Calendar Years
2022 – 2024

Medicare Beneficiary and Competitive Acquisition Ombudsmen

Report to Congress

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

A Message from the Medicare Beneficiary Ombudsman

I am pleased to present this Report to Congress and the Secretary of the U.S. Department of Health & Human Services (HHS) for Calendar Years (CY) 2022, 2023, and 2024 highlighting the work of the Medicare Beneficiary and the Competitive Acquisition Ombudsmen (MBO and CAO). It is my continued honor to support the mission of the Centers for Medicare & Medicaid Services (CMS) in ensuring the needs of our customers are represented as CMS develops, implements, and evaluates its programs and policies. As the MBO, my role is to solicit feedback to understand how Medicare beneficiaries experience the program and share their input with agency policymakers, provide information about how to file a complaint or appeal, and collaborate with crucial partners such as the State Health Insurance Assistance Programs (SHIPs).

Section 1 of this report summarizes the activities undertaken by myself and my colleagues in the CMS Offices of Hearings and Inquiries Medicare Ombudsman Group (OHI/MOG) in support of the MBO's statutory objectives and highlights coordination with other CMS components and external entities.

Section 2 of this report describes the key activities of the CAO from CY 2022 through CY 2024 and provides perspectives from suppliers, beneficiaries, and other stakeholders who utilize or participate in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP).

I am thankful for the opportunity to serve Medicare beneficiaries as the MBO. Thank you to CMS leadership, my CMS colleagues, and external partners who are steadfast in their efforts to support the Medicare program and its beneficiaries.

Catherine A. Rippey

The information and data presented in this report were collected during the drafting period and are accurate as of that time; updates or new information released after the drafting and publication of this report are not reflected. This report is prepared in accordance with Section 1808(c) of the Social Security Act.

SECTION 1: MEDICARE BENEFICIARY OMBUDSMAN REPORT TO CONGRESS, CY 2022- CY 2024

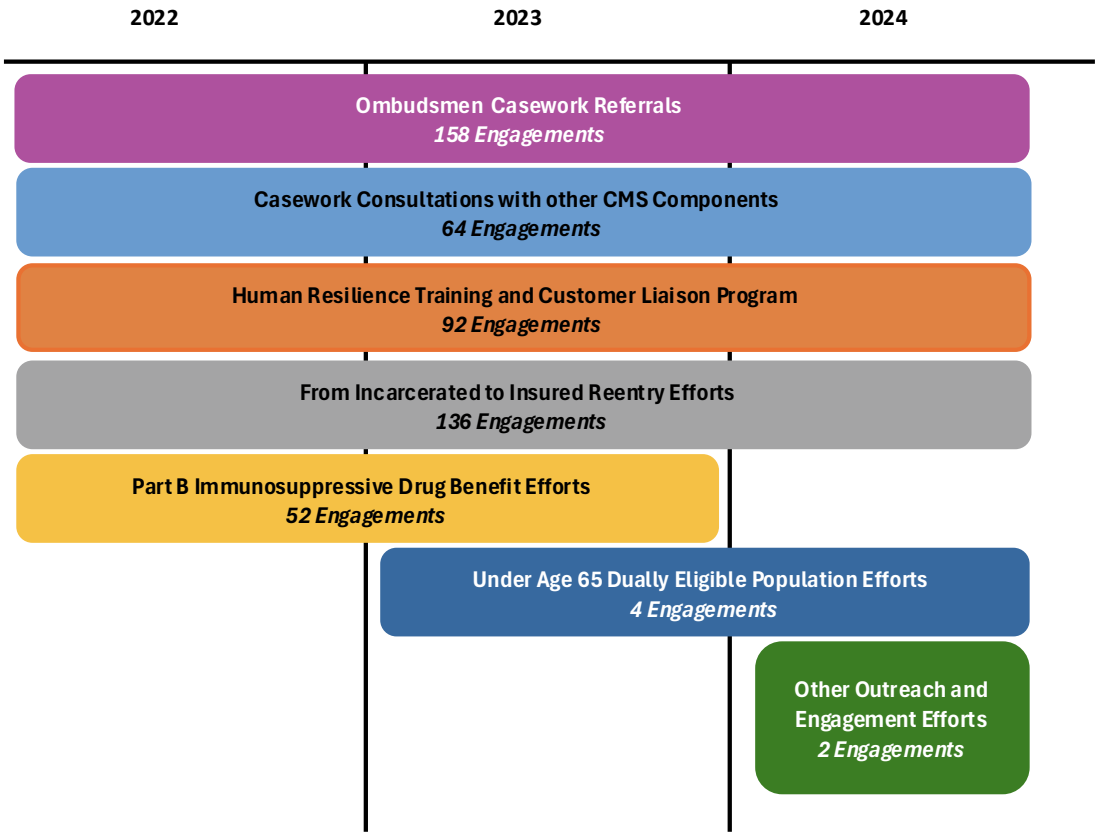
Partnerships & Engagements

To understand and improve beneficiary experience in the Medicare program, the MBO engages across HHS, as well as state partners, and beneficiary advocacy organizations (see Figure 1). The Social Security Administration (SSA) is a critical partner in helping address issues related to Medicare eligibility and enrollment. Other close partners include the Administration for Community Living (ACL), the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), as well as the CMS Office of Program Operations and Local Engagement (OPOLE) and their regional staff. The MBO also works closely with the Federal Bureau of Prisons (BOP) and the Department of Veterans Affairs, as well as multiple beneficiary advocacy organizations such as the Medicare Rights Center (MRC), Justice in Aging (JIA), the SHIPs, and the Senior Medicare Patrol (SMP).

Figure 1: MBO Partners

From CY 2022 through CY 2024, the MBO focused engagement activities on six key priorities (see Figure 2). Some of these activities included leading the Customer Liaison Program, which helps improve and strengthen customer service for Medicare beneficiaries and holding human resilience training for CMS staff so they have the tools they need to best support customers. The MBO also played a significant role in communicating new benefits established by the Consolidated Appropriations Act (CAA) of 2021, including the new Part B-ID[i], as well as the new Medicare special enrollment period (SEP) for formerly incarcerated individuals. Additional activities included helping address casework alongside other CMS staff and providing casework consultations for challenging or complex situations.

Figure 2: Count of MBO Partner Engagements in CY 2022-CY 2024



Operational Improvements to the Medicare Program

From CY 2022 through CY 2024, the MBO supported several operational improvements to the Medicare program including the redesign of the Medicare premium bill, efforts to improve the state buy-in process and customer service in the Medicare Advantage (MA) and Part D Programs.

