FISCAL YEAR 2013 REPORT TO CONGRESS

Office of the Medicare Ombudsman

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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MESSAGE FROM
THE MEDICARE BENEFICIARY OMBUDSMAN

It is my pleasure to present the Office of the Medicare Ombudsman's (OMO) 2013 annual Report to Congress and to the Secretary of the U.S. Department of Health & Human Services. In 2013, the OMO continued its efforts to provide direct beneficiary assistance, identify systemic issues and research their root causes, develop recommendations to address systemic issues, and assist with and guide the implementation of those recommendations. Several notable accomplishments in 2013 furthered the OMO's mission. First, the OMO completed three comprehensive studies focused on (1) the OMO's role in the beneficiary appeals process, (2) beneficiary liability for ambulance services, and (3) the implications of the Affordable Care Act Marketplace for Medicare beneficiaries. Second, the OMO formalized its approach to tracking and guiding efforts to implement the recommendations that the office has made over the past several years. Third, the OMO developed a partnership with local State Health Insurance Assistance Programs (SHIPs) to obtain a firsthand understanding of beneficiary concerns and requests for assistance, which will help the OMO improve its ability to advocate for beneficiaries.

The OMO looks forward to strengthening existing partnerships, developing new partnerships, and looking at new ways to identify and address systemic issues impacting beneficiaries. All of these efforts aim to continue to improve how we serve Medicare beneficiaries.

I would also like to take this opportunity to thank the talented, hard-working individuals within the OMO and at its partner organizations, including other Centers for Medicare & Medicaid Services components, Regional Offices, SHIPs, and advocacy organizations. Every day, these dedicated individuals are actively engaged in improving Medicare by providing direct assistance to individuals and systemic issue resolution support.

Lois Serio

Acting Medicare Beneficiary Ombudsman

LIST OF ACRONYMS

Acronym	Term
ABN	Advance Beneficiary Notice of Noncoverage
BCT	Beneficiary Contact Trend
CAH	Critical Access Hospital
CAO	Competitive Acquisition Ombudsman
CBA	Competitive Bidding Area
CBP	Competitive Bidding Program
CCIIO	Center for Consumer Information and Insurance Oversight
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CM	Center for Medicare
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COB	Coordination of Benefits
CSR	Customer Service Representative
CTM	Complaint Tracking Module
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
EOB	Explanation of Benefit
ESRD	End-Stage Renal Disease
FCHCO	Federal Coordinated Health Care Office
FFM	Federally Facilitated Marketplace
FFS	Fee-for-Service
FY	Fiscal Year
HHS	U.S. Department of Health & Human Services
HSA	Health Savings Account
IRMAA	Income-Related Monthly Adjustment Amount
IVR	Interactive Voice Response

Acronym	Term
LCD	Local Coverage Determination
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAISTRO	Medicare Administrative Issue Tracker and Reporting of Operations (System)
MSN	Medicare Summary Notice
NCC	National Casework Calls
OA	Office of the Administrator
OC	Office of Communications
OFM	Office of Financial Management
OIS	Office of Information Services
OMO	Office of the Medicare Ombudsman
OPM	Office of Personnel Management
RO	Regional Office
RTC	Report to Congress
SAD	Self-Administered Drug
SBM	State-Based Marketplace
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SHOP	Small Business Health Options Program
SNF	Skilled Nursing Facility
SPM	State Partnership Marketplace
SSA	Social Security Administration

ESTABLISHING THE OFFICE OF THE MEDICARE OMBUDSMAN

Section 1808(c) of the Social Security Act requires the OMO to assist Medicare beneficiaries with their complaints, grievances, and requests for information, as well as problems arising from disenrollment from Medicare Advantage plans.

Section 1808(c) of the Social Security Act requires the Secretary of the U.S. Department of Health & Human Services (HHS) to appoint a Medicare Beneficiary Ombudsman.[1] In establishing the position and primary functions of the Medicare Beneficiary Ombudsman, Congress recognized the need for an entity that would serve as a resource for Medicare beneficiaries.

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

COMPETITIVE ACQUISITION OMBUDSMAN

The Centers for Medicare & Medicaid Services (CMS) is the largest purchaser of health care in the United States. Among many other benefits, it provides coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for Medicare beneficiaries.

Prior to the Medicare DMEPOS Competitive Bidding Program, CMS paid for DMEPOS using a fee schedule rather than the market-based prices of certain DMEPOS products. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 amended section 1847 of the Social Security Act to establish the Medicare DMEPOS Competitive Bidding Program, under which DMEPOS suppliers compete to become Medicare contract suppliers to furnish certain items in competitive bidding areas.

The Medicare Improvements for Patients and Providers Act of 2008 established the Competitive Acquisition Ombudsman (CAO) to respond to complaints and inquiries made by suppliers and individuals relating to the application of the Program. In 2009, the Medicare Beneficiary Ombudsman appointed Tangita Daramola as the CAO within the Office of the Medicare Ombudsman.

The Affordable Care Act of 2010 expanded the number of areas for Round 2 of the Medicare DMEPOS Competitive Bidding Program.

The authorizing legislation requires the OMO to assist Medicare beneficiaries with their complaints, grievances, and requests for information, as well as with problems arising from disenrollment from Medicare Advantage (MA) plans. To this end, the OMO is also required to help collect relevant information for appealing decisions made by fiscal intermediaries, carriers,[2] MA plans, and the HHS Secretary. Its assistance is also necessary for presenting information to beneficiaries concerning income-related premium adjustments. Although the statute allows the OMO to identify issues and problems related to payment or coverage policies, the law prohibits the OMO from serving as an advocate for any increase in payments or new coverage of services.

The OMO must also work with health insurance counseling programs (e.g., State Health Insurance Assistance Programs [SHIPs]), when possible, to help provide information to beneficiaries regarding traditional Medicare (i.e., Parts A and B) and any changes to MA plans. Lastly, the statute requires the OMO to submit annual reports to Congress and to the HHS Secretary that describe its activities and provide recommendations for improving the administration of Medicare.

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[2] Fiscal intermediaries and carriers mentioned in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 are now referred to as Medicare Administrative Contractors.

MISSION, VISION, AND ORGANIZATION

The OMO ensures that Medicare beneficiaries have access to the health care and coverage to which they are entitled.

MISSION

The Office of the Medicare Ombudsman (OMO) provides direct assistance to beneficiaries with their inquiries, complaints, grievances, and appeals. The OMO serves as a voice for beneficiaries by evaluating policies and procedures, identifying systemic issues, making recommendations to Congress and the Secretary of the U.S. Department of Health & Human Services, and working with partners to implement improvements to Medicare.

VISION

The OMO ensures that Medicare beneficiaries have access to the health care and coverage to which they are entitled. When issues arise, information and assistance are available for timely and appropriate resolution.

ORGANIZATION

The OMO is now located within the Centers for Medicare & Medicaid Services' (CMS) Office of Hearings and Inquiries. To handle its range of activities, the OMO is organized into three divisions: the Division of Ombudsman Exceptions (DOE), the Division of Medicare Ombudsman Assistance (DMOA), and the Division of Ombudsman Research and Trends Analysis (DORTA). Both DOE and DMOA directly assist beneficiaries through casework. DOE works on data system and transaction issues. DORTA focuses on data reporting and trending and casework collaboration, and it also conducts an Issues Management process, which identifies and addresses systemic problems affecting Medicare and its beneficiaries. The Competitive Acquisition Ombudsman, also within the OMO, responds to complaints and inquiries from individuals and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) relating to the application of the Medicare DMEPOS Competitive Bidding Program. The activities of each of the OMO divisions are discussed in more detail in this report.

FIGURE 1. OMO ORGANIZATIONAL CHART IN 2013
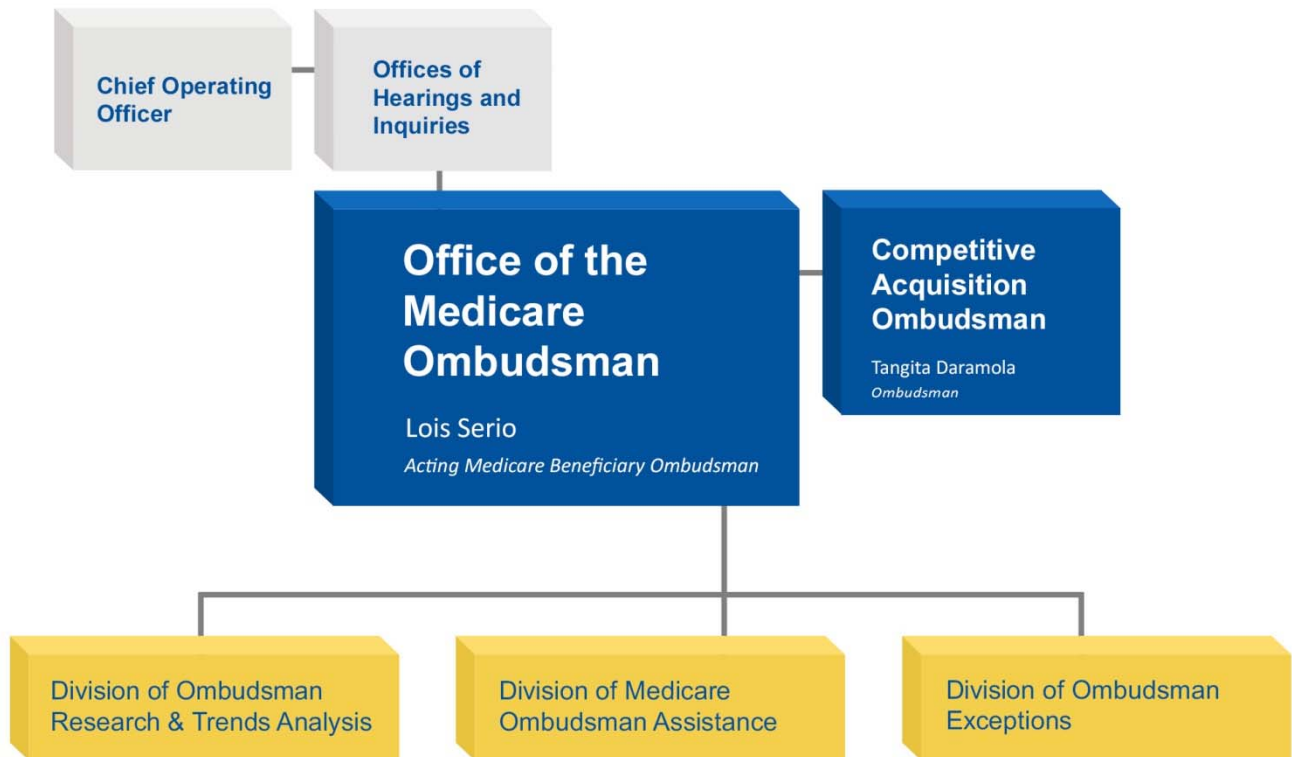
EXECUTIVE SUMMARY

The OMO's Report to Congress describes the office's core activities and key accomplishments in fiscal year 2013.

Medicare serves more than 50 million beneficiaries through a variety of coverage options, including traditional Medicare (Parts A and B), Medicare-contracted health plans (Part C), and prescription drug plans (Part D). As the features of these programs evolve to meet the changing needs of beneficiaries and the changing health care landscape in the United States, the Office of the Medicare Ombudsman (OMO) will continue to provide assistance to beneficiaries and their caregivers and to act as a catalyst to improve Medicare.

In this fiscal year (FY) 2013 Report to Congress, the OMO describes its efforts to improve Medicare and presents to Congress and the Secretary of the U.S. Department of Health & Human Services (HHS) its recommendations for addressing systemic issues affecting the program. The report is divided into three sections and contains two data appendices. The first section of this report describes the OMO's core activities in FY 2013 and key accomplishments: issues management, casework, customer service, partnership initiatives, comprehensive studies development, and recommendations tracking and implementation activities. The second section reviews key issues and provides an overview of the recommendations that the OMO has considered since the inception of the office in 2005. The third section provides an analysis of several issues affecting Medicare beneficiaries and the OMO's recommendations for addressing these issues.

MANAGING BENEFICIARY ISSUES: CORE ACTIVITIES AND KEY ACCOMPLISHMENTS

The OMO's activities in FY 2013 demonstrate its evolution into a comprehensive customer service entity within the agency, with expanded partnerships and the capacity to better serve beneficiaries. The OMO's key accomplishments in FY 2013, highlighted in figure 2, include the following:

Completed comprehensive studies: The OMO conducted three comprehensive studies in FY 2013 to identify the root causes of beneficiary issues and to develop specific, actionable recommendations for addressing them.
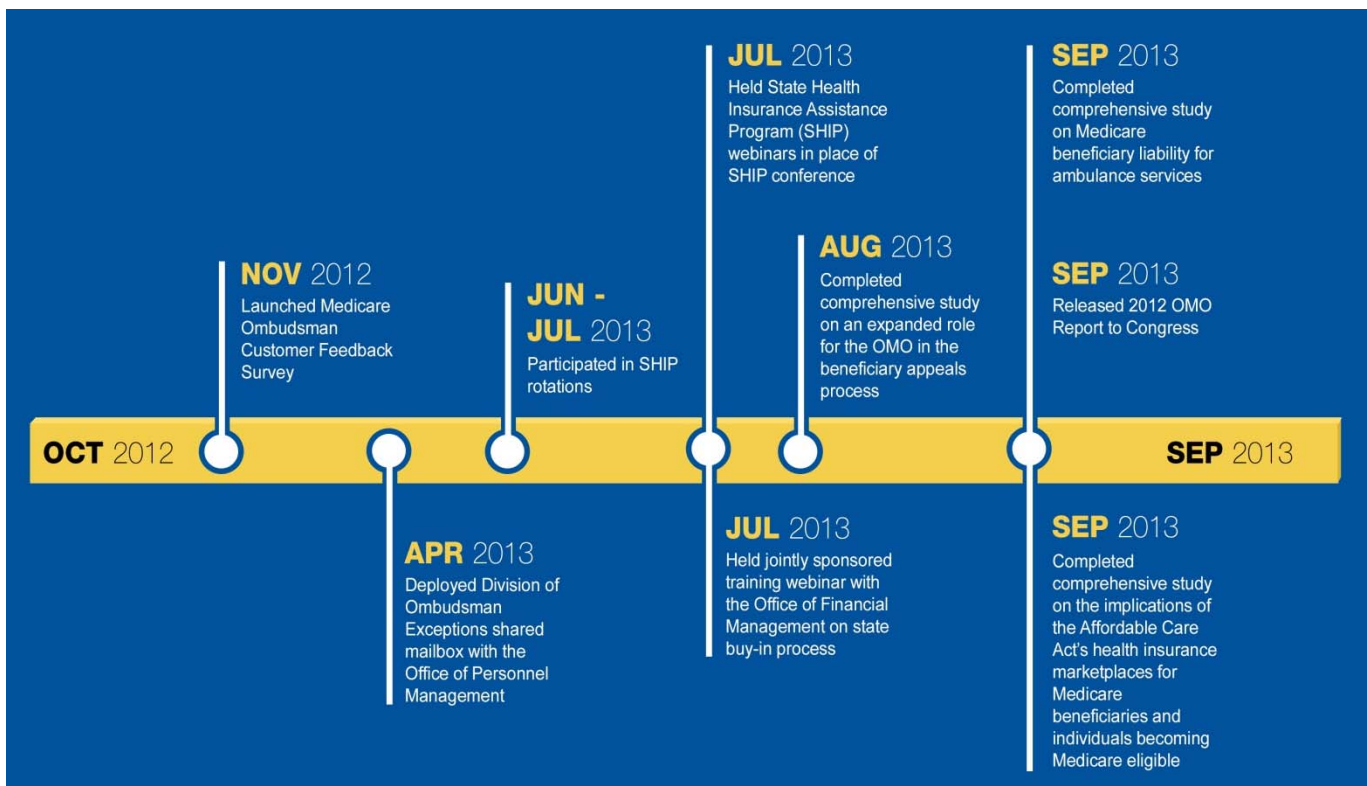
Formalized recommendation implementation tracking and guidance approach: The OMO implemented a process for tracking the progress of recommendations it has made to the Centers for Medicare & Medicaid Services (CMS) and

Congress since its inception. Thus far, the OMO has made more than 150 recommendations to improve Medicare, and nearly one third of these recommendations have been implemented.

Strengthened collaboration with State Health Insurance Assistance Program (SHIP) partners: Caseworkers in the OMO Division of Medicare Ombudsman Assistance (DMOA) traveled to local SHIPs to meet with beneficiaries face-to-face to obtain a better understanding of the SHIPs' organizational structure and management of casework activities and to bring back lessons learned.

Provided direct service to beneficiaries: DMOA's total casework volume for FY 2013 was 25,859 cases. Of these, DMOA provided direct assistance for 13,257 inquiries from beneficiaries, their caregivers, advocates, and congressional offices. DMOA directed the remaining cases to CMS Regional Offices.

FIGURE 2. NOTABLE ACCOMPLISHMENTS IN FY 2013

JUL 2013
Held State Health Insurance Assistance Program (SHIP) webinars in place of SHIP conference

SEP 2013
Completed comprehensive study on Medicare beneficiary liability for ambulance services

NOV 2012
Launched Medicare Ombudsman Customer Feedback Survey

JUN – JUL 2013
Participated in SHIP rotations

AUG 2013
Completed comprehensive study on an expanded role for the OMO in the beneficiary appeals process

SEP 2013
Released 2012 OMO Report to Congress

OCT 2012

SEP 2013

APR 2013
Deployed Division of Ombudsman Exceptions shared mailbox with the Office of Personnel Management

JUL 2013
Held jointly sponsored training webinar with the Office of Financial Management on state buy-in process

SEP 2013
Completed comprehensive study on the implications of the Affordable Care Act's health insurance marketplaces for Medicare beneficiaries and individuals becoming Medicare eligible

Corrected data discrepancies: The Division of Ombudsman Exceptions (DOE) processed 60,749 cases to address discrepancies in beneficiaries' entitlement, enrollment, and premium payment data. Of these, 54.8 percent were related to direct billing, and 38.9 percent were related to third-party cases.[3] The remaining 6 percent were uncommon and esoteric exceptions that often involved manual record changes. In FY 2013, DOE worked with the CMS Office of Information Services to inventory and review these uncommon transactions to develop and document processing procedures.

