scripts are read to individuals who call 1-800-MEDICARE with questions related to paying Medicare premiums during incarceration. The script explains that even though Medicare generally does not pay for medical care for incarcerated beneficiaries, it may be beneficial for the beneficiary to continue paying Part B premiums to avoid gaps in coverage upon release. Part B coverage will be terminated if premiums are unpaid, and the individual will have to wait until the next general enrollment period to re-enroll in Part B. The MBO will continue to work with partners to ensure that clear information on Medicare premiums and Medicare coverage is available for beneficiaries who are facing incarceration, are currently incarcerated, and those being released from prison.

Figure 5: 1-800-MEDICARE Script Hits by Medicare Eligibility Sub-Topic Relevant to Recently Incarcerated Individuals, 2020-2021



Source: NDW, 1-800-MEDICARE Script Hits 2020-2021.

CUSTOMER ACCESSIBILITY RESOURCE STAFF ACTIVITIES IN CY2021

During 2021, the Customer Accessibility Resource Staff (CARS) within OHI continued to support CMS' essential functions to enhance beneficiary services and access to information in compliance with Section 504 of the Rehabilitation Act. During this reporting period, CARS continued to collaborate with CMS components and key stakeholders, as well as with CMS policy subject matter experts and leadership, to identify issues related to accessibility and seek opportunities to improve the accessibility of external CMS communication materials. CARS worked to ensure people with disabilities had an equal opportunity to participate in CMS services, activities, programs, and other benefits. Activities included investigations and market research into expanding the availability of auxiliary aids and services to improve CMS' posture on external communications to individuals with disabilities.

Throughout this reporting period, CARS coordinated with the CMS Office of Communications (OC) to refresh the [Nondiscrimination/Accessibility](#) website to create an improved customer experience and continued to promote awareness of the availability of accessible formats of CMS materials to individuals with disabilities. CMS launched the 2021 Accessibility

Awareness Training, covering Sections 501, 504 and 508 of the Rehabilitation Act of 1973. CARS continued to collaborate with the MBO throughout this reporting period on the Resiliency and Self-Care Program initiative, including the launch of the Human Resiliency "Peer-to-Peer Support" training and effective establishment of the Human Resiliency Training Work Group. Additionally, the MBO and CARS continued to collaborate to provide effective, accessible communications to program participants.

CMS is the federal agency that runs Medicare, Medicaid, and the Children's Health Insurance Program, as well as the Health Insurance Marketplace®.iii CMS doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

CMS is committed to making its electronic and information technologies accessible to people with disabilities. We strive to meet or exceed the requirements of Section 508 of the Rehabilitation Act (29 U.S.C. 794d), as amended in 1998.

APPENDIX: CENTER FOR MEDICARE, MEDICARE PARTS C & D ONLINE COMPLAINT DATA, CY2021

Among other customer service tasks, CMS operates the Complaint Tracking Module (CTM), CMS' mechanism for collecting complaints about Medicare Part C (Medicare Advantage [MA]) and Part D Prescription Drug Plans (PDPs). One of CTM's functions is to support the online electronic complaint form for Medicare Parts C and D, which is called the "Improved Medicare Prescription Drug Plan and MA-PD Plan Complaint System," and is required by law.^{iv} The electronic complaint form for Part D drug plans must be displayed in a prominent location on the Medicare.gov and MBO websites.^v The electronic complaint form was created and posted in December 2010 and can be found at <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. CMS is required to provide an analysis of complaints registered through this system in an annual Report to Congress.^{vi} This appendix fulfills the CMS reporting requirement for the CY2021 reporting period.

The online complaint form is widely accessible to all Medicare providers, beneficiaries, and their caregivers. As a result, a variety of inquiries and complaints are submitted. 1-800-MEDICARE customer service

representatives review each inquiry and complaint and log those determined to be true complaints into CTM.^{vii} CMS also requires MA plan and PDP sponsors to address and resolve complaints in CTM.^{viii} To determine whether sponsors are resolving complaints in a timely manner, CMS requires that sponsors provide information on the status and resolution timeframes for notifying beneficiaries. This allows CMS to monitor the status of complaints and work with sponsors who fail to comply with requirements for the complaints process.