Modernizing the Medicare Premium Bill

CMS-500 Modernization Benefits:

- ✓ **Reduce volume of Medicare premium-related inquiries from beneficiaries**
- ✓ **Modernize premium billing payment operations and processes**
- ✓ **Provide clarity on existing instructions**
- ✓ **Achieve cost savings for the agency**
- ✓ **Alleviate beneficiary confusion around Medicare Easy Pay by creating a new statement**

Form Links:

- Medicare Premium Bill (CMS-500)
- Medicare Easy Pay Premium Statement (CMS-20143)

In March 2022, CMS released the modernized Medicare Premium Bill (CMS-500) and a new Medicare Easy Pay Premium Statement (CMS-20143) to beneficiaries who are billed directly for Part A premiums, Part B premiums, or the Part D Income Related Monthly Adjustment Amount rather than having these premiums deducted from their Social Security Title II benefits. CMS collaborated with external government agencies and advocacy groups to design a bill and statement that would modernize premium billing payment operations and processes, align with CMS current business processes, alleviate beneficiary confusion, and achieve cost savings for the agency.

As of 2023, roughly 3.1 million direct-bill beneficiaries received the modernized CMS-500 or CMS-20143. As a result of this effort, the total correspondence sent from the Medicare Premium Collection Center to CMS in

2023 was reduced to an average of 2,507 cases per month, compared to the 2020 average of 4,902 cases per month.

One beneficiary stated: *"The new Medicare Easy Pay Premium Statement includes all the information that I need in one place."* Others expressed appreciation for all electronic payment methods highlighted on the modernized bill, described the modernized bill as being "well laid out," and stated that the bill provides information most important to them, without including irrelevant information.

Going forward, CMS will continue to monitor beneficiary inquiries and gain insight into potential opportunities for additional improvement to the CMS-500 and CMS-20143. Additionally, CMS will continue to collaborate with internal and external partners to identify and implement other operational efficiencies that will improve customer experience.

Addressing Entitlement and Enrollment Issues in State Buy-in Programs

As part of CMS' efforts to improve access to care for vulnerable populations, the Offices of Hearings and Inquiries Medicare Ombudsman Group (OHI/MOG) manages and provides oversight of Medicare entitlement and premium issues relating to the state buy-in process (when states agree to pay Medicare premiums for certain beneficiaries), and direct bill refund issues (when beneficiaries have overpaid Medicare premiums and are owed a refund). Specific activities include providing resolution for data discrepancies related to state buy-in and premium refunds, analyzing systems exceptions to identify and correct recurring issues and systems anomalies, overseeing correction of banking errors preventing or delaying processing of beneficiary payments, and educating state partners, such as state Medicaid offices, about state buy-in operational issues.

In CY 2024, OHI/MOG received requests to resolve buy-in issues for approximately 960 beneficiaries per month representing cases from most states every month. These individuals eligible for both Medicaid and Medicare are among the most vulnerable population in the Medicare program, including low-income, disabled and/or elderly beneficiaries. These cases are referred to the OHI/MOG team to triage and resolve.

In November of 2019, OHI/MOG started conducting "State Office Hours," which are quarterly, 90-minute technical assistance sessions for state buy-in staff. These sessions were designed to provide a forum to share CMS updates, discuss state buy-in issues and concerns, and share tips and tricks to improve processing and resolution of buy-in cases. The goal of these sessions is to strengthen partnership with states and to assist them with resolving operational issues encountered in completing state buy-in transactions. Representatives from over 40 states attend these sessions on a regular basis.

A key feature of the State Office Hours is continuous quality improvement. At each session, input is solicited for future discussion topics and attendees are provided a detailed, dynamic frequently asked questions document. The survey and polling questions enable the division to continue refining and improving these sessions. Information is maintained and available to states through a knowledge management portal for later reference and training.

Based on state requests and needs, the quarterly State Office Hours sessions are now augmented with annual regional specific check-ins and national monthly sessions focused on the use of CMS' case management tool. Access to this system provides states with automatic encryption, the convenience of 24 hour/7 days a week on-demand access, and the ability to track progress of state buy-in cases. Throughout 2022, the focus of the office hour meetings was on assisting states in their understanding of buy-in processes and becoming familiar with the case management system. These collaborations with the states allowed OHI/MOG to garner deeper insight into casework trends that can be used to target solutions for known issues and inform strategies for working with internal and external partners including states, the CMS Office of Financial Management, SSA,

and the Office of Personnel Management. The implementation of these learning collaborative pilots established mechanisms for knowledge sharing, and the effort to cross train staff on new workstreams increased their understanding of processes within each business unit. As compared to 2021, cases are now often closed faster due to quickly identifying trends and patterns of problems.

Focus on CMS Casework: Customer Service in Medicare Advantage and Medicare Part D Program

The CMS OPOLE Drug and Health Plan Operations component is responsible for handling enrollee-directed casework and plan monitoring across the Medicare Part C (also referred to as Medicare Advantage, or MA) and Part D programs, the Health Insurance Marketplace, and Programs for All-Inclusive Care for the Elderly plans. This section focuses on these efforts related to the MA and Part D programs.

Allegations of marketing misrepresentation-related inquiries were a continued area of focus for CMS, especially when those situations necessitate an action to correct a customer's enrollment. CMS implemented additional process improvements to centralize staffing and case adjudication, improving on timeliness and quality metrics. These process improvements for CMS-led complaints resulted in a 2.2-day average turnaround time for 2024 customer case resolution. CMS also leveraged relationships with MA organizations to review marketing materials and engaged in strategic conversations with plan partners to address marketing issues.

CMS also enhanced processes for handling over 2,000 MA and Part D program-related inquiries received from congressional district offices each year. Engaging in multiple iterations of continuous improvement activities, CMS streamlined workflows resulting in improved turnaround times and improved internal quality measures for cases that fall completely under CMS' purview.

CMS continues to provide support to providers experiencing issues with MA and Part D plans. From 2022 to 2024, CMS monitored nearly 10,000 provider-specific complaints over the course of three years in addition to providing oversight of over 220,000 other plan-led cases and direct resolution of over 53,000 CMS-led cases. CMS is conducting an analysis of complaints using enhanced data capabilities to assist in the development of new process improvements. Moving forward, we will renew our commitment to continuous process improvement to establish the CMS team as the leading payer in the country among other key objectives. Continuous improvement efforts in CY 2025 will focus on additional improvements to the provider complaint process and improved management systems for increased tracking and trending of customer facing issues.

Understanding and Supporting Unique Medicare Populations

Throughout the reporting period (CY 2022-CY 2024), the MBO worked with partners to promote new enrollment and coverage opportunities for underserved Medicare-eligible populations, including individuals at risk of losing coverage for immunosuppressive drugs following a successful kidney transplant, and individuals transitioning from incarceration. Additionally, the MBO prioritized understanding the beneficiary population under the age of 65 with Medicare entitlement due to disability, end-stage renal disease (ESRD), or amyotrophic lateral sclerosis (ALS).

Part B Immunosuppressive Drug Benefit

Most individuals with ESRD are eligible for Medicare, regardless of age. However, when an individual receives a successful kidney transplant, Medicare coverage terminates after 36 months unless the individual is otherwise entitled to Medicare (based on age or disability). As mandated by Section 402 of Title IV of Division CC of the CAA, an individual who does not have and does not expect to have certain other health insurance coverage is eligible to enroll in a new benefit beyond the 36-month post-transplant period.[ii] This new benefit,

which only provides coverage for immunosuppressive drugs, is referred to as the immunosuppressive drug benefit, or the Part B-ID benefit. Eligible individuals could enroll in the new Part B-ID benefit beginning in October 2022 with coverage beginning as early as January 1, 2023.