AREAS FOR IMPROVING BENEFICIARIES' EXPERIENCE WITH MEDICARE

In FY 2013, the OMO formalized its approach for tracking recommendations and guiding their implementation. To do so, the OMO designated staff members to assist in the implementation process, cemented existing relationships with partners, and built new relationships within the agency and with internal partners to support the implementation of these recommendations. OMO staff members assist in developing strategies to implement the recommendations through such activities as drafting documents, preparing memoranda, participating in collaborative workgroups, and facilitating discussions among key stakeholders. Through these activities, the OMO can determine the status of a recommendation and develop ways to implement it, when possible.

The OMO develops its recommendations after careful review and assessment of an issue.

Recommendations center on developing new or improved:

- Web sites, print materials, and publications
- Outreach, education, and training efforts
- Inter-agency and intra-agency communications
- Policy and regulation changes
- Assessment/data collection/monitoring

The OMO is now carrying out a full range of customer service-related activities, from assisting individual beneficiaries to helping solve systemic issues, so that CMS may better serve its beneficiaries.

ISSUES AND RECOMMENDATIONS REGARDING BENEFICIARY CONCERNS

The OMO completed three comprehensive studies in FY 2013. The OMO selected these topics of study because they were identified as affecting or having the potential to affect beneficiaries. Based on study findings, the OMO developed recommendations for addressing these issues, which are discussed in the *Issues and Recommendations Regarding Beneficiary Concerns* section.

Exploring an Expanded Role for the Office of the Medicare Ombudsman in the Beneficiary Appeals Process

According to its statutory mandate, the OMO must assist individual Medicare beneficiaries going through the appeals process with gathering necessary information. As part of this responsibility, the OMO monitors trends in appeals through a monthly and quarterly review of Medicare Appeals System data and other beneficiary contact trend data. The OMO also engages with the HHS Office of Medicare Hearings and Appeals in an effort to identify

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[3] Direct premium billing issues arise for beneficiaries who pay their Part A and/or their Part B premiums directly, rather than through a Social Security check withholding. Third parties include states, private entities, local governments, and the Office of Personnel Management.

other actions that it could take to improve the appeals process for beneficiaries.

The OMO undertook this study to determine which additional activities it could pursue that would complement the existing beneficiary support network relating to appeals, fulfill unmet needs, and fall within the OMO's scope of responsibility, as determined by its authorizing statute. The OMO analyzed appeals data, conducted an environmental scan of appeals-related educational resources for beneficiaries, and held discussions with stakeholders so that the office could understand the challenges beneficiaries may confront during the appeals process.[4]

Medicare Beneficiary Liability for Ambulance Services

Denial of ambulance services is one of the most common reasons for beneficiary-initiated appeals under Medicare. In 2011, more than 10 percent of the 16.7 million ambulance transport claims submitted to Medicare were denied, and more than 739,000 beneficiaries had one or more denied ambulance claims. Ambulance service denials may be particularly important to consider, because beneficiaries may not understand which ambulance services meet the statutory definition of an ambulance service covered by Medicare. In many cases, the usual liability protections for denials on "reasonable and necessary" grounds do not apply.

In this study, the OMO examined the circumstances that may lead Medicare to deny

coverage or payment of ambulance services. The OMO then identified strategies for reducing the number of situations in which beneficiaries are unknowingly assuming financial liability for payment of ambulance services. To complete the study, the OMO interviewed ambulance-service stakeholders, analyzed Medicare claims and appeals data, examined Medicare Administrative Contractor local coverage policies and geographic variations in denials, and conducted an environmental scan of existing informational materials available to beneficiaries and providers.

Beneficiaries and their ambulance suppliers or providers may unknowingly assume financial liability for ambulance services because of the complex structure of Medicare's ambulance benefit, and possibly because of a lack of understanding of the benefit's limitations. Under the statute, regulations, and manual provisions addressing Medicare coverage of ambulance services, Medicare will only cover ambulance transport in limited circumstances. For Medicare to pay for ambulance transport, it must be:

- A *covered benefit,* which means that other methods of transportation are contraindicated by the beneficiary's medical condition and that other coverage requirements are met.
- Reasonable and necessary for the beneficiary at the particular time.
- Used to obtain (or to return from obtaining) a Medicare-covered service from a covered origin and to a covered destination.

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[4] There are five levels of appeals. At the first two levels, decisions are made after the contractors review the evidence in the case files. The third appeal level is conducted by an Administrative Law Judge with the Office of Medicare Hearings and Appeals. The fourth and fifth levels involve a Medicare Appeals Council and a federal district court, respectively.

Understanding the Potential Implications of the Affordable Care Act's Health Insurance Marketplace for Medicare Beneficiaries and Individuals Becoming Medicare Eligible

The Affordable Care Act, signed into law in March 2010, put into place comprehensive reforms intended to improve access to health coverage. A critical element of the law is the creation of health insurance Marketplaces, through which consumers can choose private health insurance plans that fit their health needs. The Marketplaces are also known as health insurance "Exchanges."

Medicare is not part of the health insurance Marketplace established by the Affordable Care Act; however, individuals enrolled through a Marketplace may eventually age into Medicare or otherwise qualify due to disability or end-stage renal disease. Thus, individuals with coverage through a Marketplace may eventually need to make Medicare enrollment decisions, so it is critical that they be made aware of their

Medicare eligibility and important considerations for enrollment in Medicare. Without the proper outreach and education, the availability of coverage through the Marketplaces has the potential to create confusion and misunderstanding among potential Medicare beneficiaries. As a result of these concerns, the OMO sought to evaluate messaging and the information available to individuals eligible for coverage through a Marketplace who may become eligible for Medicare coverage. The OMO conducted an environmental scan involving the review of government, advocacy, insurer, Marketplace, and Navigator Web sites,[5] and it surveyed relevant laws and regulations. The purpose was to identify gaps in information available to individuals eligible for coverage through a Marketplace who may become eligible for Medicare coverage so that areas of confusion could be identified and mitigated. In general, with the exception of www.Medicare.gov and www.HealthCare.gov, information was either limited, difficult to find, or not available at all across the sites reviewed.

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[5] "Navigators" are individuals and organizations awarded grants by a State Based Marketplace, or by CMS in a Federally Facilitated Marketplace or State Partnership Marketplace, through a competitive process to assist consumers as they apply to participate in the Marketplaces and enroll in health plans offered through the Marketplace.

HOW THE OMO IDENTIFIES AND MANAGES BENEFICIARY ISSUES

The OMO carries out its mission by providing direct assistance to beneficiaries with their inquiries, grievances, and complaints.

INTRODUCTION

The Office of the Medicare Ombudsman (OMO) carries out its mission by performing six core activities that enable it to identify and address systemic issues that affect Medicare beneficiaries: issues management, casework, customer service, partnership initiatives, comprehensive studies development, and recommendations tracking and implementation activities (see figure 3). The OMO staff also support the Competitive Acquisition Ombudsman (CAO).

The following subsections, which focus on the six core activities, provide a more detailed overview and specific examples of how the OMO assisted beneficiaries and their caregivers in fiscal year (FY) 2013 and how it will build on these efforts in FY 2014.

ISSUES MANAGEMENT

The OMO uses its Issues Management process to proactively identify, evaluate, and address beneficiary issues and to help resolve systemic problems that affect Medicare and its beneficiaries. Issues are brought to the OMO's attention through a variety of channels, including inquiry and complaint trends analysis, casework from the Central Office (CO) or Regional Office (RO), communication with State Health Insurance Assistance Program (SHIP) counselors and other external partners, and environmental scans of news outlets and advocacy organizations' Web sites.

The Issues Management process involves the following:

- *Identifying, validating, and tracking issues*. The OMO analyzes data from the Centers for Medicare & Medicaid Services' (CMS) inquiry, complaint, and appeals tracking systems to identify trends that might indicate systemic problems across the different parts of Medicare. The issues that enter the Issues Management process are centrally tracked and documented, enabling a comprehensive view of the entire resolution effort for each issue.
- *Compiling research on beneficiary issues.* The OMO prepares case research, issue briefs, comprehensive study findings, and policy and regulatory guidance to understand an issue.
- *Facilitating Issues Management meetings*. Monthly Issues Management meetings give OMO leadership and analysts the opportunity to discuss newly identified concerns and to develop effective strategies for addressing them. For each

FIGURE 3. CORE ACTIVITY SUMMARY

Issues Management

is the process the OMO uses to identify systemic beneficiary issues through casework analysis and to validate issues identified by external organizations. Issue updates and recomendations are presented to CMS Leadership in the OMO's Quarterly Issue Reports.

Casework

involves the resolution of individual beneficiary inquiries, complaints, grievances, and appeals.

Customer Service

initiatives are an ongoing OMO collaborative effort with other CMS components to provide more effective and efficient customer service to beneficiaries.

Partnership Initiatives

with other CMS components and external organizations (e.g., beneficiary advocacy groups) are an integral part of the OMO's efforts to identify and address beneficiary issues.

Comprehensive Studies Development

consists of in-depth evaluations of the root causes of beneficiary issues identified through the Issues Management process or by other sources and the development of recommendations for CMS for addressing these issues.

Recommendations Tracking and Implementation Activities

is the process through which the OMO collaborates with various CMS stakeholders to validate the feasibility of the recommendations stemming from its comprehensive studies and to begin implementing them.

issue, a lead analyst performs a root-cause analysis and, when necessary, solicits feedback from CMS subject-matter experts. During Issues Management meetings, the OMO provides updates about open or monitored issues. As the resolution process continues, implementation steps

(e.g., developing new educational materials or revising a fact sheet posted on www.Medicare.gov) are also identified and reported during these meetings.

- *Developing Quarterly Issues Reports.* These internal CMS documents highlight data and trends, provide a synopsis of issues, and outline the OMO's actions to address each issue, per the scope of its purview. Figure 4 describes select issues discussed in FY 2013.

- *Compiling Beneficiary Contact Trend (BCT) Reports.* These reports, developed by the Division of Ombudsman Research and Trends Analysis, summarize beneficiary inquiries, complaints, and appeals data from several CMS sources (see appendix A). The goal of the BCT reports is multipronged: to provide a consolidated view of the reasons that beneficiaries and others are contacting the agency, to review data trends to identify indicators of any specific systemic issue(s), and to use the data and trends to validate potential issues.

CASEWORK

Beneficiaries can receive assistance from a variety of sources if they need help obtaining and understanding information about the benefits and services to which they are entitled. Nearly all beneficiary inquiries received through the CMS CO are directed to the OMO's Division of Medicare Ombudsman Assistance (DMOA) and Division of Ombudsman Exceptions (DOE) for resolution. OMO caseworkers provide direct assistance to beneficiaries on an individual basis by triaging and responding to inquiries and complaints in writing via postal mail and e-mail and over the phone.

FIGURE 4. SELECT ISSUES ADDRESSED IN 2013

Medicare Easy Pay Letter Clarification

Beneficiaries expressed confusion about the language in the Medicare Easy Pay application letter. The form did not clearly indicate that a voided check must be submitted with the application form, resulting in some beneficiaries' submitting incomplete applications. The Office of the Medicare Ombudsman (OMO) brought the issue to the attention of the appropriate Centers for Medicare & Medicaid Services (CMS) components and facilitated form revisions.

Co-Insurance for Outpatient Surgery Cap in Critical Access Hospitals and Maryland Hospitals

The 2013 *Medicare & You* handbook stated that a beneficiary's co insurance/copayment for services paid under the Hospital Outpatient Prospective Payment System will be no greater than the Part A deductible. However, beneficiaries treated at a critical access hospital (CAH) or in a hospital in Maryland may have to pay co insurance amounts for outpatient surgery services that exceed the amount of the Part A deductible. This is because neither CAHs nor Maryland hospitals participate in the Outpatient Prospective Payment System, which caps the beneficiary's co insurance payment to no more than the Part A deductible, per the Balanced Budget Refinement Act of 1999. The State of Maryland has a special waiver with Medicare that affects how it charges for hospital care. The OMO worked with CMS Office of Communications to have the 2014 *Medicare & You* handbook updated to reflect potential exceptions to the co insurance cap.

Division of Medicare Ombudsman Assistance Casework

DMOA collects data about the volume of contacts, the response time, and the reasons for contact. Figure 5 illustrates the relatively stable volume of cases that DMOA/CO handled from 2009–2013. DMOA received 25,859 inquiries in FY 2013, a decline of 2.1 percent from FY 2012 and a 3.8 percent decline from FY 2011. DMOA caseworkers directly responded to 13,257 inquiries, and the remaining 12,602 cases were sent to the ROs for resolution.

In FY 2013, DMOA reduced its targeted response time for most casework from 30 to 20 business days. Caseworkers responded to approximately 98 percent of the inquiries they received in fewer than 20 days, with an average response time of 11 days. The nature of some inquiries warrants shorter response time.

DMOA receives inquiries on a variety of topics. Figure 6 compares the number of contacts per topic in FY 2012 with the number in FY 2013. The top 10 reasons remained the same in FY 2013 as in FY 2012.

In FY 2013, premium-related questions, which accounted for 54 percent of contacts, saw a 4 percent increase from FY 2012. This category includes questions regarding premium-related direct assistance. Inquiries about Medicare eligibility or enrollment and "other topics" experienced the largest decrease (14 percent).

Other categories had moderate decreases (between 1 and 9 percent). The fact that premiums remained the most frequent reason for contact and that the number of contacts related to premiums increased while all others categories have decreased slightly since FY 2012 underscores the OMO's focus on

FIGURE 5. DMOA CASEWORK VOLUME, FY 2009–2013
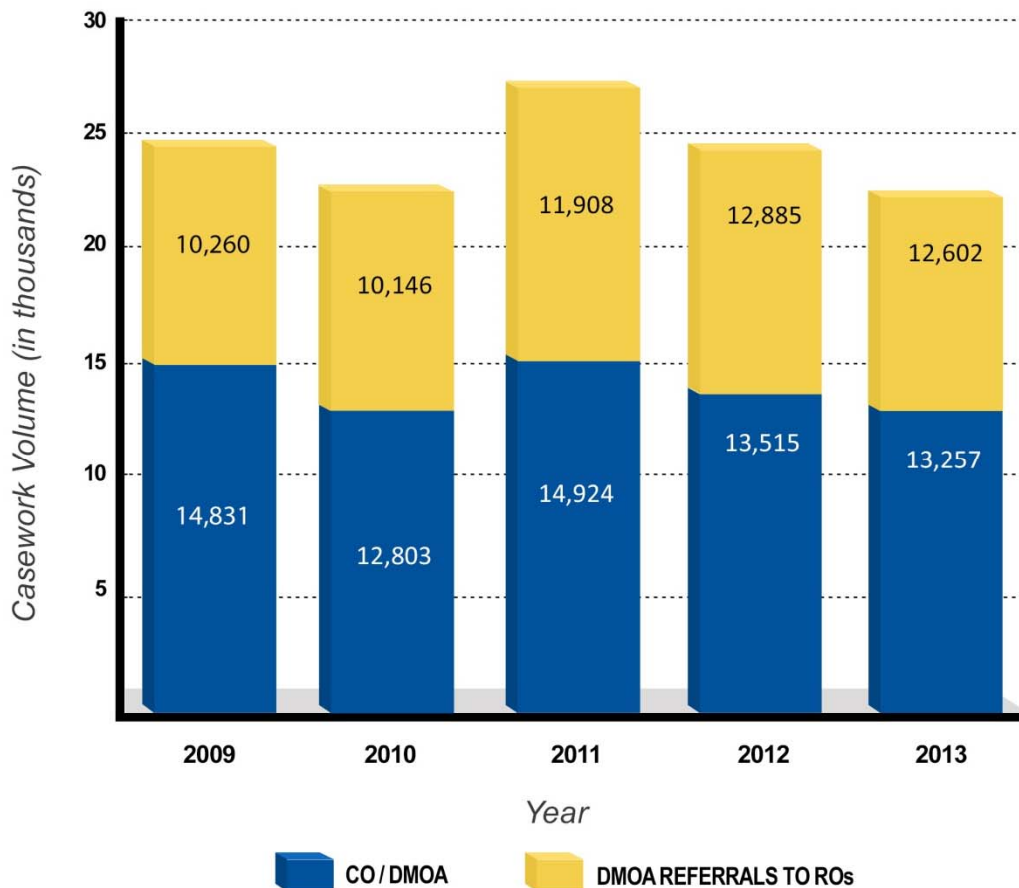
FIGURE 6. COMPARISON OF FY 2012 AND FY 2013 REASONS FOR BENEFICIARY CONTACTS TO DMOA

Reason For Contact	Contacts, FY 2012	Contacts, FY 2013	% change from FY 2012 to FY 2013
Premiums	13,457	14,035	▲ 4%
Medicare eligibility/enrollment	1,706	1,502	▼ -14%
Medicare coverage	1,302	1,197	▼ -9%
Coordination of benefits	877	842	▼ -4%
Inquiries not Medicare/Medicaid specific	772	767	▼ -1%
Medicare Advantage	745	739	▼ -1%
Claims inquiries/complaints	502	490	▼ -2%
Low-income subsidy	496	483	▼ -3%
Disenrollment/enrollment/withdrawal	357	339	▼ -5%
Health insurance replacement cards	324	302	▼ -7%
Other	5,862	5,163	▼ -14%
Total	26,400	25,859	▼ -2%

premium billing issues and its efforts to make improvements to the Medicare direct bill.

Case Example: One example of premium-related direct assistance provided by DMOA involved a request for help from a Medicare beneficiary regarding an unresolved Income-Related Monthly Adjustment Amount (IRMAA) payment. A beneficiary was charged IRMAA—increased Parts B and D premiums that higher-income individuals have to pay—despite the fact that this beneficiary had a low income. The beneficiary's appeal to the Social Security Administration (SSA) requesting that the 2012 IRMAA for Parts B and D be removed and refunded was not processed correctly.