CY2021 DATA ANALYSIS AND RESULTS

During CY2021, CMS received 11,875 online submissions, almost double the number of submissions received in 2020. Of these submissions, approximately 9% (1,110) were determined to be true complaints related to Parts C and D. The remaining 10,765 inquiries were resolved by the 1-800-MEDICARE call center. Online complaints represented 1% of all (108,052) CTM complaints received during the reporting period (Figure 6).

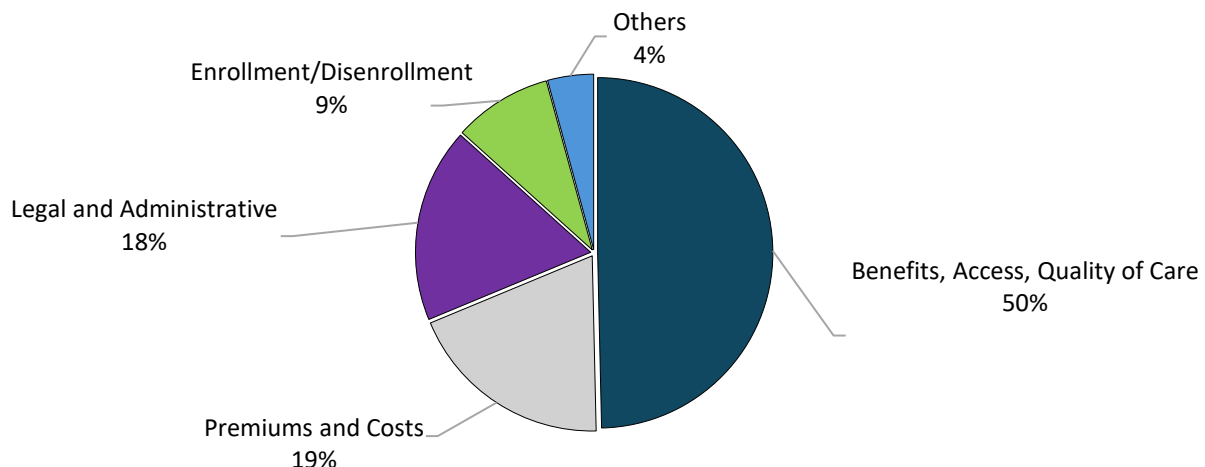
Figure 6: Total CTM Complaints by Submission Method, CY2021



Source: Complaint Tracking Module

Complaints are categorized in CTM for casework and resolution. Most of the true online complaints reported during CY2021 were related to (1) benefits, access, and quality of care; (2) premiums and costs; (3) legal and administrative issues; and (4) enrollment and disenrollment (Figure 7). These top four complaint categories accounted for approximately 96% of all true complaints in CY2021.

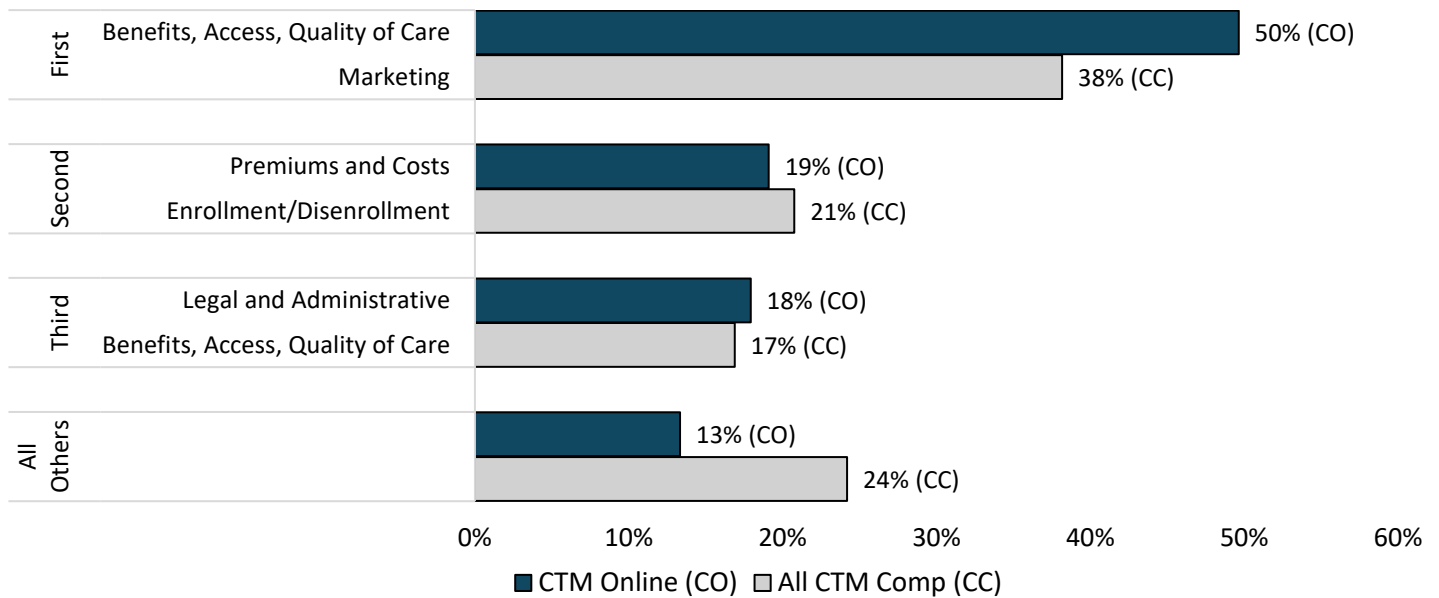
Figure 7: Online CTM Complaints by Category, CY2021