In preparation for this new benefit, the MBO collaborated with partners throughout CMS to discuss outreach and education efforts. A cross-component workgroup was established to prioritize outreach to beneficiaries and providers to ensure affected individuals were aware there may be other more comprehensive health coverage available to them, such as health insurance plans on the federal or state Marketplaces or Medicaid. The work group coordinated to produce training content, beneficiary notifications, and guidance for partners. A smaller team of OHI staff developed casework escalation scenarios and processes to assist customers with complex case situations. OHI continues to assist in processing state buy-in Part B-ID requests and will continue to monitor Part B-ID enrollments and feedback from consumers and partners to tweak outreach and education to this population as appropriate.

From Incarcerated to Insured Reentry Efforts

Formerly incarcerated individuals face unique challenges upon their release from the carceral setting, including access to health care. Per Section 120 of the CAA, 2021 effective January 1, 2023, CMS created a new Special Enrollment Period (SEP) for formerly incarcerated individuals who did not enroll (or re-enroll) in Medicare Premium Part A or Part B because they were incarcerated. This means that individuals who were released from incarceration (reentrants) on or after January 1, 2023, and missed their chance to sign up for Medicare while they were incarcerated are now eligible for an SEP to enroll in Medicare upon their release.

To be eligible for this SEP, a person must:

- Demonstrate that they are eligible for Medicare.
- Show they did not enroll or re-enroll in Medicare Part A or B during another enrollment period they were eligible for because they were in custody (as defined in 42 CFR §411.4(b)(3). (requirement in effect through 12/31/2024).[iii]
- Have proof they were officially released from custody on or after January 1, 2023 (either through the appropriate discharge documents or through data available to SSA). (requirement in effect through 12/31/2024).[iv]

In anticipation of this new SEP, the MBO and CMS colleagues established new external partnerships and identified promising practices for Medicare and/or Medicaid enrollment for reentrants at both the federal and state level to help eligible individuals gain health care coverage upon release from prison. The number of reentrants who are Medicare eligible is expected to continue to grow as the prison population ages.[v] Before this SEP, enrolling in Medicare upon release could be challenging for many reentrants due to missed enrollment periods and late enrollment penalties. With the new SEP, individuals can enroll in Medicare for coverage to begin either the month after they sign up or up to six months retroactive (provided the date does not precede the month of their release from incarceration) and will not be subject to late enrollment penalties.

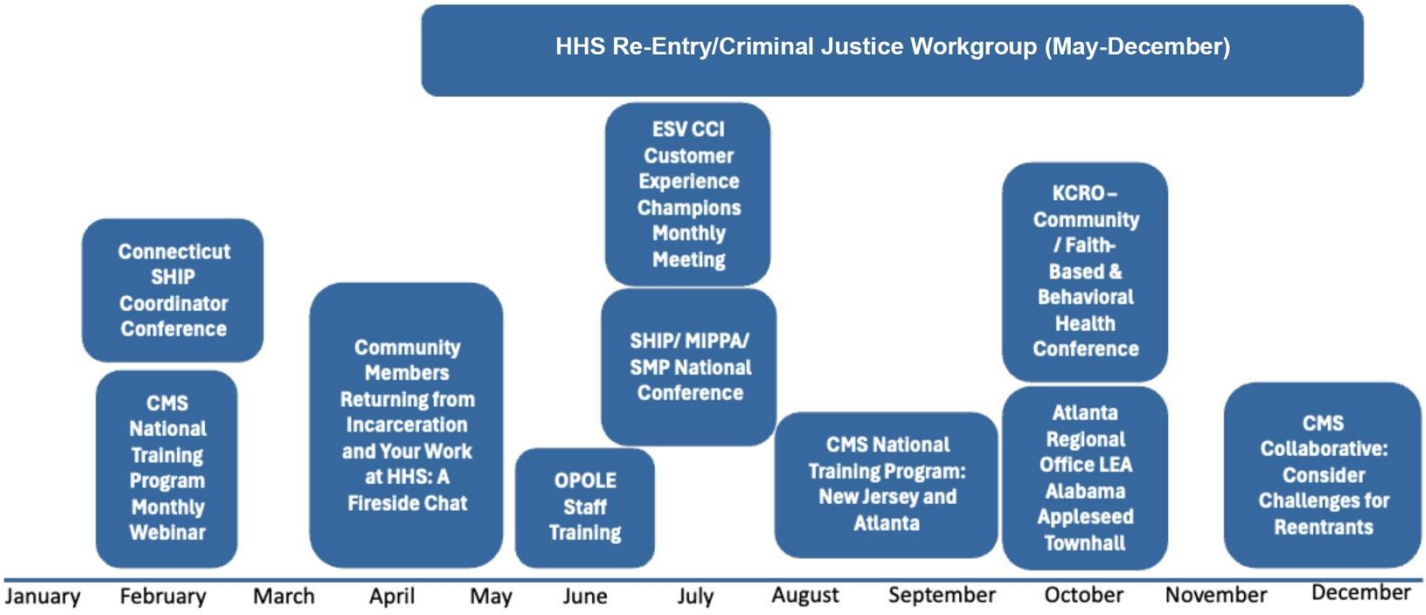
To better understand this population, the MBO and her team joined the HHS Reentry/Criminal Justice (CJ) Working Group, headed by ASPE. The HHS Reentry/CJ Working Group is a network of career staff from across HHS operating and staff divisions whose work intersects with criminal justice and reentry from incarceration, including staff from the following agencies: ACL, the Administration for Children and Families, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the National Institutes of Health, the Office of the Assistant Secretary for Health, and the Substance Abuse and Mental Health Services Administration (SAMHSA). MBO staff presented to the workgroup information on insurance options (i.e.,

Medicaid, Medicare, and Marketplace) for those being released from incarceration. Additional partnerships and outreach opportunities were formed as a result of participation in this workgroup.

The MBO found that targeted enrollment strategies can help connect reentrants with coverage, including individualized assistance programs, such as the SAMHSA Supplemental Security Income/Social Security Disability Income Outreach, Access, and Recovery program, which has improved Social Security enrollment among reentrants. Other successful strategies used by states include benefits enrollment counseling to Medicare-eligible individuals who are scheduled for release, and Section 1115 Medicaid demonstration opportunities that allow states to use Medicaid funding for pre-release services, such as case management to connect individuals with services that support individuals' reentry into the community.

In CY 2023, the MBO and her team helped establish the "From Incarcerated to Insured" (I2I) workgroup with both internal and external partners, including the HHS Re-Entry/CJ Working Group, the Federal BOP, the U.S. Department of Veterans Affairs Re-Entry Group, the Hawaii and Arizona SHIPs, and not-for-profit advocacy organizations including Justice in Aging, Legal Action Center, and Successful Reentry LLC. Throughout CY 2024, the MBO and her team participated in numerous informational and training events to promote the SEP (Figure 3), reaching over 1,500 event attendees.