The DMOA analyst assigned to the case reviewed the beneficiary's records and, after confirming that the Parts B and D IRMAA amounts were not

removed, asked the beneficiary to send documentation related to this issue. In this documentation, an analyst discovered a decision letter from SSA stating that the 2012 IRMAA amounts for Parts B and D should be removed.

Subsequently, the analyst contacted SSA's Program Service Center and requested that the 2012 Parts B and D IRMAA charges be removed. After the records were updated, the analyst took steps to ensure that the beneficiary was refunded the erroneously charged 2012 IRMAAs. With the analyst's intervention, a long-standing issue was finally resolved.

Division of Ombudsman Exceptions Casework

Due to the complexity of the various systems used to maintain entitlement and enrollment data for Medicare and Social Security beneficiaries, and

SPOTLIGHT:
DMOA Caseworkers Participate in SHIP Rotations

In accordance with Section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 , the Office of the Medicare Ombudsman (OMO) works closely with State Health Insurance Assistance Programs (SHIPs), federally funded state programs that provide free health insurance counseling to beneficiaries by telephone and through face-to-face sessions.

In fiscal year 2013, DMOA caseworkers had the chance to participate in rotations at local SHIPs. The goal of these rotations was to give caseworkers and SHIP counselors the opportunity to obtain a better understanding of their respective roles, to meet with beneficiaries face-to-face, and to bring back lessons learned.

"One observation that I made is [that] the OMO has some of the same types of cases we get in the SHIP offices, and by partnering and supporting one another we may be able to assist each other to serve beneficiaries in a more effective and timely manner."

—Local SHIP Coordinator

"It was informative to see the type of cases the SHIP deals with to gain a better understanding of what we can refer to them and to give them an idea of how the OMO can help them."

— DMOA caseworker

An OMO caseworker and a Frederick County Maryland SHIP Coordinator pose for a picture during the rotations.

the evolving policies and regulations that govern this, problems may occur in the accurate transfer of information. It is important to correct these problems. DOE works to maintain the integrity of enrollment and premium payment data by executing a variety of quality-control functions to ensure that discrepancies are resolved and that all systems reflect the correct information. It also works with other CMS components to identify potential anomalies before they become widespread and to develop procedures for correcting them.

Previously, DOE, whose work includes resolving beneficiary data system anomalies, was housed within the CMS Office of Information Services (OIS). In 2008, DOE moved to the OMO and since then has developed a customer service-oriented approach and a more global perspective on its focus area of resolving data system anomalies and ensuring the quality and integrity of

entitlement, enrollment, and premium data. In addition to working with various CMS components on issues involving a variety of Medicare systems, DOE staff members communicate directly with beneficiaries, states, SSA, and the Office of Personnel Management (OPM) to resolve record discrepancies and obtain updated information.

In FY 2013, DOE processed 60,749 cases. Of these, 54.8 percent were related to direct billing, and 38.9 percent were related to third-party cases.[6] The remaining 6.3 percent were uncommon and esoteric exceptions that often involved manual record changes. In FY 2013, DOE worked with OIS to inventory and review these uncommon

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[6] Direct premium billing issues arise for beneficiaries who pay their Part A and/or their Part B premiums directly rather than through a Social Security check withholding. Third parties include states, private entities, local governments, and OPM.

transactions to develop and document processing procedures.

DOE also assisted OIS with system revisions or improvements relating to the order in which premium payments are applied, automated refunds for Part D IRMAA, and the processing of Part B premium billing transactions from Civil Service Retirement System beneficiaries.

DOE enhanced processes for working with various entities, including ROs, state Medicaid offices, and most recently OPM. Shared secure e-mail accounts were created so that these entities could share cases with DOE seamlessly and keep track of the communication flow. DOE uses an internal Issues Management process similar to the OMO-wide Issues Management process to identify, validate, track the progress of, and resolve systemic issues. See the spotlight box for more information on DOE's work with OPM.

CUSTOMER SERVICE

The OMO engages in and supports activities to improve beneficiary customer service within CMS. In particular, the OMO promotes efforts to address beneficiary issues in a consistent manner through national casework calls (NCCs), caseworker training, standard-language letters, foreign-language correspondence, and an annual customer service feedback survey. Additionally, a standard interim response process was implemented for issues requiring intensive research or interagency cooperation to improve timeliness and overall OMO customer service.

National Casework Calls and Training Programs

The OMO facilitates NCCs, which include staff members from the CMS CO and its ROs. Through these calls, the OMO communicates changes in policies, regulations, or other important programs that may affect beneficiaries and their caregivers. The OMO also conducts training sessions to improve the quality of customer service in inquiry and complaint management. Figure 7 summarizes

SPOTLIGHT: DOE Works with OPM to Ensure Civil Servants Maintain Medicare Coverage

The Division of Ombudsman Exceptions (DOE) processes direct billing and third-party refunds to proactively resolve situations in which beneficiaries are owed refunds. The refunds are not always in response to an error made by the Centers for Medicare & Medicaid Services (CMS); for example, they could be necessitated by unreported earnings or Social Security Administration (SSA) system errors.

The Office of Personnel Management (OPM) processes retirement benefits for federal employees. It must work closely with CMS and SSA to ensure that retirees are also receiving Medicare and Social Security benefits. Due to the divergence between the Social Security retirement age of 67 for those born after 1943 and the Medicare eligibility age of 65, CMS must work with OPM to ensure that Medicare premiums are deducted appropriately from federal retirement benefit checks to ensure that beneficiaries do not experience an interruption in coverage.

DOE ensures that beneficiaries get credit for the number of quarters worked, which can result in reduced Part A premiums or free Part A coverage.

the number of training programs in FY 2013 and selected topics.

Customer Feedback Survey

In FY 2013, the OMO began conducting its Medicare Ombudsman Customer Service Feedback Survey annually to assess whether the OMO is meeting the needs of beneficiaries and advocates. Previously done every other year, the survey was sent to individuals who contacted the OMO for assistance. The OMO sought opinions about the timeliness, quality, and clarity of the assistance they received and feedback about their

FIGURE 7. FY 2013 OMO NATIONAL CASEWORK CALLS AND TRAININGS

Type of Call	Number of Sessions	Selected Topics
NCC Parts A and B	7	• Cap on outpatient therapy reimbursement amount • Redesign of Medicare Summary Notices • Updates on Round 2 Competitive Bidding
NCC Parts C and D	9	• Medicare managed care manual updates • Updates regarding the annual reassignment of beneficiaries into Part C and Part D plans • Casework best practices
Casework Training	9	• Medicare secondary payer rules • Medicare direct billing • Coordination of benefits

overall satisfaction with that assistance. The ratings scale ranged from 1 (strongly dissatisfied) to 5 (strongly satisfied).

In FY 2013, changes were made to the survey. First, a description of the issue for which the beneficiary initially contacted the OMO was included to remind him or her of the interaction. Second, the survey was further modified to guide the beneficiary to provide feedback on the service the OMO provided, as opposed to that offered by other agencies or CMS components.

The OMO sent 1,483 surveys between November 2012 and October 2013. With a response rate of 60 percent, the OMO maintained an overall average score of 4.5 out of a possible 5.0 points from FY 2012 to FY 2013. The highest-rated measure was clarity, with an overall average score of 4.6. The lowest-rated measure was timeliness, which had an overall average score of 4.3.

Standard-Language Letters

To help CMS caseworkers consistently and accurately respond to beneficiary inquiries about various Medicare topics, the OMO has developed standard-language letters. These letters use plain-language principles to ensure uniformity and the appropriate delivery of information.

In FY 2013, a standard explanation of what the Ombudsman is and its function was added to every type of correspondence from the OMO in response to beneficiary feedback on the Customer Feedback Survey. Additionally, the OMO developed 25 new standard-language letters as changes in program information occurred, bringing the total number of standard-language letters in FY 2013 to 568.

Foreign-Language Correspondence

Frequently, written notices and publications are used to provide beneficiaries with vital information they need about Medicare. Beneficiaries with limited English proficiency may need additional help and clarification to understand and reply to such notices and publications. The OMO received 1,163 foreign-language inquiries in FY 2013, with 86 different languages represented. Correspondence in Spanish accounted for the greatest number of foreign-language inquiries, with additional inquiries in other languages, including Albanian, Chinese, French, Greek, Japanese, Russian, German, Hmong, Italian, and Vietnamese.

In FY 2013, the OMO changed how Spanish-language correspondence is handled. Previously, Spanish-language correspondence was managed

on a case-by-case basis by bilingual staff members. However, the OMO received beneficiary feedback from the Customer Service Feedback Survey that indicated that the Spanish-language letters needed to be clearer. Consequently, in FY 2013, the OMO began collaborating with the Office of Communication to obtain assistance with ensuring that existing and future Spanish standard-language letters meet the same tone of voice and plain-language criteria as English correspondence.

PARTNERSHIP INITIATIVES

The OMO endeavors to build relationships with partners to identify and resolve beneficiary issues and to develop and implement solutions to systemic problems. The OMO strives to strengthen its internal partnerships within CMS, intra-agency relationships with other government entities, and external partners.

Internal Partnerships

Since its inception, the OMO has focused on capacity building and collaboration with other components and offices within CMS. Figure 8 provides some examples of internal collaboration efforts and participation in a variety of cross-agency workgroups.

Partnerships with Other Government Entities

In FY 2013, OMO staff members continued relationships with SSA, the Railroad Retirement Board, OPM, the Administration for Community Living/Administration on Aging, the Small Business Administration, the U.S. Department of the Treasury, and the states. These collaborations helped the OMO identify and address issues and improve operations in some instances. See the previous Spotlight box for one such example.

The OMO also works closely with SHIPs. In addition to the SHIP casework rotations that DMOA participated in, the OMO also participated in "train the trainer" Web-based training sessions for SHIPS, advocates, and other partners who

provide assistance to beneficiaries. Upon completion of the training, these advocates were able to train other staff members at their organizations. The OMO provided casework scenarios for these sessions. Further, in lieu of an in-person conference, the annual SHIP conference was structured into a webinar series presented to SHIPs over several weeks. During one of these webinars, the OMO presented a session highlighting recent OMO activities.

External/Advocacy Partnerships

In addition to working directly with thousands of Medicare beneficiaries each year, the OMO also works in partnership with advocacy organizations that help identify issues and share information with beneficiaries and providers. The OMO communicates with these external partners via Medicare Ombudsman partner and beneficiary advocate meetings and national conferences. As appropriate, the OMO investigates the issues raised during these meetings, shares them at Issues Management meetings, and presents concerns to CMS stakeholders for evaluation and possible resolution.

The OMO held several partner calls in FY 2013 to discuss general topics and specific issues. During meetings with the National Council on Aging, the OMO discussed general issues that affect Medicare beneficiaries. At a meeting with the United Spinal Association, issues surrounding power mobility devices were discussed. Finally, a working relationship with the American Ambulance Association evolved out of the comprehensive study on ambulance services, which is discussed in the *Issues and Recommendations Regarding Beneficiary Concerns* section of this report.

By attending conferences, the OMO has the opportunity to learn firsthand which issues are affecting the Medicare population and to conduct stakeholder outreach. In FY 2013, the OMO participated in four external partner conferences:
- Government Customer Service Conference

FIGURE 8. OMO'S INTERNAL CMS STRATEGIC RELATIONSHIPS

Partner	Example of collaborative efforts and strategic relationships
Center for Consumer Information and Insurance Oversight (CCIIO)	The OMO, through collaborations with other CMS components, seeks to anticipate and communicate to beneficiaries the effects of the changing health care landscape and the implementation of the Affordable Care Act. The OMO collaborates with CCIIO and other agency components in drafting responses to complex inquiries related to the new provisions of the Affordable Care Act.
Center for Medicare (CM)	CM provides valuable insight into issues related to health plan operations, policies, and communications. CM collaborates with the OMO during the Issues Management process to assess and address issues regarding Medicare Parts A and B payment policy and concerns or programs involving Medicare fee-for-service contractors.
Center for Medicare-Medicaid Innovation (Innovation Center)	The OMO and the Innovation Center discussed the potential beneficiary implications of the new Medicare-Medicaid financial alignment demonstration and progress on implementing recommendations related to the comprehensive study of the information needs of Medicare-Medicaid enrollees.
Federal Coordinated Health Care Office (FCHCO)	The OMO collaborates with FFHCO on issues affecting Medicare-Medicaid enrollees. The OMO participates in FCHCO-led cross-cutting workgroup on Marketplace messaging. This workgroup is developing suggested messages to be sent to individuals who are Medicare eligible as they enter the Marketplace or who are in a Marketplace plan or new Medicaid adult group and then become Medicare eligible.
Office of the Administrator (OA)	The OMO elevates systemic issues to OA and obtains OA's support in addressing these issues, as needed.
Office of Communications (OC)	The OMO collaborates with OC to facilitate updates to existing CMS publications and to develop new publications or fact sheets, as needed. The OMO also works with 1-800-MEDICARE customer service representatives located within OC to resolve a small percentage of highly complex beneficiary issues.
Office of Financial Management (OFM)	The OMO works with OFM to address payment, data, and policy issues, including Medicare secondary-payer and third-party liability policies and practices and coordination of benefits issues. The OMO and OFM collaborated on a national webinar training about state buy-in.
Office of Information Services (OIS)	DOE engages with OIS components to identify changes to CMS data systems that may affect Medicare beneficiaries.
Regional Offices (ROs)	The OMO collaborates with ROs to identify and facilitate the resolution of systemic issues related to CMS' processes and to develop standard casework procedures. The OMO provides information and training to RO staff through National Casework Calls and training programs.

- California Association of Medical Product Suppliers Annual Convention
- American Health Lawyers Association Conference
- Chronic Obstructive Pulmonary Disease USA Conference

COMPREHENSIVE STUDIES DEVELOPMENT

The OMO conducts comprehensive studies to identify the root causes of beneficiary issues and

to develop specific, actionable recommendations for addressing them. Since it began conducting studies in 2010, the OMO has completed 11 comprehensive studies.

In FY 2013, the OMO completed an additional three studies:

1. Exploring an Expanded Role for the Office of the Medicare Ombudsman in the Beneficiary Appeals Process

2. Medicare Beneficiary Liability for Ambulance Services
3. Implications of the Affordable Care Act's Health Insurance Marketplaces for Medicare Beneficiaries and Individuals Becoming Medicare Eligible

Two of the three studies—Medicare Beneficiary Liability for Ambulance Services and Exploring an Expanded Role for the Office of the Medicare Ombudsman in the Beneficiary Appeals Process—were the result of greater communication between the OMO and the Office of Medicare Hearings and Appeals staff.

Study Methodology

The studies each used a variety of methods to research the various issues, including:

- Environmental scans of pertinent legislation, Medicare regulations, policy background materials, CMS Web sites, and other relevant external Web sites
- Evaluation and gap analyses of available communications and education materials for beneficiaries and other target audiences
- Interviews with stakeholders, such as CMS subject-matter experts, beneficiary advocacy groups, providers, and commercial organizations
- Analyses of CMS data or data from external sources

Based on findings from the studies, the OMO has been able to develop specific, actionable short- and long-term recommendations to address issues identified by the study. The OMO presents each study to CMS stakeholders and summarizes the findings in its annual Report to Congress. The development and progress of these recommendations is described in detail in the *Improving Medicare: OMO Efforts to Foster Program Change* section of this report.

Recommendations Tracking and Implementation Guidance

Since its 2005/2006 Report to Congress, the OMO has transitioned from identifying issues with Medicare and making recommendations, to identifying issues, offering recommendations, and helping implement solutions. The first step in this evolution came in 2010, when the OMO began developing comprehensive studies, allowing it to make more specific and better informed recommendations to CMS. In FY 2012, the OMO went a step further and began facilitating and tracking the implementation of its recommendations. In FY 2013, the OMO continued to refine its processes for tracking recommendations and implementing solutions.

The comprehensive study findings serve to inform the OMO of specific potential areas for program improvement. To assist implementation efforts, the OMO meets with components to discuss recommendations and brings various decision makers together to discuss the feasibility of recommendations and potential means to implement them.

To date, the OMO has made more than 150 recommendations. The *Improving Medicare: OMO Efforts to Foster Program Change* section of this report provides more information on the development and tracking of recommendations (e.g., categorization and status assignment), examples of recommendations, and implementation efforts.

COMPETITIVE ACQUISITION OMBUDSMAN SUPPORT

One of the CAO's priorities in FY 2013 was helping CMS prepare beneficiaries and suppliers for the implementation of Round 2 of the Competitive Bidding Program (CBP) and the National Mail-Order Competition for diabetes testing supplies. The CBP established competitive bidding areas (CBAs) throughout the United States by which durable medical equipment,

prosthetics, orthotics, and supplies (DMEPOS) vendors that meet certain product quality and financial requirements are eligible to submit bids to be selected as Medicare contract suppliers for certain items and services. The selected pool of suppliers in each CBA provides services and products to DMEPOS beneficiaries in that area.

The contract awards for the Round 2 bidding competition and a National-Mail Order Competition for diabetes testing supplies were announced in the spring of 2013 and became active on July 1, 2013. Contracts for the Round 1 Rebid were announced in the fall of 2013. These overlapping CBP phases require that the CAO and CMS customer service components be prepared to respond to suppliers and beneficiaries who may be navigating one of several different stages.

The CAO works closely with CMS components and partners to respond to the inquiries and complaints of suppliers and individuals, help CMS resolve inquiries and complaints by communicating and coordinating with CMS components, and support a comprehensive process for timely responses to suppliers and individuals. The OMO and CAO work closely together, as their mission and activities are closely aligned. Both ombudsmen serve as voices for beneficiaries, respond to inquiries and complaints, and identify potential systemic issues. In FY 2013, the OMO supported some of the CAO's activities, assisting with customer service training, supporting the CAO's inquiry handling, and engaging stakeholders in discussions about the CBP. Several of the OMO's trainings and NCCs dealt with CAO and CBP topics. The OMO also incorporates CAO issues into its Issues Management process to identify, validate, and discuss potential systemic issues when needed.

The CAO prepares a separate annual Report to Congress.