Source: Complaint Tracking Module

The top complaint categories among the CTM online complaints differed from the top categories among all CTM complaints (Figure 8). While nearly half of all online complaints related to benefits, access, or quality of care, fewer than one in five of all CTM complaints fell into that category. Marketing issues were the most common reason for all CTM complaints, comprising approximately 40 percent of total complaints, whereas just 3% of online complaints fell into that category. This is different from previous years in which enrollment and disenrollment issues made up the largest proportion of complaints.

Figure 8: Top Categories for Online and All CTM Complaints, CY2021



Source: Complaint Tracking Module

CMS ACCESSIBILITY & NON-DISCRIMINATION FOR INDIVIDUALS WITH DISABILITIES NOTICE

Non-Discrimination Notice

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, as well as the Health Insurance Marketplace[®].^{ix} CMS doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

CMS Accessible Communications

CMS provides free auxiliary aids and services including information in accessible formats like Braille, large print, data/audio files, relay services, and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you will get extra time to take any action if there's a delay in fulfilling your request.

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

1. Call us:

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

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

2. Email us: altformatrequest@cms.hhs.gov

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

4. Send us a letter:

Centers for Medicare & Medicaid Services

Offices of Hearings & Inquiries

7500 Security Boulevard, Room S1-13-17

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff

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

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

How to File a Complaint:

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

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

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

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

In writing: Send information about your complaint to:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

CMS Accessibility & Compliance with Section 508

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

Additional Information

- [What is Section 504 & how does it relate to Section 508?](#)
- [Civil Rights for Individuals & Advocates](#)
- [Section 504 Regulation Applicable to CMS](#)

REFERENCES

ⁱ Social Security Act § 1808(c), 42 U.S.C. § 1395b-9.

ⁱⁱ At the time of the drafting of this report, the most recent Medicare enrollment statistics on data.cms.gov were from 2021.

ⁱⁱⁱ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

^{iv} 42 U.S.C. § 1395w-154(a).

^v 42 U.S.C. § 1395w-154(b).

^{vi} 42 U.S.C. § 1395w-154(c).

^{vii} A “true complaint” is a situation in which a contact with CMS results in a complaint being logged into the CTM. For example, a beneficiary call to 1-800-MEDICARE seeking clarification regarding their benefit or a grievance against their respective plan is not a “true complaint.” In such cases, the beneficiary may be directed to contact the plan directly for further help and no CTM complaint(s) results. A beneficiary call to check the status of a pending complaint or to provide additional information for an existing complaint may also fall into this category. Complaints catalogued in the CTM are “true complaints” and are issues that require investigation and/or action on the part of CMS, a plan, or the Medicare Drug Integrity Contractor at the request of a beneficiary, partner, or other stakeholder, often (but not always) after they have first sought resolution with a plan. Complaints may relate to (but are not limited to) enrollment, access to care, costs, marketing, or customer service.

^{viii} 42 CFR §§ 422.504(a)(15) and 423.505(b)(22).

^{ix} Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

^x Ibid.