Figure 3: Special Enrollment Period (SEP) Events and Trainings, CY 2024



Note: ESV CCI – Evaluating Stakeholder Voices Cross Cutting Initiative; KCRO – Kansas City Regional Office; LEA – Local Engagement & Administration.

The MBO sought to understand the challenges related to coverage and health care receipt, identify strategies to maximize SEP utilization, and identify and minimize any unintended adverse outcomes that may be associated with the SEP, particularly those that could cause delays or gaps in coverage.

As a result of the MBO's I2I activities, CMS has gained valuable insight to consider when examining policies and programs impacting this population. The MBO has learned how to improve communication and materials presented to the target population by prioritizing accessibility and considering barriers formerly incarcerated populations encounter, and how to craft effective SEP promotional materials based on models provided by I2I workgroup participants. Through her work, the MBO has identified new stakeholders and opportunities for

outreach and has established a pathway within OHI for reporting case management and beneficiary coverage and enrollment issues related to the new SEP.

Understanding the Needs of Medicare Beneficiaries Under the Age of 65

While most beneficiaries enrolled in Medicare are over the age of 65, beneficiaries under the age of 65 represent approximately 11% (around 7 million people) of the total Medicare population (around 68 million people) in 2024.[vi]

Beneficiaries who are under the age of 65 have higher per capita spending and more often report their health status as fair or poor than the over 65 Medicare population.[vii] To better understand the needs and challenges of Medicare beneficiaries under the age of 65, the MBO's team examined the characteristics of this population, including demographics and common chronic conditions, as well as possible barriers and challenges to accessing health care.

Research indicates the under 65 population is much more likely to be dually eligible for Medicare and Medicaid.[viii] Medicare beneficiaries under 65 with a disability are more likely to report poorer physical and mental health status than Medicare beneficiaries over the age of 65 with a disability.[ix] Similarly, younger Medicare beneficiaries with a disability (65%) have a cognitive or mental impairment compared to 29% of Medicare beneficiaries over the age of 65.[x]

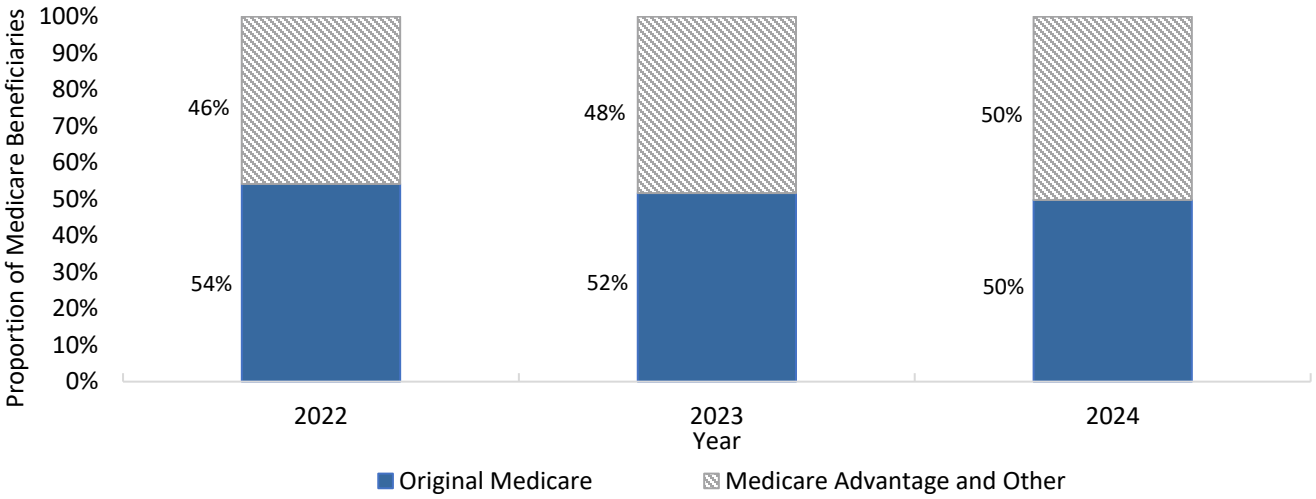
Medicare beneficiaries under the age of 65 also experience cost and coverage related barriers to accessing necessary health care services. For example, a larger proportion of beneficiaries under age 65 experienced denials or delays in getting prior approval or insurance declining payment for care received compared to beneficiaries aged 65 years or older.[xi] This population is also more likely to report that they were unable to receive necessary or recommended medical treatment and report issues navigating financial assistance options and provider networks compared to beneficiaries over age 65.[xii] Notably, beneficiaries with a disability under age 65 were more likely to report problems related to mental health care availability and access compared to beneficiaries over age 65.[xiii] The MBO shared these findings internally within CMS and HHS as well as to external partners to increase understanding of the needs of this population and target resources to improve enrollment decisions and access to care.

Data Highlight: Beneficiary Snapshot

Medicare Beneficiary Demographics

From CY 2022 through CY 2024, an increasing number of Medicare beneficiaries enrolled in MA plans, also known as Part C. The percentage of total Medicare beneficiaries in MA or other programs (cost plans, pilot demonstrations, etc.) grew from 46% in 2022 to 50% in 2024, while the percentage of Original Medicare beneficiaries has decreased from 54% to 50% over the same period (Figure 4).