IMPROVING MEDICARE: OMO EFFORTS TO FOSTER PROGRAM CHANGE

In an effort to improve beneficiaries' experience with Medicare, the OMO makes recommendations to the agency based on evidence compiled through its diverse activities and assists with and guides the implementation of those recommendations.

INTRODUCTION

Starting in fiscal year (FY) 2012, the Office of the Medicare Ombudsman (OMO) engaged in a new activity to track and assist with implementing the recommendations it has made to the agency through its annual Report to Congress (RTC) and, since 2010, through comprehensive studies circulated to the Centers for Medicare & Medicaid Services (CMS) leadership. In FY 2013, the OMO continued to refine this effort. This section explains the recommendations' tracking process, which involves the assignment of an open or closed status and the categorization of each recommendation based on its focus (e.g., data collection and monitoring, outreach, education, and training). Examples of recommendations are provided to illustrate how the process works.

RECOMMENDATIONS

The OMO works with other CMS components to implement its recommendations, serving as a catalyst for improving Medicare. Although being positioned within CMS has challenged the OMO's ability to maintain an appropriate level of independence, it also allows the OMO to build close relationships with other CMS components and subject-matter experts. Because the OMO works diligently to develop a collaborative relationship with the agency's leadership and staff, it enjoys a level of access to experts and decision makers that allows the OMO to enhance its advocacy for Medicare beneficiaries. Additionally, because some of the OMO's recommendations require actions by parties outside CMS, cross-agency relationships are important.

Status of Prior OMO Recommendations

The OMO has made recommendations to CMS and Congress since the release of its first RTC in 2007, which covered FY 2005 and FY 2006. Since then, the OMO has shared more than 150 recommendations with CMS through its annual RTC and other intra-agency communications. Of these, 86 were discussed in RTCs and with the Secretary of the U.S. Department of Health & Human Services. The specificity of its recommendations increased with the introduction of comprehensive studies in 2010, which resulted in a set of more actionable recommendations for improving Medicare. Thus, although the agency had more time to implement earlier recommendations, it also required more effort on the part of CMS components to translate a recommendation into a set of concrete steps.

To track the progress of each recommendation, the OMO undertook a process of assigning one of four status designations to each recommendation:

- **Pending Review:** Assessment of the recommendation has not started.
- **In Progress:** The recommendation is being considered. Continued progress

requires further action by a CMS component or other agency.
- **Implemented:** The recommendation has been partially or fully implemented. No further action is expected.
- **Monitored:** The agency has decided not to implement the recommendation. This decision can be made for a variety of reasons, including resources, staff, time, competing priorities, and/or lack of concurrence on the value of the recommendation. The OMO will monitor the issue to determine whether additional action is warranted and/or to look for future opportunities to make the issue an agency priority.

The OMO updates the status of its recommendations as they progress from the review phase to the implemented or monitored phase. A few examples are highlighted in the next section. To maximize its impact, the OMO pursued a strategy of prioritizing those recommendations that could be implemented most quickly. As a result, the speed of implementation is expected to slow as more complex recommendations are implemented.

The status of a recommendation and how quickly it moves to the implementation phase, if at all, depends on a number of factors, ranging from the feasibility of implementation to the relevant CMS component's acceptance of its value. Even the OMO's most specific recommendations vary in their feasibility and ease of implementation. For example, recommendations that involve either external agencies or policy changes require significant coordination and resources in order to be implemented. These recommendations may move directly from the pending review to the monitored phase so that the effects of the issue on beneficiaries can be determined and a decision can be made regarding whether or not a reassessment of the costs and benefits of implementing a recommendation is warranted.

TYPES OF RECOMMENDATIONS MADE BY THE OMO

OMO recommendations can be classified as one of several types:

- Web site and print material, or publication recommendations
- Outreach, education, and training effort recommendations
- Inter-agency and intra-agency communication recommendations
- Policy and regulation recommendations
- Assessment, data collection, monitoring recommendations

Figure 9 shows the percentages of recommendations that are associated with each category.

Web Site and Print Material, or Publications

Recommendations related to Web sites and print materials, or publications are the most common type. These recommendations can include revisions, additions, or updates to content on www.cms.gov, www.Medicare.gov, or other Web sites, such as www.ssa.gov. Recommendations can also include creating or updating materials or publications, such as the *Medicare & You* handbook, Initial Enrollment Package, fact sheets, or forms.

In one such recommendation, the OMO suggested that CMS enhance information about self-administered drug (SAD) coverage. In response to the recommendation, CMS took several actions, such as updating a fact sheet that explains how hospital status affects the amount that a beneficiary pays for hospital services,[7] updating www.Medicare.gov to include a publication that provides information about how to get reimbursed through Medicare Part D for SADs received in hospital outpatient settings,[8] and updating www.Medicare.gov to include other information regarding limited outpatient prescription drug coverage.[9,10]

Additionally, the OMO recommended that CMS develop an employer community portal within www.Medicare.gov or www.cms.gov to facilitate access to resources meant to assist employers (and other stakeholders who commonly advise employers) in providing guidance to their Medicare-eligible and Medicare-enrolled employees and retirees. The portal would include information or links to other resources related to important topic areas (e.g., Medicare enrollment, coordination of benefits [COB], specific beneficiary populations). This recommendation would have required several divisions within CMS to contribute content. Consequently, at the time of this recommendation's release, the CMS Office of Communications did not have the resources to pursue it. The OMO continues to monitor the opportunity to advance this recommendation.

Another recommendation called for improved accessibility to a publication titled *Medicare and Other Benefits: Your Guide to Who Pays First*.[11] This important reference needed to be more easily accessible for beneficiaries seeking COB information. To address this recommendation, CMS made the publication easier to find on www.Medicare.gov—it now appears as either the

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[7] Centers for Medicare & Medicaid Services. (2011). *Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask?* (CMS Pub#11435). Retrieved from http://www.medicare.gov/Pubs/pdf/11435.pdf.

[8] Centers for Medicare & Medicaid Services. (2011). *How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings*. (CMS Pub#11333). Retrieved from http://www.medicare.gov/Pubs/pdf/11333.pdf.

[9] Medicare.gov. *Drug Plan Coverage Rules*. Retrieved from http://www.medicare.gov/part-d/coverage/rules/drug-plan-coverage-rules.html.

[10] Medicare.gov. *Your Medicare Coverage*. Retrieved from http://www.medicare.gov/coverage/prescription-drugs-outpatient-limited-coverage.html.

[11] Centers for Medicare & Medicaid Services. (2011). *Medicare and Other Health Services: Your Guide to Who Pays First.* (CMS Pub#02179). Retrieved from http://www.medicare.gov/Pubs/pdf/02179.pdf.

FIGURE 9. DISTRIBUTION OF RECOMMENDATIONS BY TYPE

SOURCE: OMO
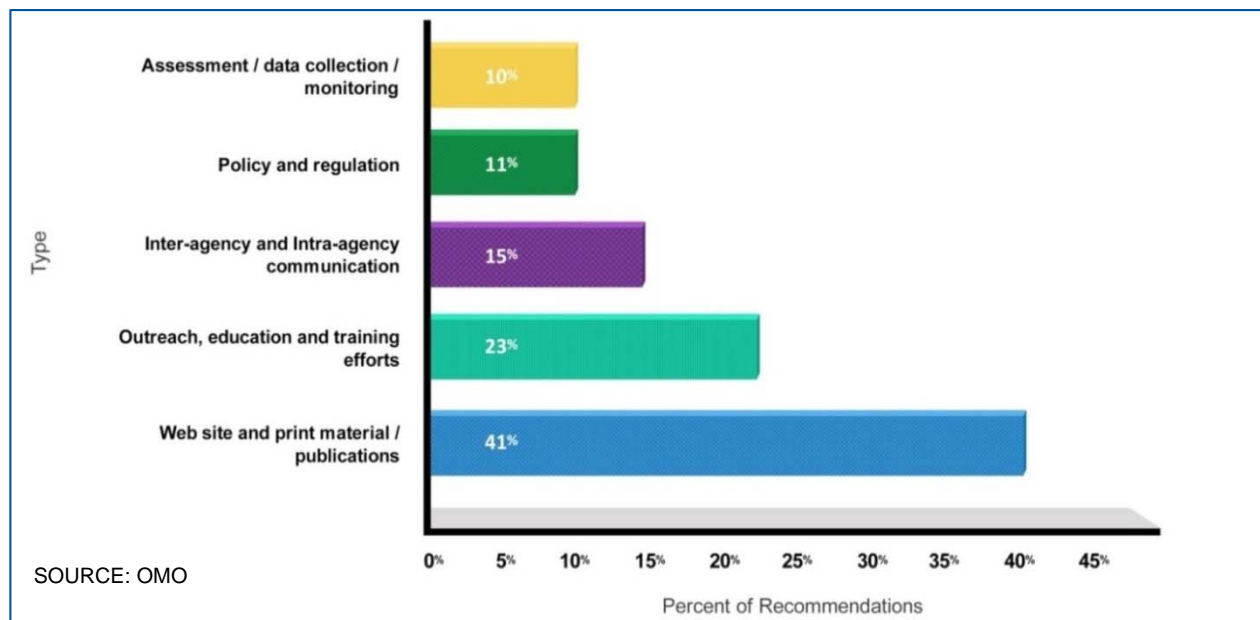
first or second result in most searches on www.Medicare.gov that reference "coordination of benefits." In addition, this information is more prominently featured in the *Medicare & You* handbook. The OMO also leveraged its relationships with external partners to help publicize this information.

Outreach, Education, and Training

The second most common type of recommendation involves outreach, education, and training efforts. These recommendations include such activities as outreach events to communicate and distribute information or additional training and guidance. These outreach and education efforts can be targeted to a variety of audiences, such as beneficiaries, providers, employers, or advocates. Examples of outreach and education recommendations are those relating to the Medicare Secondary Payer Conditional Payment Recovery Process, which can be complex and confusing for beneficiaries. The OMO recommended increased outreach and education to beneficiary advocates

and legal representatives so they could better support beneficiaries. In May 2013, CMS' Medicare Secondary Payer Recovery Audit Contractor held a series of webinars to educate stakeholders on the Medicare Secondary Payer process. Similar webinars are planned for the future and will include beneficiaries and their representatives. CMS has also met with organizations that provide beneficiaries with representation in these matters for discussing targeted concerns and plans to continue those efforts.

Inter-Agency and Intra-Agency Communication

Throughout its history, the OMO has established relationships through partnerships, collaboration, and coordination to improve Medicare. Inter-agency and intra-agency communication recommendations are associated with a new or enhanced communication effort within CMS or with other internal and external partners, such as the Social Security Administration, State Health Insurance Assistance Programs, and the Internal Revenue Service.

Based on its research into provider balance billing[12] of Medicare-Medicaid enrollees, the OMO recommended that CMS convene key components within the agency that are involved with Medicare-Medicaid enrollee issues, including the Center for Medicaid and Children's Health Insurance Program Services, and the Center for Medicare, to identify internal process improvements that would help mitigate potential challenges for beneficiaries and providers. This need to collaborate further on Medicare-Medicaid enrollee issues contributed to the Affordable Care Act's subsequent establishment of the Federal Coordinated Health Care Office.

Policy and Regulation

The OMO's authorizing legislation states, "[The] Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies."[13] The OMO has identified policies that are potentially not being applied as Congress intended and that may lead to unintended consequences for beneficiaries. This type of policy-related recommendation may also include the improvement of processes or the creation of a new process within CMS that is necessary to correctly execute a policy. Provider use of beneficiary notices is one of the policies that the OMO recommended for review. The OMO has recommended that providers increase their use of beneficiary notices in certain circumstances where Medicare coverage depends on a variety of factors, as in the case of home health services or ambulance services. Over the past several years, CMS has streamlined and simplified beneficiary protection notices, developed guides for several notices, and provided guidance to providers via an advanced beneficiary

notice informational update on the Medicare Learning Network.[14]

Assessment, Data Collection, Monitoring

These recommendations involve collecting and monitoring additional data elements to better assess the scope of an issue or the impact of a policy. With access to additional data sources, CMS has the opportunity to assess the effectiveness of various aspects of Medicare.

One example is the OMO's recommendation that CMS create a standard process for all Medicare entities to report beneficiary inquiries, complaints, and issues. This standardization will aid efforts to track trends and problems across the Medicare program. Subsequently, the Complaint Tracking Module to track Parts C and D complaints, and the Medicare Administrative Issues Tracking and Reporting of Operations System to track Parts A and B complaints, were developed. The OMO consolidates data from these sources and several others into a monthly and quarterly Beneficiary Contact Trend report. A high-level summary of these data is available in appendix A.

Looking Forward

As the OMO continues to assist beneficiaries with Medicare, it will monitor the impact of recommendation implementation on the volume of inquiries, complaints, and appeals when possible. As illustrated in appendices A and B, the OMO reviews and analyzes data from a variety of systems to identify trends in beneficiary concerns. The OMO will also continue its work on tracking and facilitating new and existing recommendations to support the improvement of Medicare for beneficiaries.

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[12] "Balance billing" refers to the practice of providers' wrongly attempting to bill beneficiaries for amounts above the rates that Medicare or Medicaid authorizes them to receive.

[13] 42 CFR §1395b1-9.

[14] Centers for Medicare & Medicaid Services. (2013). *Advanced Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131.* (MLN #MM8404). Retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8404.pdf.

ISSUES AND RECOMMENDATIONS REGARDING BENEFICIARY CONCERNS

The OMO conducted three comprehensive studies in fiscal year 2013; this section summarizes the topics of those studies and the corresponding recommendations made to CMS based on study findings.

INTRODUCTION

The Office of the Medicare Ombudsman (OMO) conducted three comprehensive studies in fiscal year (FY) 2013 that enhanced the OMO's understanding of the root causes of issues. The study topics included (1) the OMO's role in Medicare claims appeals made by beneficiaries, (2) beneficiary liability for ambulance services, and (3) implications of the Affordable Care Act's Health Insurance Marketplace for Medicare beneficiaries and individuals becoming Medicare eligible. The *Improving Medicare: OMO Efforts to Foster Program Change* section of this report explains the categories of recommendations.

The subsections below present summaries of each of the study topics, the studies' findings, and the recommendations made to Centers for Medicare & Medicaid Services (CMS) leadership and other stakeholders within the agency. The OMO will track the implementation of study recommendations, and, in some instances, OMO staff will support and help guide the implementation process (see the *Improving Medicare: OMO Efforts to Foster Program Change* section). This section also includes FY 2013 updates on other issues that the OMO was monitoring in FY 2012.
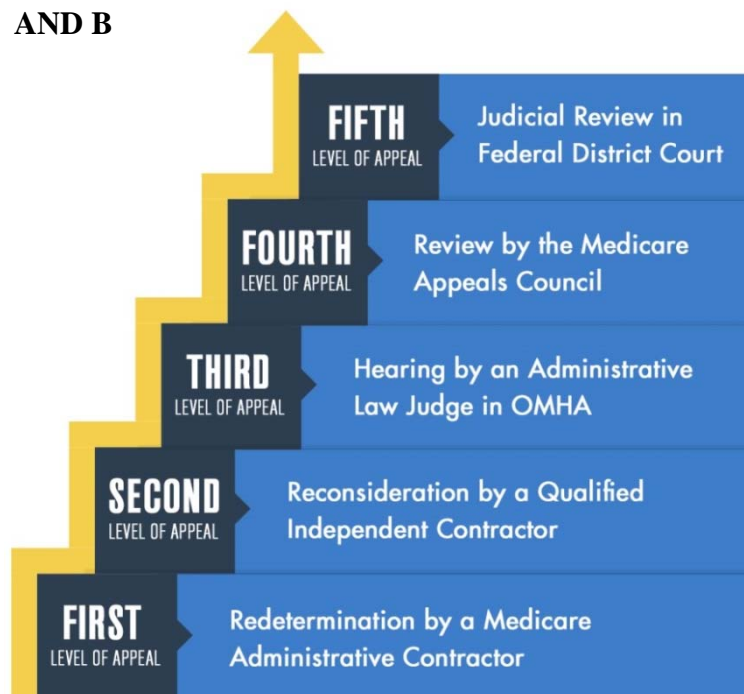
23

THE ROLE OF THE OMO IN BENEFICIARY APPEALS

Medicare beneficiaries, Medicare providers (e.g., physicians, suppliers, and hospitals), and state Medicaid agencies[15] may appeal CMS payment decisions related to health care claims. The standard appeals process for Medicare Parts A and B, which includes five levels, is illustrated in figure 10. If an appellant receives an unfavorable decision at one level, he or she may appeal to the next level.[16] Medicare beneficiaries enrolled in Part C or Part D health plans have similar appeal rights when the plan denies coverage or payment of a health care claim.[17]

According to its statutory mandate, the OMO has a responsibility to assist beneficiaries with complaints and grievances. Specifically, the OMO must provide "assistance in collecting relevant information for [beneficiaries] to seek an appeal of a decision or determination."[18] Although providers submit the majority of appeals, the OMO's comprehensive study focused on beneficiary-initiated appeals, given its statutory mandate.

FIGURE 10. THE FIVE LEVELS OF THE APPEALS PROCESS FOR MEDICARE PARTS A AND B

FIFTH LEVEL OF APPEAL — Judicial Review in Federal District Court

FOURTH LEVEL OF APPEAL — Review by the Medicare Appeals Council

THIRD LEVEL OF APPEAL — Hearing by an Administrative Law Judge in OMHA

SECOND LEVEL OF APPEAL — Reconsideration by a Qualified Independent Contractor

FIRST LEVEL OF APPEAL — Redetermination by a Medicare Administrative Contractor

As part of this responsibility, the OMO monitors appeals trends through a monthly and quarterly review of Medicare Appeals System data and other beneficiary contact trend data. The OMO also provides informal individual counseling to Medicare beneficiaries going through the appeals process when inquiries and complaints received by the office require such assistance. In addition, it communicates with the U.S. Department of Health & Human Services (HHS) Office of Medicare Hearings and Appeals (referred to as OMHA in figure 10) and the Medicare Enrollment and Appeals Group within the Center for Medicare in an effort to better understand the broader policy issues regarding appeals and to identify other actions that it could take to improve the appeals process for beneficiaries.

Discussions with Office of Medicare Hearings and Appeals personnel prompted the OMO to investigate whether it needed to expand its role in assisting beneficiaries through the appeals process. The OMO aimed to:

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[15] State Medicaid agencies may appeal whether Medicare rather than Medicaid should pay for the services or items received by Medicare-Medicaid enrollees.

[16] The first two levels of appeal do not require a minimum dollar amount to be at issue, but the Administrative Law Judge and judicial review levels do. For calendar year 2013, the threshold for Administrative Law Judge hearings is $140, and the threshold for judicial review is $1,400. None of the levels of appeal require appellants to pay a filing fee. For more information, see https://www.federalregister.gov/articles/2012/09/28/2012-23992/medicare-program-medicare-appeals-adjustment-to-the-amount-in-controversy-threshold-amounts-for.

[17] Levels three through five of the appeals process also apply to Part C and D enrollees, with the first two levels occurring at the plan and an Independent Review Entity, respectively.

[18] Social Security Act §1808(c)(2)(B), Medicare Beneficiary Ombudsman, http://www.ssa.gov/OP_Home/ssact/title18/1808.htm.

- Understand the scope and specific nature of the challenges encountered by beneficiaries during the appeals process.
- Identify opportunities to improve the current system.
- Determine how the OMO can address the challenges that beneficiaries and those who assist them face during the appeals process.

The OMO was particularly concerned with determining which additional activities it could undertake that would complement the existing support network,[19] fulfill unmet needs, and fall within the OMO's scope of authority.

In an effort to understand the challenges that beneficiaries may confront during the appeals process, the OMO:

- Analyzed appeals data, including provider- and beneficiary-initiated appeals.
- Conducted an environmental scan of appeals-related educational resources for beneficiaries.
- Held discussions with Central Office (CO) and Regional Office (RO) staff, State

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[19] The existing support network includes SHIP counselors; advocacy groups, such as the Center for Medicare Advocacy and the Medicare Rights Center; and CMS caseworkers from OMO and CMS ROs.

Health Insurance Assistance Programs (SHIPs), and advocacy groups that assist beneficiaries with appeals. One of the issues that emerged from the study, related to beneficiary understanding of Parts C and D plan coverage, was the use of network and non-network providers. The OMO is planning a separate study to examine whether beneficiaries and providers need additional education regarding the use of network versus non-network providers, including pharmacy networks.

Environmental Scan of Notifications and Educational Information Resources

Parts A and B
Five kinds of coverage and payment notifications can be considered educational resources for beneficiaries. These notices include information about the steps a beneficiary can take to request a coverage decision or appeal for Parts A and B services:

- *Medicare Summary Notice* (MSN): This notice, which lists claims, Medicare Administrative Contractor (MAC) coverage, and payment decisions, is sent to beneficiaries every 3 months.
- *MyMedicare.gov:* On this site, beneficiaries can view their claims 24 hours after a MAC has made a decision.
- *Inpatient Hospital Notice*: Acute care hospitals issue *An Important Message from Medicare About Your Rights* (IM) to all Medicare patients at the time of admission and at the time of discharge if the discharge occurs more than 2 days after the initial delivery of the IM.
- *Service Termination Notice*: Skilled Nursing Facilities (SNFs), home health agencies, comprehensive outpatient rehabilitation facilities, and hospices give written notice to beneficiaries before ending Medicare-covered services or discharging beneficiaries from their care.

The notice states the provider's opinion that the beneficiary no longer meets Medicare's coverage rules for the service.

- *Advance Beneficiary Notice of Noncoverage (ABN):* Medicare Parts A and B health care providers and suppliers may issue one of the CMS-approved ABNs prior to providing a usually covered item or service that is not expected to be covered in a particular instance. The ABN informs the beneficiary that the service may not be covered, that the notice does not represent an official Medicare decision, and that Medicare must be billed for the beneficiary to obtain an official decision about payment and appeal rights. In certain situations, issuing an ABN shifts financial liability for the cost of the item or service from the provider or supplier to the beneficiary.

Parts C and D

Part C Medicare Advantage (MA) and Part D drug plans send Explanation of Benefit statements (EOBs) to beneficiaries following their receipt of medical services. Like MSNs, EOBs provide a list of claims (including denials), the cost of the claims, and the beneficiary liability/cost share. Part C plans are also required to provide a notice of denial of medical coverage and a notice of denial of payment. Plans can issue the notices separately from the EOB or include the mandatory language in the EOB itself.[20]

Beginning in April 2014, MA organizations will be required to send a plan member an EOB (1) in the month following the one in which his or her claims for medical and supplemental benefits were processed, or (2) for each claim, in addition to sending quarterly summary EOBs. CMS provided

EOB templates to Part C plans, detailing appropriate format and language.[21]

In addition to these notifications, the scan identified targeted information documents, which were found to be generally effective in providing beneficiaries with the information they need to file an appeal. Notably, the CMS publication *Medicare Appeals* and the Medicare Web site clearly explain the appeals process for Parts C and D plans. However, the OMO also identified potential areas of improvement in beneficiary education on appeals in these plans. In particular, beneficiaries often need a simple explanation of the appeals process and straightforward directions for filing their appeals.

Findings

The following findings can be used to improve or supplement existing educational resources:

- *The type of publication is critical.* Self-help packets have advantages over handbooks, Web sites, and other publications because they are targeted and action-oriented.
- *Concision is key for clear communication.* The length of educational publications for beneficiaries varied greatly, ranging from a few Web pages to more than 50 pages of text. Longer materials can be a challenge for beneficiaries to navigate, yet shorter resources may leave out some important information. A balance between length and essential information should be sought.
- *Publications should contain actionable information.* Publications that clearly laid out the actions that beneficiaries need to take during the appeals process, such as

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[20] "MA Denial Notices." Retrieved from http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html.

[21] The "Part C EOB" materials are available online at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html.

noting deadlines for submitting appeals and the particular forms that need to be completed, were deemed the most helpful.

- *The resource should be related to a specific appeal type and indicate how it differs from other types.* All resources differentiated among Medicare Parts A, B, C, and D appeals. Some resources also discussed appeals for specific situations, such as inpatient care, SNF care, observation services, and physical therapy appeals. Key informants mentioned that beneficiaries noted that specificity increased the resource's utility.

Discussions with CMS caseworkers and SHIP counselors identified areas where the OMO can assist with process improvements, and/or create or revise educational materials. The major findings of these discussions are as follows:

- In the case of beneficiary-initiated appeals, beneficiaries are sometimes unaware that a claim has been denied and then have difficulty gathering the necessary information related to the service denial. This situation occurs because MSNs are only provided quarterly, or every 3 months, and many beneficiaries are not aware that more timely information is available on MyMedicare.gov or by contacting 1-800-MEDICARE.
- Beneficiaries enrolled in Parts C and D plans may not adequately understand the impact of using network providers, and beneficiaries and providers may not adequately understand which drugs are not covered under Part D. SHIP counselors often have difficulty finding up-to-date, appeals-related contacts at Part C and D health plans. SHIP staff members use varying processes for (1) referring appeals-related beneficiary contacts to CMS

customer service representatives (CSRs) and (2) obtaining information on the status of beneficiary appeals cases assigned to them.

Recommendations

The OMO identified potential opportunities for CMS interventions that address process improvements and that support and complement the existing appeals-process network. Recommendations are categorized into three groups: (1) those concerning SHIP staff, (2) those concerning beneficiary resources, and (3) those concerning information gathering.

The following recommendation aims to help SHIP counselors more broadly understand the resources available to them so that they can better assist beneficiaries with appeals:

- Ensure that SHIP counselors know how to appropriately refer appeals-related cases to other CMS customer service segments and where to find appeals-related contact information for CMS and Part C and Part D plans.

Recommendations to CMS for improving beneficiary appeals resources include:

- Developing additional beneficiary education materials.
- Improving the placement of existing appeals resources on Medicare.gov.
- Considering revising and recirculating previously available publications.

Recommendations to CMS for helping beneficiaries gather necessary information include:

- Assessing the feasibility of providing more timely or more frequent notifications when claims are denied.
- Enhancing beneficiary education on the availability of claims information through MyMedicare.gov and 1-800-MEDICARE.

MEDICARE BENEFICIARY LIABILITY FOR AMBULANCE SERVICES

Denial of ambulance services is one of the most common reasons for beneficiary-initiated appeals under Medicare Part B. In 2011, more than 739,000 beneficiaries had one or more denied ambulance claims. That year, 13.98 percent of all beneficiary-initiated appeals were for ground ambulance services. Denials for ambulance services may be particularly important to consider because beneficiaries may not understand which ambulance services meet the statutory definition of an ambulance service covered by Medicare. In many cases, the usual liability protections for denials on "reasonable and necessary" grounds do not apply. Data on the number of beneficiaries who were held liable for payment of denied ambulance services are not available; however, approximately 14 percent of beneficiary-initiated appeals for Medicare Part B in 2011 were for ambulance services, indicating that some beneficiaries have been held liable for ambulance service charges.

The specific definition of what constitutes a covered ambulance service and whether a particular service meets this definition can be difficult to understand for those not familiar with Medicare requirements. Nevertheless, beneficiaries need to know which services meet the statutory definition in order to know whether or not they can be held financially liable for the cost of the transport.

Medicare liability protections for beneficiaries apply when a service that meets the statutory definition of a covered service is denied because it was deemed not "reasonable and necessary" in that particular instance. However, many ambulance services are denied because they do not meet the statutory definition of a covered service at all, so the usual liability protections for denials on "reasonable and necessary" grounds do not apply. Therefore, Medicare beneficiaries may unknowingly be financially liable for some ambulance services that are denied by Medicare.

Through involvement with the claim appeals process, the OMO learned that the parameters of what Medicare considers to be covered ambulance services might not be clear to some beneficiaries or to the health care providers who arrange for transport services on behalf of beneficiaries.

The OMO examined the circumstances that may lead Medicare to deny coverage or payment of ambulance services and identified strategies for reducing the situations in which beneficiaries are unknowingly assuming financial liability for payment of ambulance services. To gain a better understanding of the circumstances that contribute to denials of ambulance claims and to develop approaches to minimizing unexpected beneficiary liability for ambulance services, the OMO:

- Interviewed ambulance service stakeholders and CMS subject-matter experts, CMS beneficiary services staff, beneficiary advocates, SHIPs, and ambulance industry associations.
- Analyzed Medicare claims and appeals data.
- Examined MAC local coverage policies and geographic variations in denials.
- Conducted an environmental scan of existing informational materials available to beneficiaries and providers.

Overview of Medicare Ambulance Coverage Policy

Medicare will only cover ambulance transport in limited circumstances. For Medicare to pay for ambulance transport, it must be:

1. A *covered benefit*, which means that other methods of transportation are contraindicated by the beneficiary's medical condition and that other coverage requirements are met.
2. Reasonable and necessary for the beneficiary at the particular time.
3. Used to obtain (or return from obtaining) a Medicare-covered service.
4. From a covered origin and to a covered destination.

Specifically, Medicare will only cover an ambulance transport when "the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations."[22] In other words, Medicare will only cover an ambulance transport if the beneficiary's condition at the time of transport is such that transport by other means would endanger the beneficiary's health (regardless of whether another mode of transportation is actually available to the beneficiary). For an ambulance service to be considered medically necessary, the beneficiary's condition must require the ambulance transport itself and the level of service provided.[23]

If the beneficiary could have been transported in another manner without endangering his or her health, the transport is not a covered Medicare benefit, as previously noted, and the beneficiary may be held liable for the charges.

An ambulance transport claim could be denied because the service type or level provided was not "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member"[24] (the threshold coverage standard for most Medicare benefits). In the case of ambulance services, this definition can encompass the appropriateness of the level of the service (e.g., basic versus advanced life support), the method of delivery (e.g., ground versus air transport), or the efficiency of delivering another service (e.g., bringing a portable x-ray machine to a nursing home rather than having an ambulance transport a nursing home resident to and from the hospital).

Medicare regulations and the Medicare Benefit Policy Manual also stipulate that for an ambulance transport to be covered, beneficiaries must use it to obtain a Medicare-covered service or to return from receiving a Medicare-covered service,[25] and the transport must meet origin and destination requirements.[26] Medicare will only cover ambulance transports between the following places:

- From any point of origin to the nearest hospital, critical access hospital (CAH), or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury.
- From a hospital, CAH, or SNF to the beneficiary's home.
- From a SNF to the nearest supplier of medically necessary services not available at the SNF (includes return trip).
- From the home of a beneficiary who is receiving renal dialysis for the treatment of end-stage renal disease (ESRD) to the nearest renal dialysis facility (includes return trip).[27]

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[22] The ambulance benefit is defined in Section 1861(s)(7) of the Social Security Act.
[23] 42 CFR § 410.40(d).

[24] Social Security Act § 1862(a)(1)(A).
[25] Medicare Benefit Policy Manual, Ch. 10, § 10.2.1.
[26] 42 CFR § 410.40(e).
[27] 42 CFR § 410.40(e).

Findings

Beneficiaries may unknowingly be held financially liable for ambulance services because of the complex structure of the ambulance benefit and possibly because of misunderstandings regarding the benefit's limitations.

Furthermore, when the transport does not meet the statutory definition of a covered ambulance service, Medicare's usual beneficiary liability protections for denials on "reasonable and necessary" grounds do not apply. In addition, for non-covered services (services that do not meet the definition of a covered ambulance service), a provider is not required to issue an ABN, which would give the beneficiary notice that he or she may be liable for non-covered charges. Thus, a beneficiary may not know in advance that he or she may be liable for ambulance transport charges unless the provider voluntarily issues an ABN.

Medicare-Medicaid enrollees are more likely to have multiple Medicare ambulance claim denials than those with only Medicare.

Circumstances

The OMO analyzed claims data to determine whether denials of payment are more likely to occur in emergency or non-emergency situations. The results showed that denial rates are higher when an ambulance transport is for a non-emergency situation than for an emergency situation.

Destination

The OMO identified the ambulance transport routes that are most likely to be denied. They include:

- *Transport to a physician's office.* In most situations, Medicare does not cover ambulance transport to a physician's office. These transports are covered only when the ambulance is on its way to a Medicare-covered destination; the

ambulance stops en route at a physician's office because the patient has a dire need for professional attention; and, immediately thereafter, the ambulance continues to a covered destination.[28]

- *Transport to and from a renal dialysis facility.* Medicare will cover transports to and from the nearest appropriate renal dialysis facility for beneficiaries who are receiving treatment for ESRD and whose condition necessitates an ambulance transport. However, transports to renal dialysis facilities are usually non-emergency, scheduled, and repetitive. Ambulance transport due to convenience or because transportation by another means is difficult is not deemed medically necessary, and the service may be denied.

- *Transport from one provider to another.* Medicare will only cover transport from one institution to another if the original institution does not have adequate or available facilities to provide the required care.[29] In such cases, mileage payment for the transport would be made only to the extent of the mileage to the nearest institution that has the appropriate and available facilities.

Beneficiary Characteristics

Relatively few beneficiaries account for a large share of denied ambulance claims. In 2011, more than 5.1 million beneficiaries had claims for ambulance transports. For the majority of these beneficiaries (more than 85 percent), Medicare paid for all submitted claims. However, a small number of beneficiaries (34,532) each had more than five denied ambulance claims. These beneficiaries'

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[28] Medicare Benefit Policy Manual, Chapter 10, 10.3.8.
[29] Medicare Benefit Policy Manual, Chapter 10, 10.3.2.

claims represent nearly 40 percent of the total number of denied transport claims. Medicare-Medicaid enrollees[30] account for a substantial share of the beneficiaries whose ambulance claims are denied.[31] Some states require that a claim for someone who is eligible for both Medicare and Medicaid be submitted to Medicare first; only after Medicare denies it will the claim be paid under a state's broader Medicaid benefit.[32] In addition, Medicare-Medicaid enrollees are more likely to have multiple ambulance claim denials than those with only Medicare. Partial-year Medicare-Medicaid enrollees[33] have a higher rate of ambulance claim denials than beneficiaries who are only eligible for Medicare or those who are eligible for both programs for the entire year. These results may indicate that some providers or beneficiaries do not understand that Medicare ambulance coverage is more restrictive than Medicaid coverage in some cases.

Geographic Variation

The OMO analyzed ambulance claims data to determine whether denial rates varied across geographic areas and in urban versus rural areas. Some states were found to have higher rates of denied ambulance claims, including Texas (23.42 percent), New Mexico (23.09 percent), Nevada (14.99 percent), Utah (14.64 percent), Georgia (14.41 percent), and Colorado (14.01 percent). Additionally, Washington, D.C. (18.75 percent),

and Puerto Rico (37.79 percent) had high denial rates for ambulance claims.

When the transport was an emergency transport, denial rates were higher in urban settings (8.47 percent) compared with rural settings (6.77 percent). When the transport was a non-emergency transport, denial rates were higher in rural settings (14.08 percent) than in urban settings (12.15 percent). Interviewed stakeholders suggested anecdotally that beneficiaries in rural areas who have to travel long distances to a hospital might find the distance itself or possible adverse driving conditions challenging, and opt to call an ambulance. Additionally, beneficiaries in rural areas may not have people to drive them to receive treatment and so may choose to call an ambulance.

The OMO also found that local coverage determinations (LCDs) do not explain variations in ambulance denial rates across MAC regions. MACs may issue LCDs that set forth coverage criteria not otherwise addressed in regulations or guidance. These LCDs, which may vary slightly between contractor jurisdictions, may result in differing coverage determinations across the country. However, differences in LCDs across MACs are relatively minor, suggesting that their effect on coverage differences may be limited. Further, average denial rates vary across regions that use the same ambulance LCDs, and variation occurs within a MAC region among states that use the same LCD.

Figure 11 presents overall ambulance claims and denial data as well as characteristics associated with variation in the rates of denial.[34] Following a redetermination by a MAC, level II appeals (referenced in figure 11) are made to Qualified

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[30] In this discussion on ambulance services, the term "Medicare-Medicaid enrollees" is used to refer only to Medicare beneficiaries who are also eligible for Medicaid benefits, including ambulance benefits. It does not include Medicare beneficiaries who only receive Medicaid assistance with Medicare cost-sharing or payment of premiums.