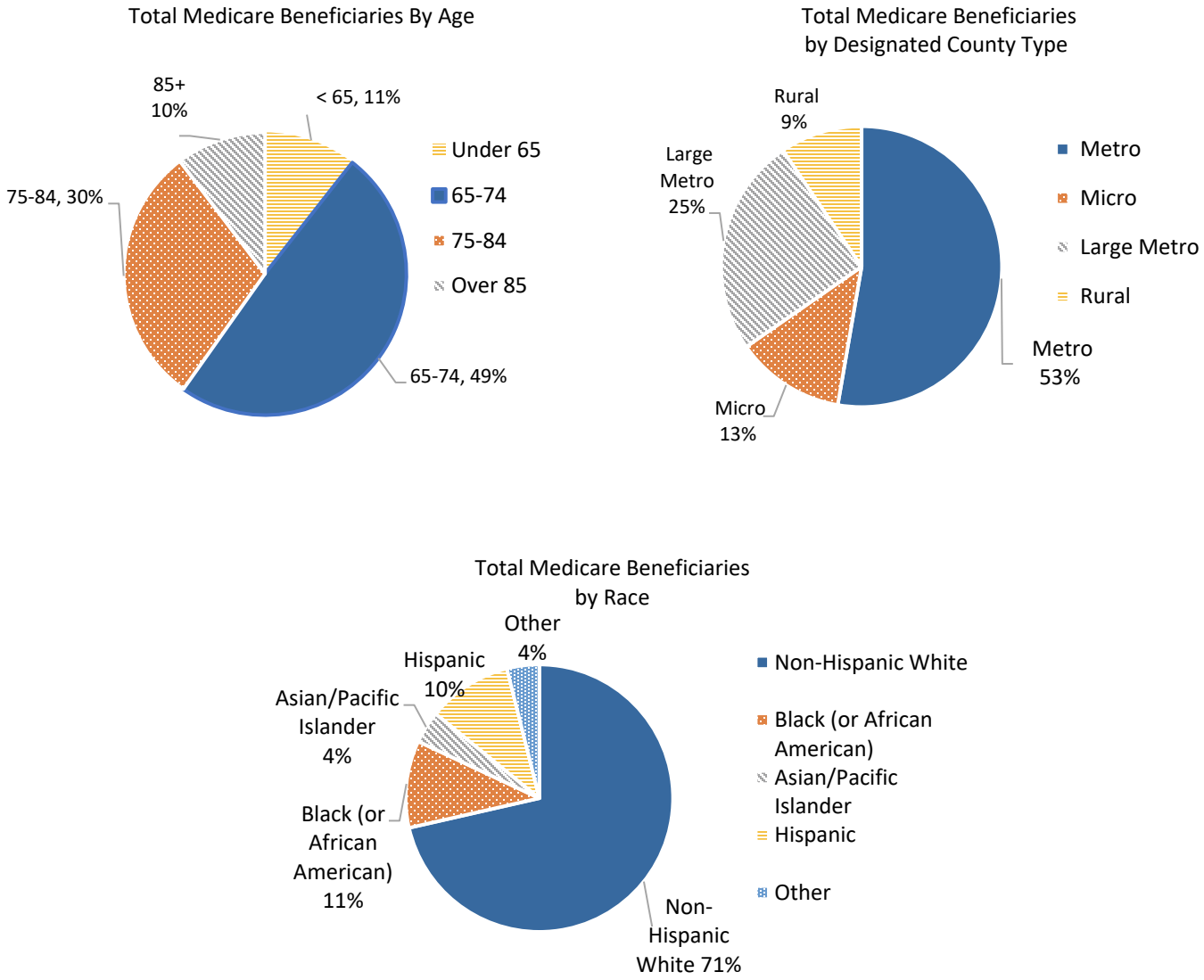
Figure 4: Proportion of Medicare Beneficiaries Enrolled in Original Medicare vs. Medicare Advantage and Other Plans, CY 2022-CY 2024



Source: Data.cms.gov, Medicare Monthly Enrollment Table, 2022-2024

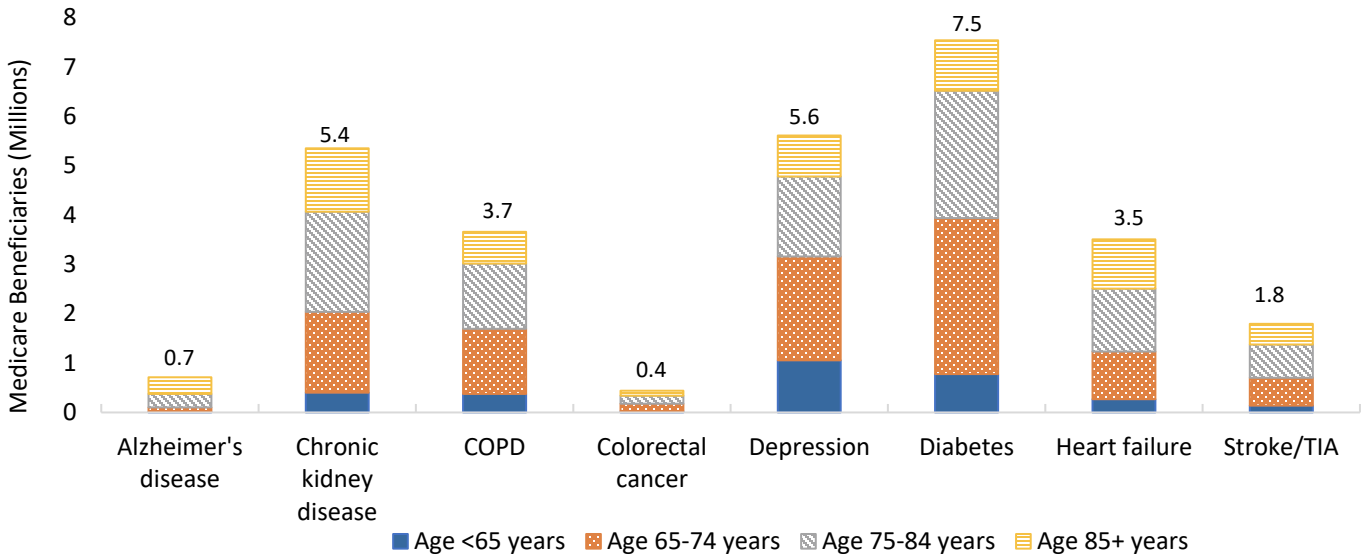
Figure 5 displays other key characteristics and demographic information for the Medicare population as of 2024. For example, about half of all Medicare beneficiaries in 2024 were between the ages of 65 and 74 (49%), and another 30% were between 75 and 84 years old. The majority of Medicare beneficiaries identified as non-Hispanic White (71%) with about 11% of beneficiaries identifying as Black or African American and another 10% identifying as Hispanic.

Figure 5: Demographics of Medicare Beneficiaries, CY 2024



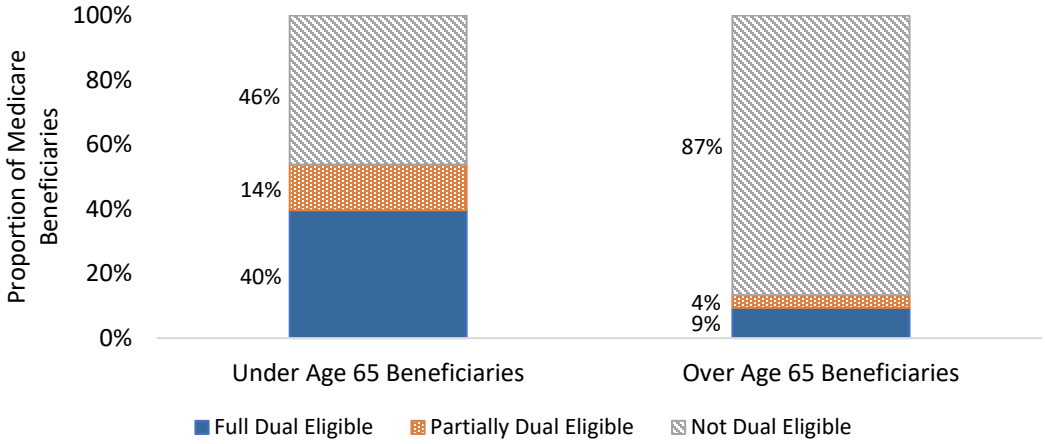
Source: Data.cms.gov, Medicare Monthly Enrollment Table, 2024

Figure 6: Chronic Condition Prevalences for Medicare Beneficiaries by Age Group, CY 2022



Source: www2.ccwdata.org, 2022 Medicare Chronic Conditions Charts
Note: The most recent public data available for Medicare beneficiaries with chronic conditions is from 2022. COPD – chronic obstructive pulmonary disease; TIA – transient ischemic attack.