[31] The number of Medicare beneficiaries liable for charges related to a denied claim is lower than the number of denied claims because Medicaid may cover the service or because one beneficiary may have multiple denied claims.

[32] Some Medicaid programs have broader coverage for ambulance transport than Medicare.

[33] The term "partial-year Medicare-Medicaid enrollees" refers to beneficiaries who are only eligible for Medicaid benefits (including ambulance benefits) for part of a year in which they are enrolled in Medicare.

[34] The analysis includes appeals submitted through Fee-for-Service (FFS)-Part B and FFS-Part B of A in the analysis of Part B appeals. Only nine level II appeals for transportation were submitted through Medicare Part A, of which two were beneficiary initiated. Ground transportation is not the most common beneficiary-initiated appeal for Medicare Part A.

Independent Contractors. These findings suggest that opportunities exist to educate beneficiaries and health care providers who schedule ambulance transports for beneficiaries. Easily available resources to educate beneficiaries and providers about covered ambulance benefits and potential beneficiary liability are particularly important.
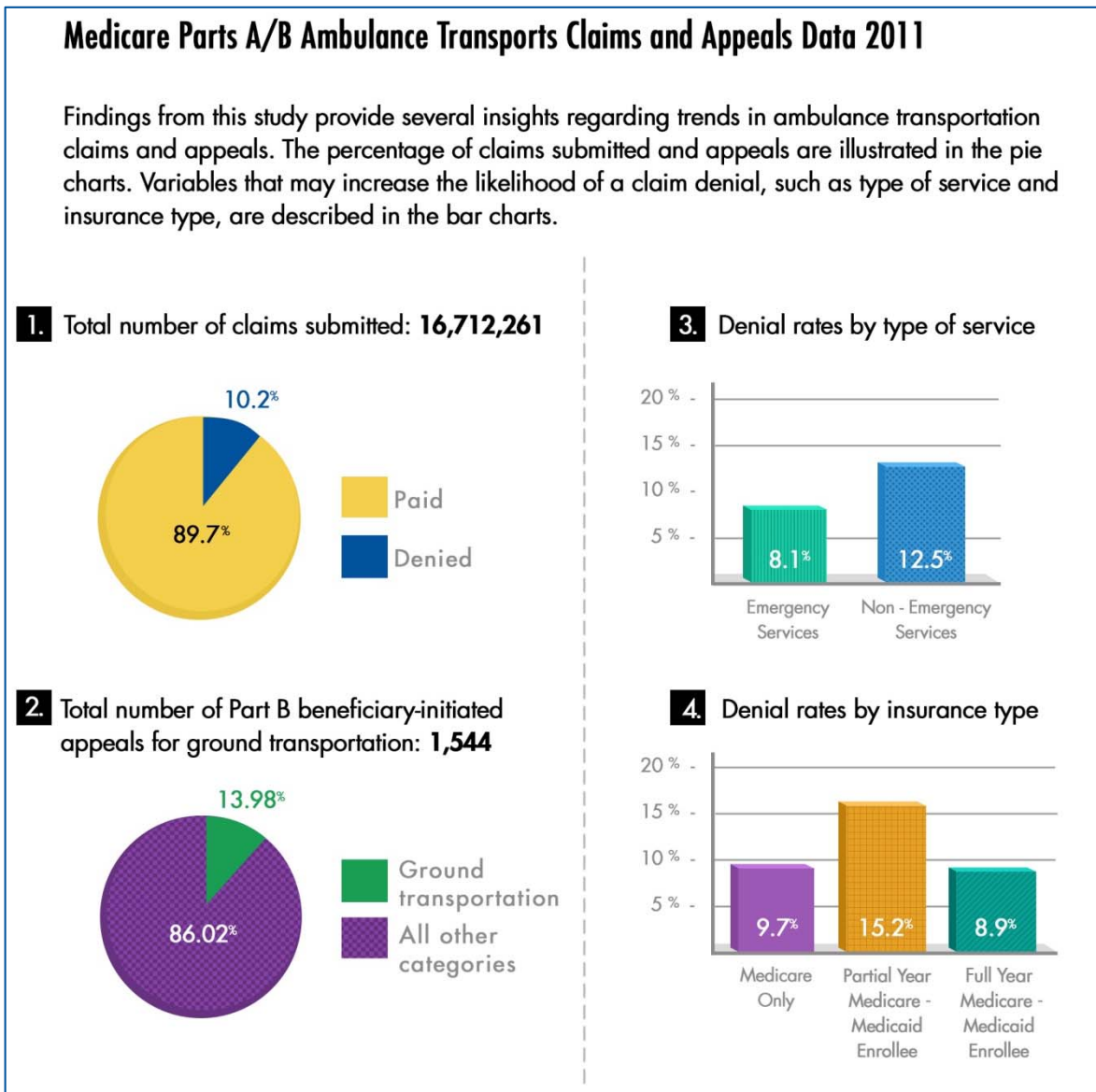
Recommendations

The OMO developed the following recommendations regarding information,

resources, and other improvements that may help beneficiaries and providers better understand the limitations of Medicare ambulance coverage and decrease unexpected financial liability:

- Develop targeted educational materials for beneficiaries, caregivers, and providers that explain the ambulance service benefit.
- Add more specific language to the *Medicare & You* handbook on the limitations of ambulance coverage, such as the fact that in most cases, Medicare will

FIGURE 11. MEDICARE PARTS A AND B AMBULANCE TRANSPORT CLAIMS AND APPEALS DATA, 2011

Medicare Parts A/B Ambulance Transports Claims and Appeals Data 2011

Findings from this study provide several insights regarding trends in ambulance transportation claims and appeals. The percentage of claims submitted and appeals are illustrated in the pie charts. Variables that may increase the likelihood of a claim denial, such as type of service and insurance type, are described in the bar charts.

1. Total number of claims submitted: **16,712,261**
   - 10.2% Denied
   - 89.7% Paid

2. Total number of Part B beneficiary-initiated appeals for ground transportation: **1,544**
   - 13.98% Ground transportation
   - 86.02% All other categories

3. Denial rates by type of service
   - Emergency Services: 8.1%
   - Non-Emergency Services: 12.5%

4. Denial rates by insurance type
   - Medicare Only: 9.7%
   - Partial Year Medicare - Medicaid Enrollee: 15.2%
   - Full Year Medicare - Medicaid Enrollee: 8.9%

not cover ambulance transport to a physician's office.

- Consider the feasibility of providing targeted education to beneficiaries identified as having frequent denials based on claims analysis.
- Consider the feasibility of providing more timely notifications via MSNs to beneficiaries when claims are denied.

UNDERSTANDING THE POTENTIAL IMPLICATIONS OF THE AFFORDABLE CARE ACT'S HEALTH INSURANCE MARKETPLACE FOR MEDICARE BENEFICIARIES AND INDIVIDUALS BECOMING MEDICARE ELIGIBLE

The Affordable Care Act, signed into law in March 2010, put into place comprehensive reforms intended to improve access to health coverage. A critical element of the law is the creation of Health Insurance Marketplaces, through which consumers can choose private health insurance plans that fit their health needs. The Marketplaces, also known as health insurance "Exchanges," enable consumers to shop for qualified health plans;[35] apply for determinations of eligibility for coverage through the Marketplace and for affordability programs, such as reduced premiums or cost sharing or Medicaid or Children's Health Insurance Program (CHIP) coverage; and enroll in coverage.[36]

There are three options for the formation and operation of Marketplaces:

1. State-Based Marketplace (SBM): The state operates the Marketplace.
2. Federally Facilitated Marketplace (FFM): The federal government operates the Marketplace.
3. State Partnership Marketplace (SPM): A type of Federally Facilitated Marketplace in which the state engages actively with the federal government to operate certain aspects of the Marketplace.

The District of Columbia and 17 states are operating SBMs, and CMS is operating an FFM in 33 states, seven of which are SPMs. Eligible consumers could begin enrolling in coverage purchased through the individual health insurance Marketplaces on October 1, 2013, with coverage taking effect as early as January 1, 2014.

Medicare is not part of the Marketplaces established by the Affordable Care Act, so beneficiaries do not have to replace Medicare coverage with Marketplace coverage. Regardless of whether beneficiaries have original Medicare (Parts A and B) or an MA Plan (Part C), their benefits will remain largely the same, with few changes.[37] Provisions of the Affordable Care Act require that Medicare now cover certain preventive services (e.g., screening mammograms, screening colonoscopies, and yearly "Wellness" visits) without charging beneficiaries co-insurance or applying the Part B deductible.[38] The Affordable Care Act also affects the "donut hole"—the gap in Part D prescription drug coverage when out-of-pocket expenses are not covered until catastrophic coverage applies. Under the Affordable Care Act, beneficiaries in

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[35] HealthCare.gov provides the following definition of a qualified health plan: *Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.* Retrieved from https://www.healthcare.gov/glossary/qualified-health-plan/.
[36] WhiteHouse.gov. (2013). *About the New Law*. Retrieved from http://www.whitehouse.gov/healthreform/healthcare-overview.

[37] Medicare.gov. (2013). *Medicare & the Marketplace*. Retrieved from http://www.medicare.gov/about-us/affordable-care-act/medicare-and-the-Marketplace.html.
[38] HealthCare.gov. (2014). *What If I Have a Marketplace Plan but Will Be Eligible for Medicare Soon?* Retrieved from https://www.healthcare.gov/what-if-i-have-a-marketplace-plan-but-will-be-eligible-for-medicare-soon/.

the donut hole automatically receive a 50 percent discount when buying brand-name prescription drugs covered by Part D. The law also incrementally closes the donut hole by 2020.

The Medicare open-enrollment period is the time when all people with Medicare are encouraged to review their current health and prescription drug coverage, including any changes in costs, coverage, and benefits that will take effect in the next year. Although the 2014 Marketplace open-enrollment period for the individual market (October 1, 2013, through March 31, 2014) overlapped with the Medicare open-enrollment period (October 15, 2013, through December 7, 2013), Medicare's open enrollment is not part of the Marketplace, as it is generally against the law to sell an individual market Marketplace plan that is known to duplicate Medicare coverage to someone who has Medicare coverage.

Individuals who will not become eligible for Medicare until after Marketplace coverage is available generally can sign up for a Marketplace plan to obtain coverage before their Medicare coverage begins. These individuals can then terminate their Marketplace coverage once Medicare coverage begins if they so choose. It is advantageous for individuals to sign up for Medicare when they first become eligible to avoid late-enrollment penalties. In addition, once they are considered to be eligible for Medicare Part A coverage, individuals will not be able to qualify for subsidies to get lower costs for Marketplace plans based on their incomes.[39]

> **Future beneficiaries would benefit from receiving notification of their Medicare eligibility status and potential late enrollment penalties.**

Many individuals enrolled through a Marketplace may eventually age into Medicare or otherwise qualify due to disability or ESRD. Thus, many individuals who purchased coverage through a Marketplace will eventually need to make Medicare enrollment decisions, so it is critical that they be made aware of their Medicare eligibility and important considerations for enrollment in Medicare. Adequate outreach and education for Medicare beneficiaries and soon-to-be beneficiaries is important.

In addition to the individual Marketplace, the Affordable Care Act establishes the Small Business Health Options Program (SHOP). Plans offered through SHOP are for small group insurance coverage, and, until 2016, are generally available to employers with 50 or fewer employees. The OMO reviewed laws and regulations to obtain clarity and reduce confusion regarding whether an employee enrolled in a SHOP plan is granted a Medicare special enrollment period (SEP) that provides the opportunity to make changes to Medicare coverage offered to beneficiaries when certain events happen (e.g., if a beneficiary moves out of state or loses other insurance coverage, such as group health insurance from an employer).

Because Medicare beneficiaries could become confused about how the Marketplace affects their Medicare coverage, it is important that available information be sufficient, accurate, or easily located. Findings of the OMO's comprehensive study suggest that some Medicare beneficiaries may receive conflicting guidance in the media, from their health plans, or from their providers and may be uncertain how the Marketplace affects their Medicare coverage.

Consequently, the OMO sought to evaluate the messaging and information available to

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[39] HealthCare.gov. (2013). *What If I Have Medicare?* Retrieved from https://www.healthcare.gov/if-i-have-medicare-do-i-need-to-do-anything/.

individuals eligible for coverage through a Marketplace who may become eligible for Medicare coverage. Phase I of the assessment, the findings of which are presented below, focused on the results synthesized from the following approaches:

- Environmental scan and review of government, Medicare advocacy, insurer, Marketplace, and Navigator Web sites.
- Survey of relevant laws and regulations. Specifically, the study team wanted to identify which consumer assistance functions are required by HHS for all Marketplaces, and to clarify how the Marketplace and Medicare will coordinate. In addition to the Affordable Care Act, the OMO study reviewed relevant sections of the Code of Federal Regulations (CFR), the Social Security Act, and the Public Health Service Act.

Findings

Key findings from the environmental scan and review of laws and regulations that were conducted in August 2013 are presented below. However, it is likely that additional information was updated or made available in the weeks leading up to the Marketplace enrollment start date of October 1, 2013, and through the first weeks of the individual market Marketplace open-enrollment period. These findings will be included in Phase II.

UNDERSTANDING KEY TERMS

"Navigators" are individuals and organizations awarded grants by a state-based Marketplace, or CMS in a federally facilitated Marketplace (FFM) or state partnership Marketplace (SPM), to assist consumers as they apply to participate in the Marketplaces and enroll in health plans offered through the Marketplace.

CMS awarded cooperative agreements to **105 entities** in August 2013 to serve as Navigators in the FFMs and SPMs and provides these entities and their staff with comprehensive training.

Environmental Scan

The Web sites reviewed varied in the amount and level of information they provided about how the Marketplace affects Medicare. However, in general, with the exception of Medicare.gov and HealthCare.gov, information for those with a Marketplace plan who become eligible for Medicare was either limited, difficult to find, or not available at all across the sites reviewed. Scan results are summarized in figure 12.

Medicare.gov, cms.gov, the American Association of Retired Persons' (AARP) Health Law Answers Web site, and HealthCare.gov included the most information about how the Marketplace will affect Medicare. However, this information was primarily directed at currently enrolled Medicare beneficiaries rather than those who are or will become eligible for Medicare while insured through an individual Marketplace or SHOP plan. Also, the information that was available about Medicare and the Marketplace varied greatly in scope and detail.

No Medicare and Marketplace information was found on ssa.gov, the SSA Program Operations Manual System Web site, AARP's Health Law Facts Web site, or any of the insurer Web sites that were reviewed. Of the 18 SBM Web sites (17 states and the District of Columbia), only nine (50 percent) included any type of information on how the Marketplace affects Medicare. Lastly, of the seven FFM Navigator Web sites that were operational during the study team's review in August 2013, only two (29 percent) addressed the interaction between the Marketplace and Medicare.

FIGURE 12. ENVIRONMENTAL SCAN RESULTS, BY TYPE OF WEB SITE, AS OF AUGUST 2013
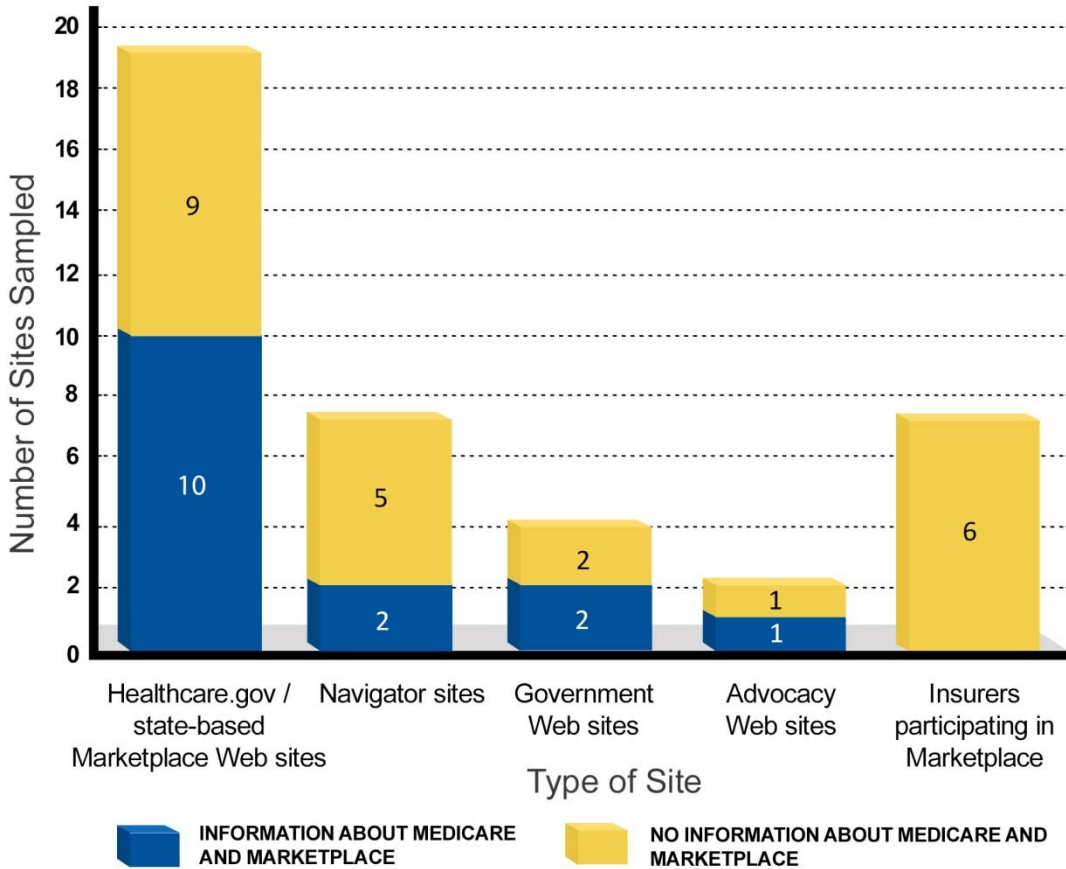
Review of Laws and Regulations

A review of the existing laws and regulations regarding the Marketplaces identified the following information gaps, which could represent areas of confusion or concern for Medicare beneficiaries and those individuals who would transition from coverage through the Marketplace to Medicare.

First, there is no requirement to inform individuals that they should generally be enrolling in Medicare and not continue in a Marketplace or SHOP plan when they become eligible for Medicare. The environmental scan revealed that some resources clarified this detail, but not all Web sites made this point clear, as it is not a

required notification. Given the divergence of the Social Security retirement age and the Medicare eligibility age, beneficiaries would benefit from receiving notification of their Medicare eligibility status and potential late-enrollment penalties.

Second, although the Marketplace must "periodically examine" available data sources to determine an enrollee's eligibility for Medicare coverage, "periodic examination" during a benefit year is undefined. A review of the CFR provides no specific requirement regarding the frequency of this examination, which means that individuals with Marketplace coverage who might become eligible for Medicare may not be notified in a timely manner by the Marketplace.

Third, no explicit written guidance explaining that SHOP plans are considered group health plans for the purposes of Medicare SEP qualification were found at the time of the OMO's review, other than in the March 27, 2012 final rule in the Federal Register.[40] However, subsequent guidance was provided by CMS following the OMO's review, clarifying that SHOP plans are considered group health plans for the purposes of Medicare SEP qualifications.[41]

Fourth, the OMO found that the definition of "small employer" differs between Medicare (fewer than 20 employees) and SHOP Marketplaces (until 2016, generally will be 50 or fewer employees) for purposes of coordination of benefits (COB) and primacy of coverage. This difference may be a source of confusion for beneficiaries and employers.

Recommendations
As the agency continues implementation of the Affordable Care Act initiatives in a rapidly evolving health care landscape, it should consider the following recommendations for future education and outreach:
- Ensure the consistency of the information provided to beneficiaries and encourage states operating SBMs to provide links on their Marketplace Web sites to the information available on Medicare.gov.
- Medicare.gov, HealthCare.gov, cms.gov, and other Medicare materials (e.g., manuals, fact sheets) should be updated to include information for people who are becoming eligible for Medicare while

insured through the individual Marketplace or SHOP.
- Ensure through the Medicare Learning Network that providers are adequately informed regarding the relationship between Medicare and the new Marketplace.

OTHER MONITORED ISSUES

Direct Billing
Efforts to improve the Medicare direct billing process started in FY 2013 and will continue throughout FY 2014. The Notice of Medicare Premium Payment Due (CMS-500) is sent to beneficiaries who are directly billed for their Medicare Part A, Part B, or both premiums and to beneficiaries who are billed for the Income-Related Monthly Adjustment Amount for their Medicare Parts B and D premiums. In FYs 2012 and 2013, premium billing was a key topic reason for beneficiary contact to the 1-800-MEDICARE call center (see figure A-2 in appendix A). Through the OMO Issues Management process, CMS ROs alerted the OMO about an increase in the number of beneficiaries who were having difficulty understanding how the premium amount due was calculated on CMS-500, especially in circumstances when previous amounts due had been carried forward.

The OMO, in collaboration with the CMS ROs, has analyzed problems with and the costs incurred from responding to CMS-500 inquiries. The OMO engaged in ongoing efforts to work with other CMS components to consider revisions to the premium bill and improve Medicare customer service related to Medicare premium inquiries.

[40] "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule." (March 27, 2012). 77 Federal Register 18310. Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf.

[41] Marketplace.CMS.gov. (2014). *Key Facts About the Small Business Health Options Program (SHOP) Marketplace*. Retrieved from http://marketplace.cms.gov/getofficialresources/publications-and-articles/key-facts-about-shop.pdf.

Insulin Used for Insulin Pumps

CMS received feedback from beneficiaries who were unsuccessful in locating a new supplier of insulin for their insulin pumps because their previous suppliers indicated that they were no longer accepting Medicare for insulin used with a pump. The Center for Medicare received feedback that some suppliers, including mail-order companies and local retail pharmacies, were refusing to submit claims to Medicare because the rate for Medicare reimbursement did not cover the cost of the drug, making it difficult for some beneficiaries to secure a supplier.

Insulin used with a pump is covered by Part B when medically necessary and considered under the Medicare durable medical equipment benefit. The statute requires that the Medicare reimbursement rate for insulin when used with a pump be 95 percent of the average wholesale price in October 2003.

Suppliers of insulin used with a pump can only charge the beneficiaries a co-pay amount and then receive the rest of the payment from Medicare. Some suppliers believe that the Medicare payments are too low and, therefore, have refused to accept Medicare payments at all. As a result, some beneficiaries have had to change suppliers several times, while others have been unable to find another supplier and had to pay out of pocket for insulin. CMS caseworkers assisted beneficiaries in these instances as much as possible, but it has become increasingly difficult.

CONCLUSION

In 2013, the Office of the Medicare Ombudsman (OMO) continued to fulfill its mission: providing assistance to Medicare beneficiaries and their caregivers with their inquiries and complaints, and working with stakeholders to facilitate improvements to Medicare. OMO staff provided direct assistance on over 13,000 inquiries and complaints from Medicare beneficiaries or those acting on their behalf, and handled over 60,000 corrections or fixes for beneficiary data system transactions. In addition, the OMO completed three comprehensive studies in 2013 on issues affecting beneficiaries and provided recommendations for addressing those issues.

The OMO will build upon established tools, relationships, and capabilities in order to support beneficiary services through fiscal year 2014 and beyond. It will continue to serve as a voice for Medicare beneficiaries through its core activities: issues management, casework, customer service, and partnership initiatives.

# APPENDIX A: TRENDS IN MEDICARE BENEFICIARY CONTACTS

INTRODUCTION

The Office of the Medicare Ombudsman (OMO) reviews and analyzes data from a variety of systems to assist in identifying potentially systemic beneficiary issues. These systems were designed around business needs, operating purposes, and tracking workloads, such as the number of contacts and broad reasons for beneficiary contact. Because of the aggregate nature of these data, they are not used to identify the exact root causes of beneficiary issues or to assess the effectiveness of the OMO's or the Centers for Medicare & Medicaid Services' (CMS) efforts to mitigate or address issues. Instead, the OMO conducts comprehensive studies to identify the causes of systemic beneficiary issues and develop recommendations for addressing them.

CONTACTS RECEIVED THROUGH 1-800-MEDICARE

To find answers to their Medicare benefit inquiries, beneficiaries, their families, and other members of the public are directed to the 1-800-MEDICARE helpline first. When people call 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). To provide assistance with beneficiary inquiries, CSRs access defined scripts based on keywords related to the caller's issue.

FIGURE A-1. TOTAL NUMBER OF CONTACTS RECEIVED BY 1-800-MEDICARE: FY 2003–2013, PER THOUSAND BENEFICIARIES

SOURCE: 1-800-MEDICARE National Data Warehouse
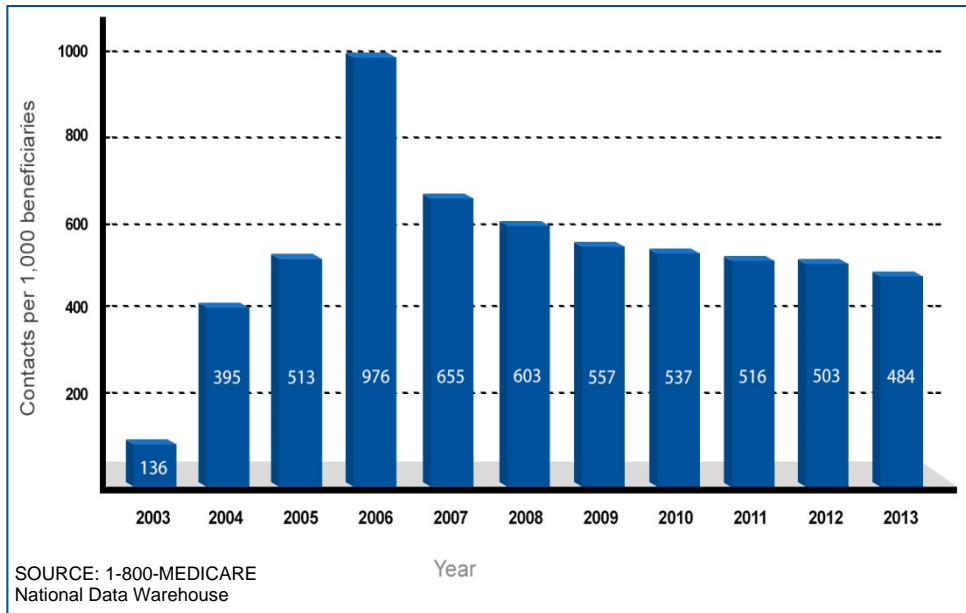
- The total volume of calls to 1-800-MEDICARE per 1,000 beneficiaries has decreased every year since 2006, the year Part D was implemented.

- This trend likely reflects both the maturation of the Part D program and the growing availability and use of online resources to address beneficiary questions, among other factors.
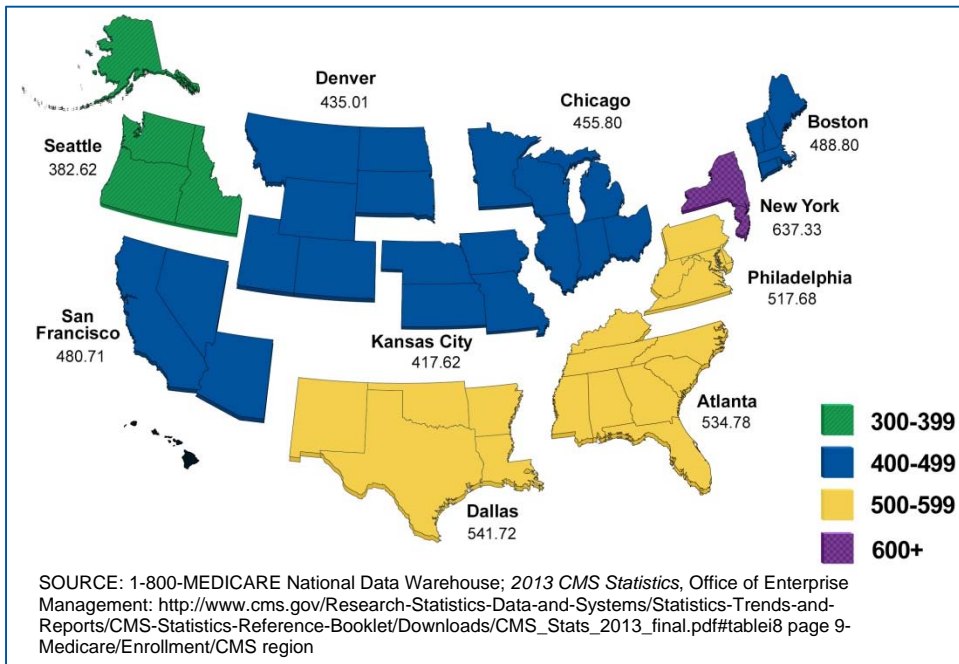
FIGURE A-2. COMPARISON OF 1-800-MEDICARE SCRIPT HITS IN 2012 AND 2013 BASED ON THE TOP 10 SCRIPT HITS IN 2013

SOURCE: 1-800-MEDICARE National Data Warehouse
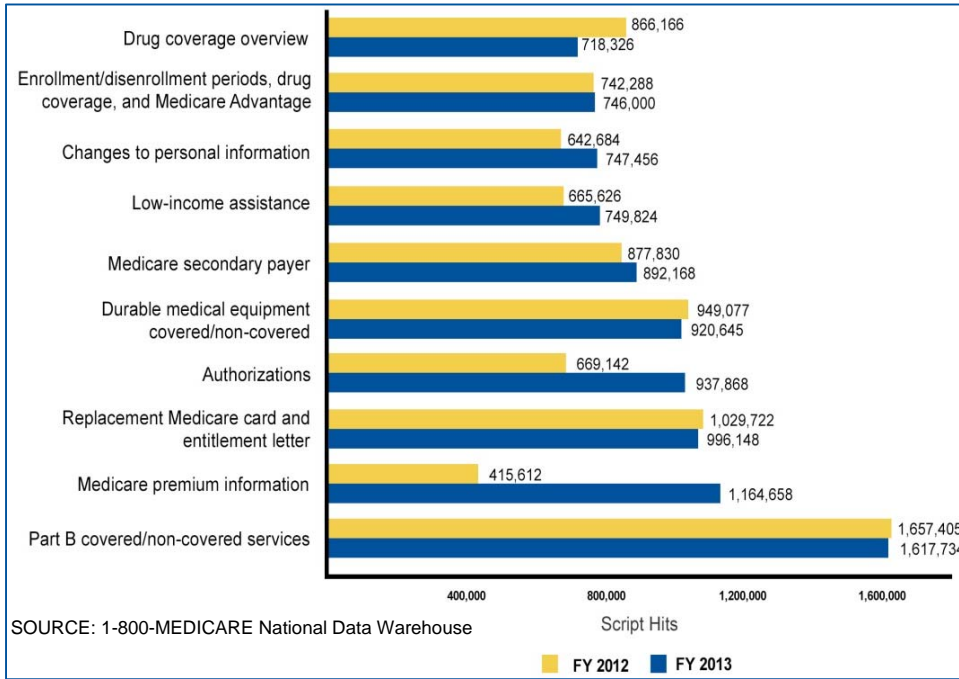
- Consistent with the prior year, scripts on Part B covered/non-covered services were accessed most in fiscal year (FY) 2013.

- Between 2012 and 2013, reductions in script hits were seen in four of the top 10 categories.

- Medicare premium information had the largest increase at 180 percent. However, the increase is largely due to the fact that the category was added in mid-2012, so a full year of data was not available that year.

- Authorizations had the second highest increase at 40 percent.

FIGURE A-3. MAP OF 1-800-MEDICARE CONTACTS PER THOUSAND BENEFICIARIES, BY REGION: FY 2013

SOURCE: 1-800-MEDICARE National Data Warehouse; *2013 CMS Statistics*, Office of Enterprise Management: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf#tablei8 page 9-Medicare/Enrollment/CMS region

- The number of contacts to 1-800-MEDICARE varied considerably across CMS regions, with as few as 383 calls per 1,000 beneficiaries in the Seattle Regional Office (RO) states to 637 calls per 1,000 beneficiaries in the New York RO states.

- The overall number of contacts per thousand enrollees is 510.

FIGURE A-4. TOP 10 REASONS FOR BENEFICIARY INQUIRY RECORDED IN MAISTRO: FY 2012 AND FY 2013

SOURCE: MAISTRO   FY 2012   FY 2013
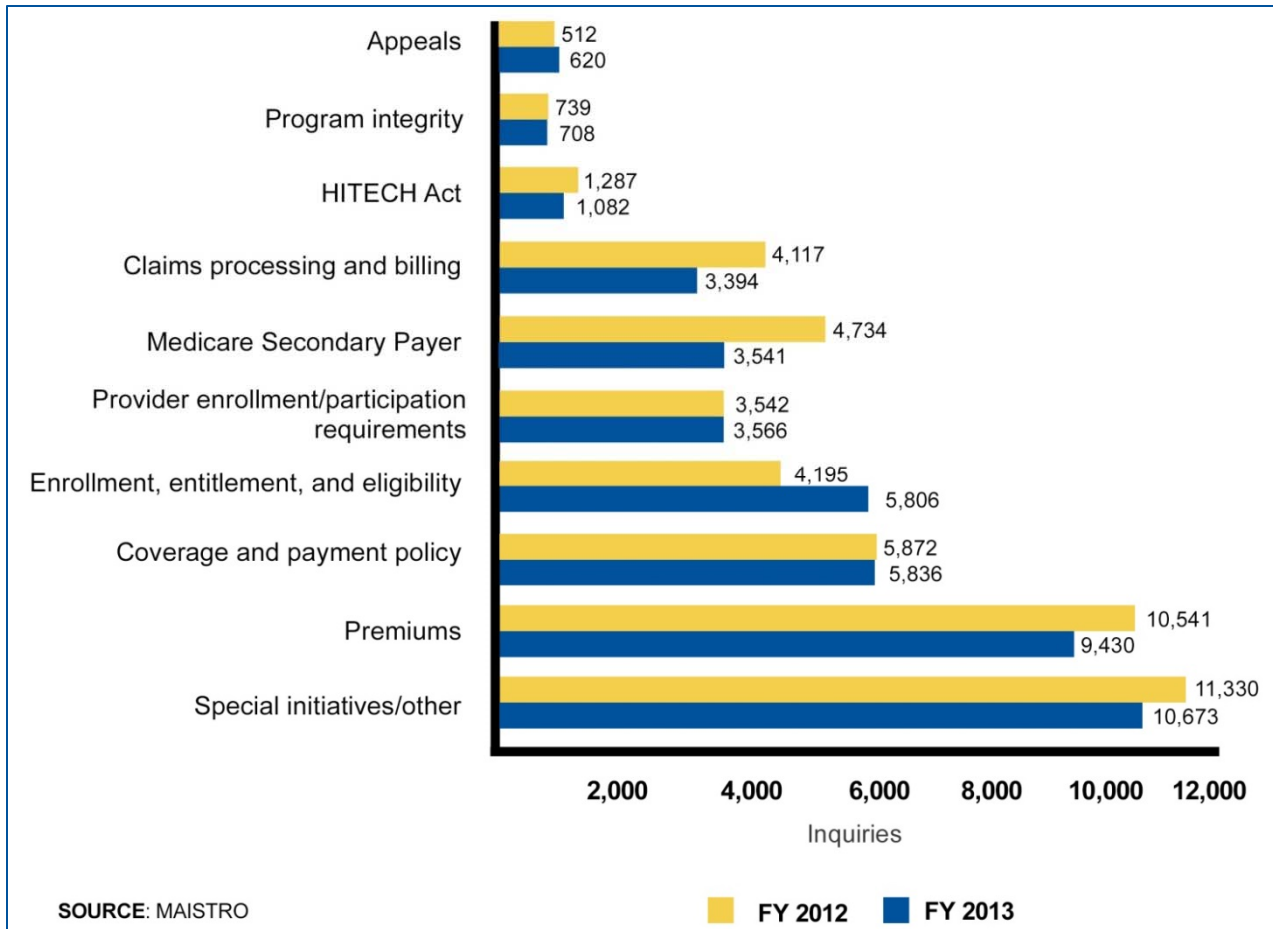
COMPLAINTS RELATED TO MEDICARE PARTS A AND B

The Medicare Administrative Issue Tracker and Reporting of Operations System (MAISTRO) is used to collect and report complaints and inquiries related to fee-for-service Medicare (that is, Medicare Parts A and B) that come directly to and are managed by CMS staff.