Figure 7: Proportion of Medicare Beneficiaries who are Dually Eligible and Younger or Older than Age 65, CY 2021



Source: data.cms.gov, 2021 Medicare Monthly Enrollment table and Medicare Medicaid Dual Enrollment Table
Note: The most recent public data available for Medicare beneficiaries who are dually eligible and younger or older than age 65 is from 2021.

SECTION 2: COMPETITIVE ACQUISITION OMBUDSMAN REPORT TO CONGRESS, CY 2022-CY 2024

Thank You from Tonya Davis, Acting Competitive Acquisition Ombudsman

CMS is grateful for the talent Tangita Daramola brought to the Competitive Acquisition Ombudsman role and the impact her work had on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) and its stakeholders before her retirement from Federal service in early 2025. Her relationship building skills and keen focus on both industry and beneficiary perspectives were a terrific asset. I am looking forward to continuing this work on the tremendous foundation she built. The following report is provided on her behalf.

A Message from the Former Competitive Acquisition Ombudsman

I am pleased to share the Competitive Acquisition Ombudsman (CAO) Report to Congress, required by section 1847(f) of the Social Security Act.[xiv] This report describes key activities from CY 2022-CY 2024 and provides Congress with perspectives from suppliers, beneficiaries, and other stakeholders who utilize or participate in the DMEPOS CBP.

Round 2021 of the DMEPOS CBP contract performance began on January 1, 2021, and ended on December 31, 2023. This round included off-the-shelf (OTS) orthotic back and knee braces in 127 competitive bidding areas (CBAs).[xv,xvi] A brace is a rigid or semi-rigid device used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.[xvii] The designation of "OTS" refers to items that require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling or customizing to fit a beneficiary.[xviii] The DMEPOS CBP requires beneficiaries living in or visiting CBAs to obtain competitively bid OTS back and knee braces from a contract supplier; however, a beneficiary could obtain an OTS back or knee brace from a non-competitive bidding supplier in certain situations.[xix]

Throughout CY 2022 and CY 2023 CMS received 7,042 competitive bidding related inquiries via the 1-800-MEDICARE call center and 1,362 inquiries through the Competitive Bidding Implementation Contractor's (CBIC) call center.[xx] Beneficiary inquiries focused on general DMEPOS CBP questions; returning an unsolicited brace; finding or switching suppliers; and complaints about potential fraud. All Round 2021 competitive bidding contracts expired on December 31, 2023, commencing a temporary gap period during which CMS aims to strengthen the program and establish sustainable prices for DMEPOS through rulemaking. During the temporary gap period, OTS back and knee braces, and other formerly competitively bid products, follow the payment rules described in 42 CFR 414.210(g)(10).[xxi] More information may be found at the DMEPOS Competitive Bidding webpage.[xxii]

It has been a privilege to serve as the CAO and I thank my colleagues at CMS and HHS for their help and support in amplifying the voices of stakeholders.

Tangita Daramola, Former CAO (Retired from Federal service April 2025)

Activities of the Competitive Acquisition Ombudsman

Meetings with Stakeholders

During CYs 2022-2024, the CAO met with national supplier organizations; state supplier associations; large and small suppliers; and manufacturers, which allowed her to gather information on a diverse set of issues raised at the national, regional, and local levels. The CAO worked to cultivate connections with stakeholders at the local level by strengthening relationships between suppliers and the CMS Regional Office liaisons. Through these connections, the CAO collected real-time feedback on the challenges of providing DMEPOS. Several key themes emerged from stakeholder feedback in CYs 2022-2024, including:

- DMEPOS access challenges due to supply chain disruptions
- Decreases in the number of DMEPOS suppliers
- Challenges with providing DMEPOS in rural areas
- Concerns about equipment quality and the increasing number of DMEPOS recalls

DMEPOS Access During Disasters and Emergencies

Supporting DMEPOS Access Following Disasters

In an effort to understand and improve the experience of suppliers and beneficiaries, the CAO worked with the CMS Office of Healthcare Experience and Interoperability on a human-centered design initiative to capture feedback from over one hundred stakeholders on the impact of providing DMEPOS following disasters. The feedback focused on payment rates and how suppliers experienced challenges meeting the needs of Medicare beneficiaries, especially when additional costs were generated due to the disaster.

Stakeholder Listening Sessions

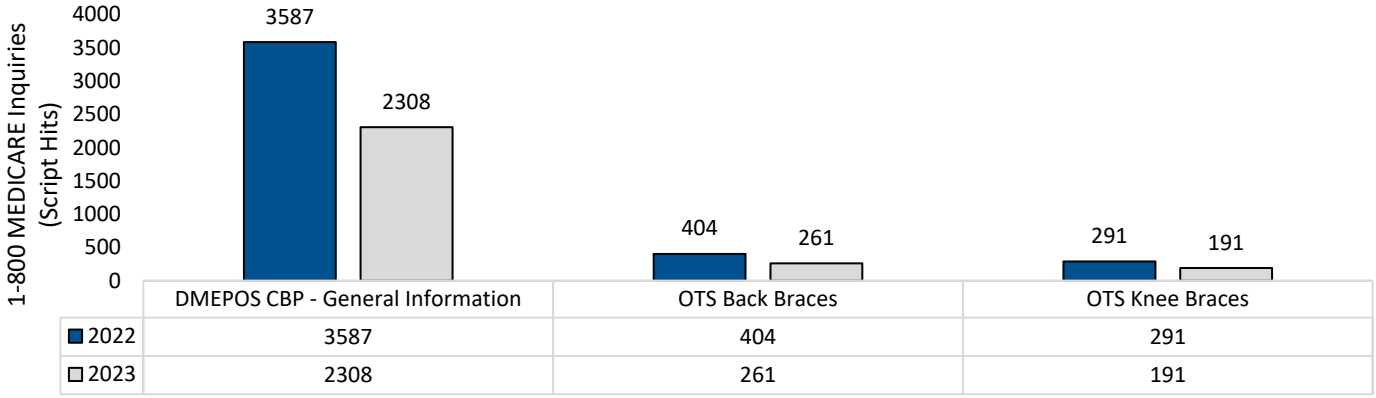
As a special initiative, the CAO strengthened her connections with the Federal Emergency Management Agency (FEMA) and other disaster organizations. After the devastating effects of Hurricanes Beryl, Helene, and Milton, the CAO conducted listening sessions with affected suppliers to hear their on-the-ground assessments. These meetings were coordinated with various partners, such as FEMA, the American Red Cross, state and national DMEPOS supplier associations, DMEPOS Medicare Administrative Contractors, the Administration for Strategic Preparedness and Response, and the Small Business Administration.

Inquiries and Complaints on Competitive Bidding Product Categories

Medicare beneficiaries are encouraged to contact 1-800-MEDICARE with questions or concerns related to their Medicare benefits. Competitive bidding-related inquiries are defined as “complaints” if they cannot be resolved by the initial customer service representative who receives the call and are escalated for further assistance. The CAO monitors inquiries (received via 1-800-MEDICARE) and complaints (received via the CBIC) related to the DMEPOS CBP and the products subject to competitive bidding to stay abreast of issues and concerns.

Figure 8 displays the annual volumes of 1-800-MEDICARE inquiries about the DMEPOS CBP in general, as well as product-specific inquiries for OTS back and knee braces. Inquiry volumes were lower in 2023 compared to 2022 across all three topics. This suggests that as Round 2021 continued, fewer individuals had questions or concerns about the program. Due to the temporary gap period, 1-800-MEDICARE inquiry data on these topics was not available for CY 2024.

Figure 8: 1-800-MEDICARE Inquiries Related to the DMEPOS CBP, OTS Back Braces, and OTS Knee Braces, CY 2022- CY 2023



	DMEPOS CBP - General Information	OTS Back Braces	OTS Knee Braces
2022	3587	404	291
2023	2308	261	191

Source: National Data Warehouse, 1-800-MEDICARE Script Hits CY 2022-CY 2023

The majority of product category specific inquiries focused on allegations of potential fraud; complaints[xxiii]; returns; and finding or switching suppliers. In 2022, there were a few callers that expressed dissatisfaction with the DMEPOS CBP; however, throughout 2022 and 2023 there were no complaints escalated from 1-800-MEDICARE to the CBIC.

Conclusion

Access to affordable, high-quality DMEPOS is essential for the millions of people with Medicare that rely on it. The DMEPOS CBP continues to be a critical component of Medicare. As Round 2021 progressed, inquiries continued to decrease, and no complaints were escalated about the program. Throughout the DMEPOS CBP temporary gap period in 2024, the CAO continued collaborative engagement with CMS partners and external stakeholders to identify, monitor, and respond to complaints and inquiries related to the application of the DMEPOS CBP from beneficiaries and suppliers.

APPENDIX A: CENTER FOR MEDICARE, MEDICARE PARTS C & D ONLINE COMPLAINT DATA, CY 2022 - CY 2024

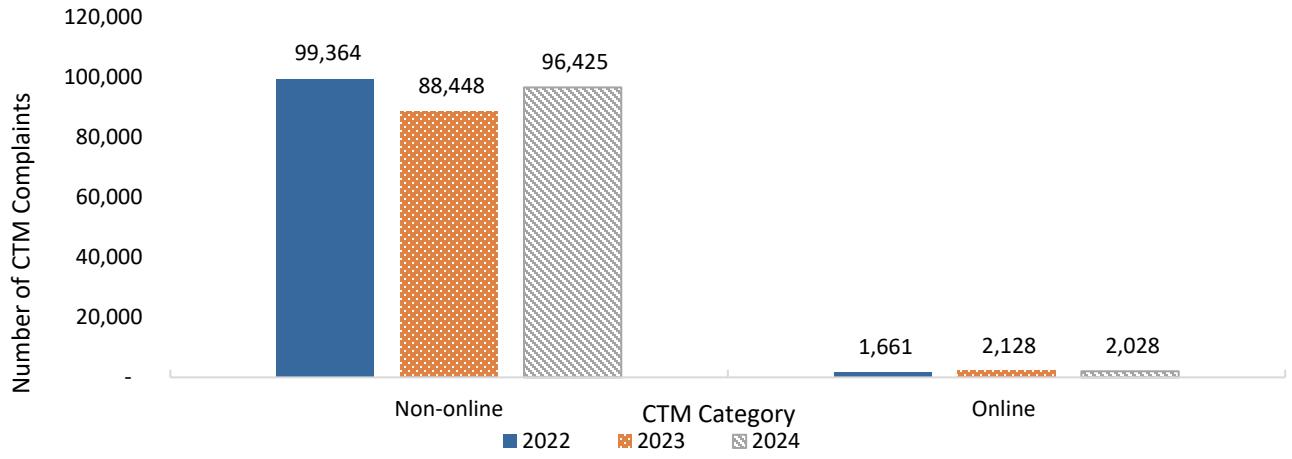
Among other customer service tasks, CMS operates the Complaint Tracking Module (CTM), CMS' mechanism for collecting complaints about Medicare Part C (also referred to as Medicare Advantage, or MA), including MA plans with Part D coverage (MA-PD plans), and Part D Prescription Drug Plans (PDPs). One of 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.[xxiv] The electronic complaint form for Part D plans must be displayed in a prominent location on the Medicare.gov and MBO websites.[xxv] 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.[xxvi] This appendix fulfills the CMS reporting requirement for the CY 2022 through CY 2024 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.[xxvii] CMS also requires MA organizations and Part D plan sponsors to address and resolve complaints in CTM.[xxviii] 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.

CY 2022-CY 2024 Data Analysis and Results

From CY 2022-CY 2024, CMS received 16,836 online submissions. Of these complaints, approximately 35% (5,817) were determined to be true complaints related to Parts C and D. The remaining 11,019 inquiries were resolved by the 1-800-MEDICARE call center. Online complaints represented 2% of all (290,054) CTM complaints received during the reporting period (CY 2022-CY 2024) (Figure 9).

Figure 9: Total CTM Complaints by Submission Method, CY 2022-CY 2024

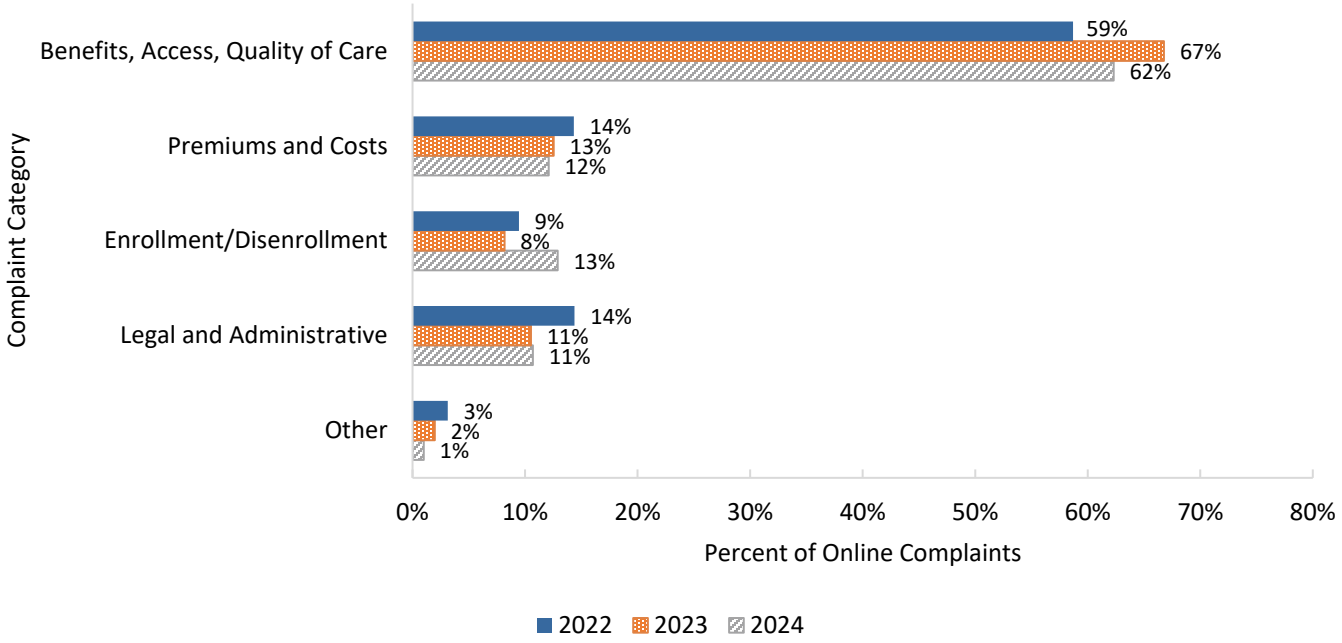


Source: CTM

Complaints are categorized in CTM for casework and resolution. Most of the true online complaints reported during CY 2022 through CY 2024 were related to benefits, access, and quality of care. The next three most common categories were enrollment and disenrollment, premiums and costs, and legal and administrative.

These top four complaint categories accounted for approximately 97% of all true online complaints in CY 2022, 99% in CY 2023, and 98% in CY 2024.

Figure 10: Online CTM Complaints by Category, CY 2022-CY 2024



Source: CTM

Between CY 2022 and CY 2024, while most online complaints related to benefits, access, or quality of care, only 22% of all CTM complaints fell into that category. Marketing issues were the most common reason for all CTM complaints, comprising just over one third (35-36%) of total complaints, whereas just 2% of online complaints fell into that category.

CMS Accessibility & Nondiscrimination 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, and the federally facilitated Marketplace. 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.

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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, 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, Mail Stop DO-01-20

    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 Medicare 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 two 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 Mail: 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 individuals with disabilities. If you can't access content or use features on this website above 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] Medicare Part B-ID is a targeted, standalone benefit that exclusively covers immunosuppressive drugs; it provides continued coverage of immunosuppressive drugs for certain kidney transplant recipients after their ESRD Medicare eligibility ends, which typically occurs 36 months after a successful kidney transplant if the individual is not otherwise eligible for Medicare due to age or disability. Before this benefit, kidney transplant recipients who lost Medicare coverage post-transplant often struggled to afford the lifelong immunosuppressive drugs needed to prevent organ rejection.

[ii] Centers for Medicare & Medicaid Services (CMS). (2022). "Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules." www.federalregister.gov. Available at https://www.federalregister.gov/documents/2022/11/03/2022-23407/medicare-program-implementing-certain-provisions-of-the-consolidated-appropriations-act-2021-and

[iii] This regulatory requirement referencing an individual being "in custody" was only in effect before January 1, 2025. Starting January 1, 2025, the requirement is that the individual couldn't use another enrollment period because they were confined in a jail, prison, or other penal institution or correctional facility. See 42 CFR 407.23(d)(2)(i). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-407/subpartB/section-407.23

[iv] The concept of being released from "custody" was only in effect before January 1, 2025. Starting January 1, 2025, the requirement is that the individual must show proof that they were released from a jail, prison, or other penal institution or correctional facility. See 42 CFR 407.23(d)(2)(i). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-407/subpart-B/section-407.23

[v] Feinberg, R et al. (2018). "Aging, Reentry, and Health Coverage: Barriers to Medicare and Medicaid for Older Reentrants." Office of the Assistant Secretary for Planning and Evaluation. Available at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//185306/Reentry.pdf

[vi] Data.cms.gov. Medicare Monthly Enrollment Table. (2024).

[vii] Cubanski, J et al. (2016). Medicare's Role for People Under Age 65 with Disabilities. Kaiser Family Foundation. Available at https://www.kff.org/medicare/issue-brief/medicares-role-for-people-under-age-65-with-disabilities/

[viii] Peña, M et al. (2024). The Landscape of Medicare and Medicaid Coverage Arrangements for Dual-Eligible Individuals Across States. Kaiser Family Foundation. Available at https://www.kff.org/medicare/issue-brief/the-landscape-of-medicare-and-medicaid-coverage-arrangements-for-dual-eligible-individuals-across-states/

[ix] Cubanski, J et al. (2023). Overall Satisfaction with Medicare is High, But Beneficiaries Under Age 65 With Disabilities Experience More Insurance Problems Than Older Beneficiaries. Kaiser Family Foundation. Available at https://www.kff.org/medicare/issue-brief/overall-satisfaction-with-medicare-is-high-but-beneficiaries-under-age-65-with-disabilities-experience-more-insurance-problems-than-older-beneficiaries/

[x] Cubanski, J et al. (2016).

[xi] Cubanski, J et al. (2023).

[xii] Ibid.

[xiii] Ibid.

[xiv] Social Security Act § 1847(f), 42 U.S.C. 1395w–3(f). https://www.ssa.gov/OP_Home/ssact/title18/1847.htm

[xv] The original number of CBAs was 130, but contracts for OTS back braces and knee braces were not awarded in three CBAs where savings would not be achieved.

[xvi] Centers for Medicare & Medicaid Services. (October 27, 2020). *Round 2021 DMEPOS Competitive Bidding Program Single Payment Amounts and Contract Offers*. Retrieved September 8, 2022, from https://www.cms.gov/files/document/round-2021-dmepos-cbp-single-payment-amts-fact-sheet.pdf

[xvii] 42 CFR § 410.2 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-A/section-410.2.

[xviii] 42 CFR § 414.402 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-F/section-414.402. See also CGS. (April 3, 2025). *Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) – Correct Coding – Revised.* https://www.cgsmedicare.com/jc/pubs/news/2021/03/cope20993.html.

[xix] 42 CFR § 414.404 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-F/section-414.404. See also Centers for Medicare and Medicaid Services. (2022). *Your Guide to Medicare's DMEPOS Competitive Bidding Program.* https://www.medicare.gov/sites/default/files/2022-02/11461-DMEPOS-Competitive-Bidding-Program-Guide.pdf

[xx] Due to the temporary gap period, inquiry data on these topics was not available for CY 2024.
[xxi] 42 CFR § 414.210(g)(10) https://www.ecfr.gov/current/title-42/part-414/section-414.210#p-414.210(g)(10).
[xxii] https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding.
[xxiii] Some inquiries labeled with "complaints and potential fraud" are not counted as complaints and are not escalated to the CBIC.

[xxiv] 42 U.S.C. §§ 1395w-154(a).

[xxv] 42 U.S.C. §§ 1395w-154(b).

[xxvi] 42 U.S.C. §§ 1395w-154(c).

[xxvii] 42 CFR §§ 422.504(a)(15) and 423.505(b)(22).