- Seven of the top 10 categories showed reductions between FY 2012 and FY 2013. The largest decreases were Medicare Secondary Payer inquiries (25.2 percent

decrease) and claims processing and billing (17.6 percent decrease).

- Of the top categories, only three increased in inquiries: enrollment, entitlement, and eligibility (18.1 percent increase); appeals (21.1 percent increase); and provider enrollment/participation requirements (0.7 percent).

- Across all categories, overall inquiries decreased by 1.6 percent from FY 2012 to FY 2013.

COMPLAINTS RELATED TO MEDICARE PARTS C AND D

The Complaint Tracking Module (CTM) registers and categorizes the complaints related to Medicare Parts C and D that are logged by 1-800-MEDICARE and CMS staff.

- Across Parts C and D, the top complaints concerned issues related to enrollment and disenrollment.

- Across categories in 2013, the number of complaints was similar to or higher than the number in 2012, except for pricing/premium/co-insurance, which decreased by 11.6 percent.

**FIGURE A-5. CTM'S TOP 10 REASONS FOR PART C AND PART D CONTACT: FY 2012 AND FY 2013**
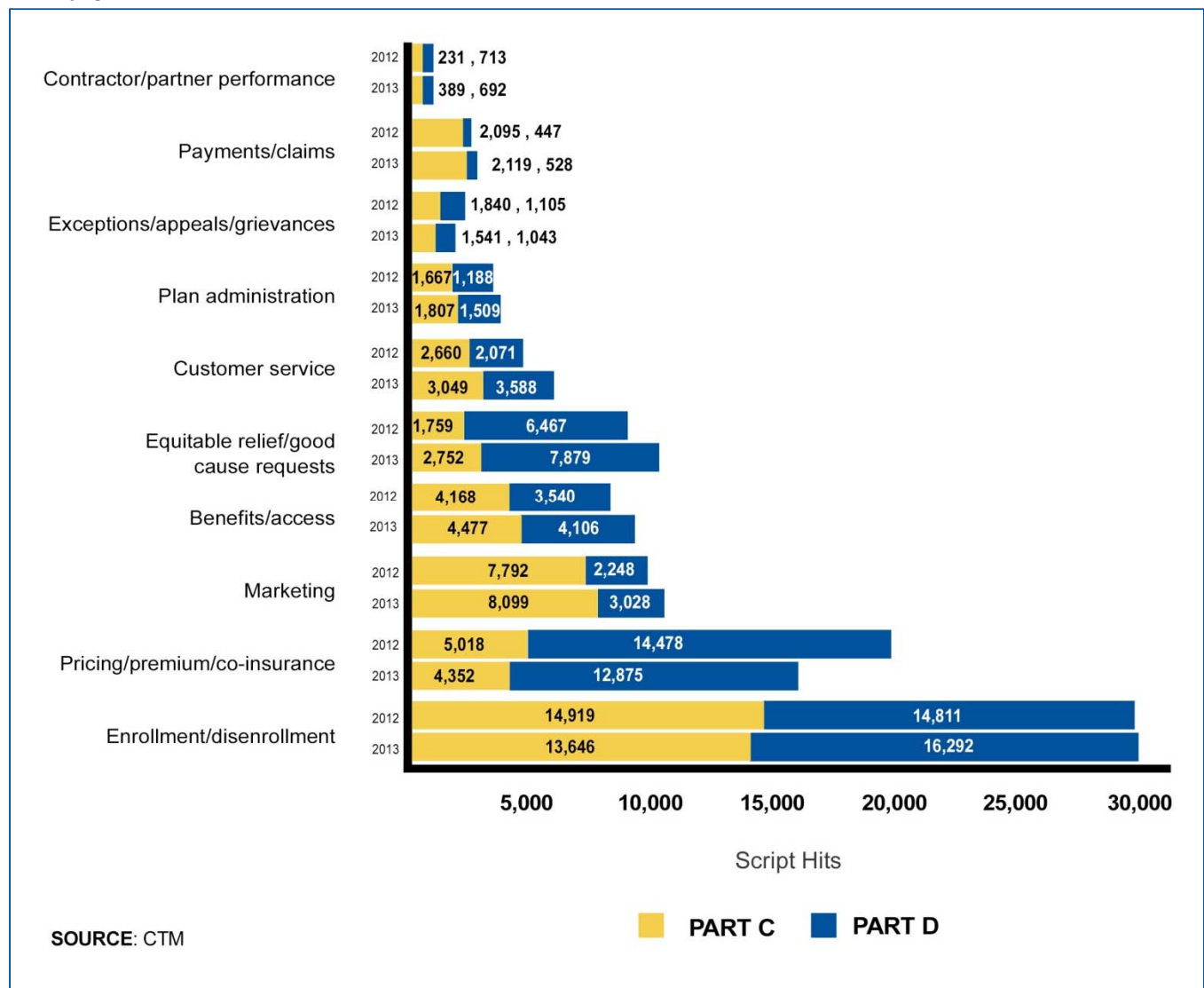
CONTACTS TO STATE HEALTH INSURANCE ASSISTANCE PROGRAMS

In addition to contacting 1-800-MEDICARE, the CMS Central Office, and ROs, Medicare beneficiaries and their families can seek assistance from State Health Insurance Assistance Programs (SHIPs). SHIPs offer counseling and assistance to Medicare beneficiaries on a wide range of Medicare, Medicaid, and Medigap issues. SHIPs report total contacts and total reasons for contact. There can be multiple reasons for one contact.

- With more than 2,719,403 contacts and 12.8 million reasons for contact in 2013, SHIPs remained an important resource for Medicare beneficiaries and their caregivers.

- Contacts to the SHIPs increased 16 percent from calendar year (CY) 2012 to CY 2013. There can be many reasons for each contact, and each reason is coded and recorded. Reasons for contact increased by approximately 33 percent from 2012 to 2013.

- SHIP contacts and reasons for contact have been increasing since CY 2007 due to several factors, including improved data reporting and performance management at SHIP offices and the growing Medicare population.

- Topics related to Part D/Low-Income Subsidy presented the most frequent reason for contact in 2013, followed by "Other" topics.

FIGURE A-6. REASONS FOR BENEFICIARY CONTACT OF SHIPS: FY 2013

SOURCE: SHIP National Performance Report
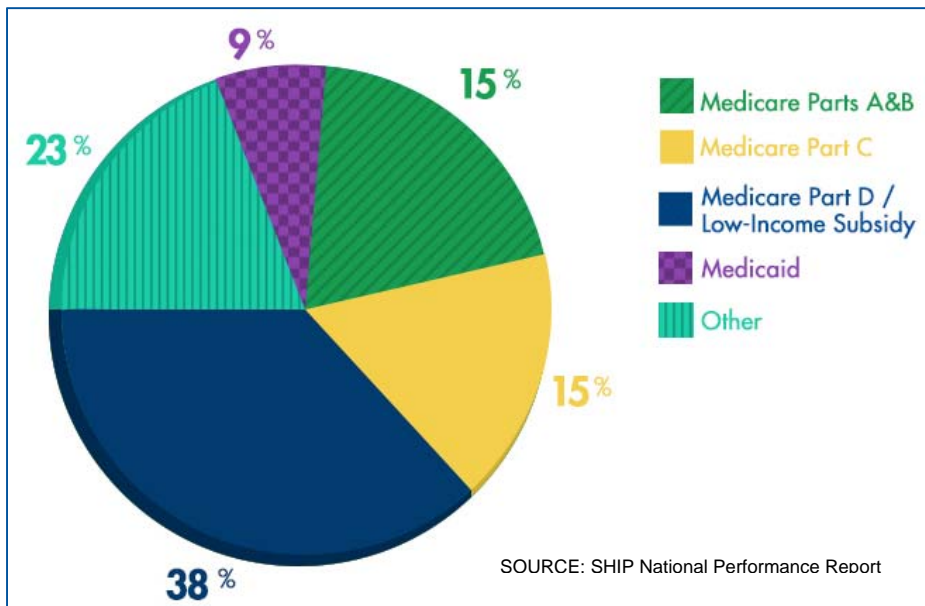
APPENDIX B: FISCAL YEAR 2013 MEDICARE PARTS C AND D ONLINE COMPLAINT FORM DATA ANALYSIS

BACKGROUND

Parts 417, 422, and 423 of Title 42 of the Code of Federal Regulations enact revisions of the Medicare Advantage (MA) Program (Part C) and Prescription Drug Benefit Program (Part D). Specifically, these regulations implement provisions outlined in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) and make other changes based on the Centers for Medicare & Medicaid Services' (CMS) experience with administering Parts C and D. The revisions also clarify various program participation requirements, make changes to strengthen beneficiary protections, remove consistently poor-performing health plans, and make other clarifications and technical changes. As required under section 3311 of the Affordable Care Act, CMS implemented an online complaint form.

The Center for Medicare at CMS worked closely with other CMS departments to develop a technical approach to implementing the complaint form that used existing infrastructure and required minimal changes to business processes. For example, to ensure consistency with existing business processes, a subset of data elements to be included in the form was selected from the agency's existing mechanism for collecting Medicare Parts C and D complaints: the Medicare Complaint Tracking Module (CTM). The CTM is a tool that allows complaints to be recorded and systematically analyzed and aggregated, providing an early indication of new or emergent policy issues that may have an impact on health plan operations and require immediate resolution.

To ensure user accessibility, the online complaint form was placed in three locations by CMS: (1) on the Medicare.gov homepage, (2) on the Medicare Plan Finder homepage, and (3) on the Office of the Medicare Ombudsman homepage. As outlined in section 3311 of the Affordable Care Act, effective January 1, 2012, Medicare Advantage Organizations and prescription drug plan sponsors are required to display this electronic complaint form prominently on their Web sites. In a November 10, 2011, Health Plan Management System memorandum, CMS provided guidance instructing MA organizations and Part D sponsors on how to comply with this requirement.

COMPLAINT PROCESS

Although the number of complaints filed with CMS and the time needed to resolve these complaints have diminished as the Part D program has matured, complaint data indicate that there is still opportunity for improvement. CMS requires that plan sponsors provide information about whether they notified beneficiaries about the status and resolution of their complaints. This allows CMS to determine whether sponsors are closing complaints in a timely manner. CMS routinely monitors the status of complaints and works with plan sponsors who fail to comply with requirements for the complaints process, illustrated in figure B-1.

Since the release of the online complaint form in December 2010, customer service representatives

(CSRs) at 1-800-MEDICARE have been the first to review online complaints and are responsible for determining whether a submission is an inquiry or a true complaint. True complaints are assigned a category, and the data are loaded into CTM for casework and resolution (figure B-1). Parts A and B fee-for-service (FFS) inquiries are also handled by 1-800-MEDICARE CSRs. CSRs have access to FFS claims systems and are able to respond to a majority of inquiries related to Parts A and B. The call center escalates inquiries that 1-800-MEDICARE is not contractually able to handle (e.g., appeals determinations, check reissues, claims adjustments, Medicare Secondary Payer payment issues) to the appropriate Medicare Administrative Contractor (MAC). Less than 2 percent of the total 1-800-MEDICARE call volume is routed to MACs.

FIGURE B-1. COMPLAINT TRACKING MODULE PART D COMPLAINT PROCESS
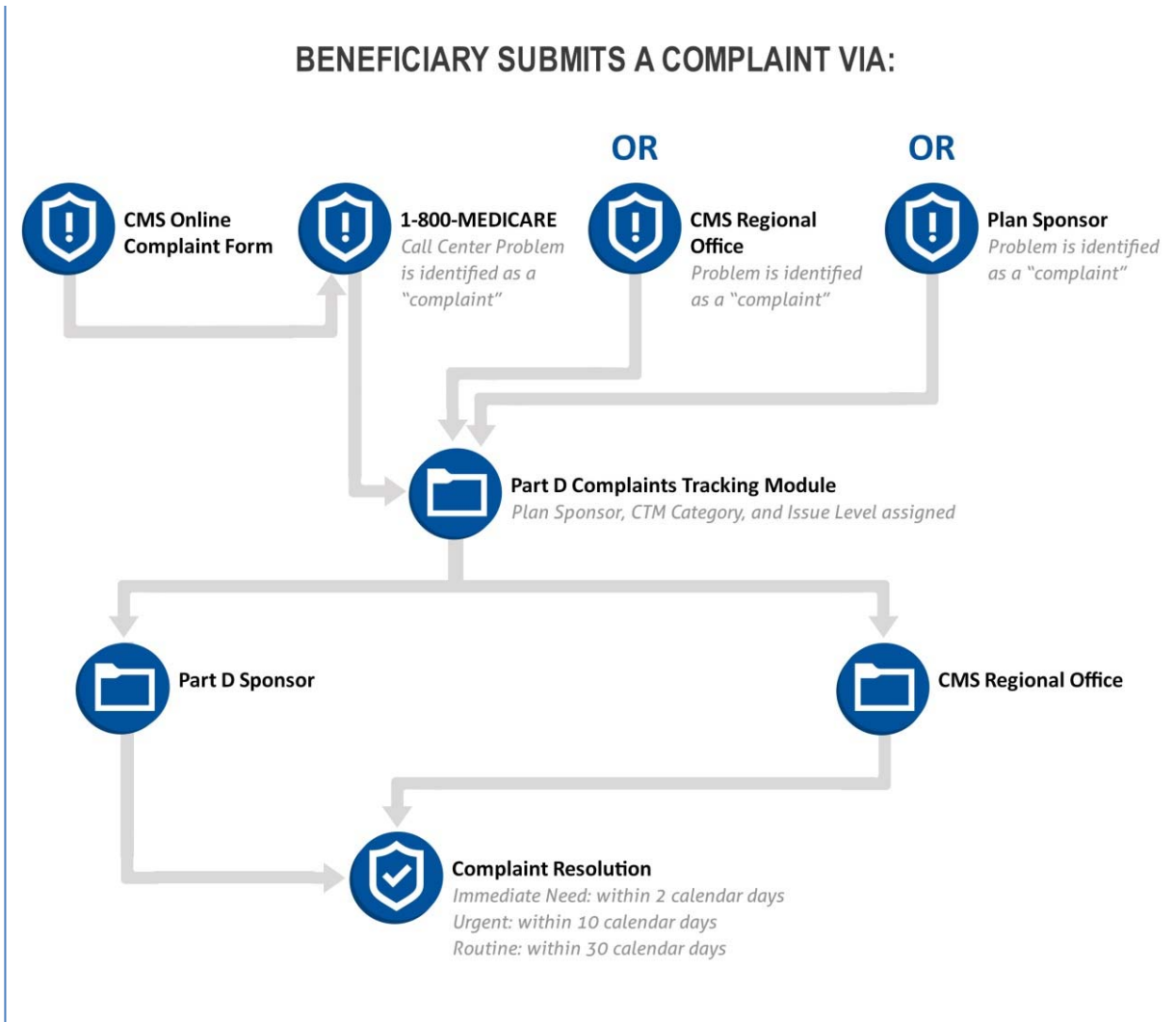
DATA ANALYSIS AND RESULTS

In fiscal year (FY) 2013, a total of 1,857 complaints were received via the online complaint form, a 26 percent decrease from FY 2012, when 2,514 online complaints were received.

Given that the online complaint form is widely accessible to all Medicare providers and beneficiaries and their caregivers, various types of inquiries and complaints are received. Of the 1,857 total online submissions received, 803 (43 percent) were related to Parts C and D.[42]

Figure B-2 provides the number and percentage of overall CTM and online form complaints by category. The most common online CTM complaint category was related to problems with customer service (49.32 percent); followed by pricing issues, such as copays and co-insurance (20.05 percent); and then complaints related to coordination of benefits and access (10.83 percent). The remaining complaints that came in via the online form were distributed among the remaining complaint categories.

FIGURE B-2. COMPLAINT CATEGORIES IN CTM: FY 2013

Complaint Category	Total CTM Complaints	% of Total Complaints	CTM Online Complaints	% of Online Complaints
Customer Service	6,635	6.83%	396	49.32%
Pricing / Premium / Co-insurance	17,552	18.08%	161	20.05%
Benefits / Access	8,775	9.04%	87	10.83%
Enrollment / Disenrollment	29,917	30.81%	73	9.09%
Exceptions / Appeals / Grievances	2,580	2.66%	59	7.35%
Plan Administration	3,306	3.41%	12	1.49%
Marketing	11,188	11.52%	11	1.37%
Payment / Claims	4,059	4.18%	2	0.25%
Contractor / Partner Performance	1,200	1.24%	1	0.12%
Coverage Gap Discount Program	95	0.10%	1	0.12%
Unassigned	12	0.01%	0	0.00%
Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information	1,075	1.11%	0	0.00%
Confidentiality / Privacy	64	0.07%	0	0.00%
Equitable Relief / Good Cause Requests	10,608	10.93%	0	0.00%
Program Integrity Issues / Potential Fraud, Waste and Abuse	26	0.03%	0	0.00%
Total	97,092	100.00%	803	100.00%

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[42] The report does not include data on how many complaints received via the online form were related to Parts A and B.

Figure B-3 illustrates the number of complaints submitted via the online form by month and year. Complaints received peaked in January 2013, with 196 complaints received. This is due to the usual increase in inquiries and complaints received at the start of the year, following the annual Medicare open-enrollment period, when a significant number of enrollments and related changes occur. Figure B-4 compares the top three complaints received by 1-800-MEDICARE with those received via the online form. The most frequent online complaint was customer service, compared with the top 1-800-MEDICARE category of enrollment/disenrollment.

FIGURE B-3. ONLINE COMPLAINTS ENTERED INTO THE CTM: FY 2013
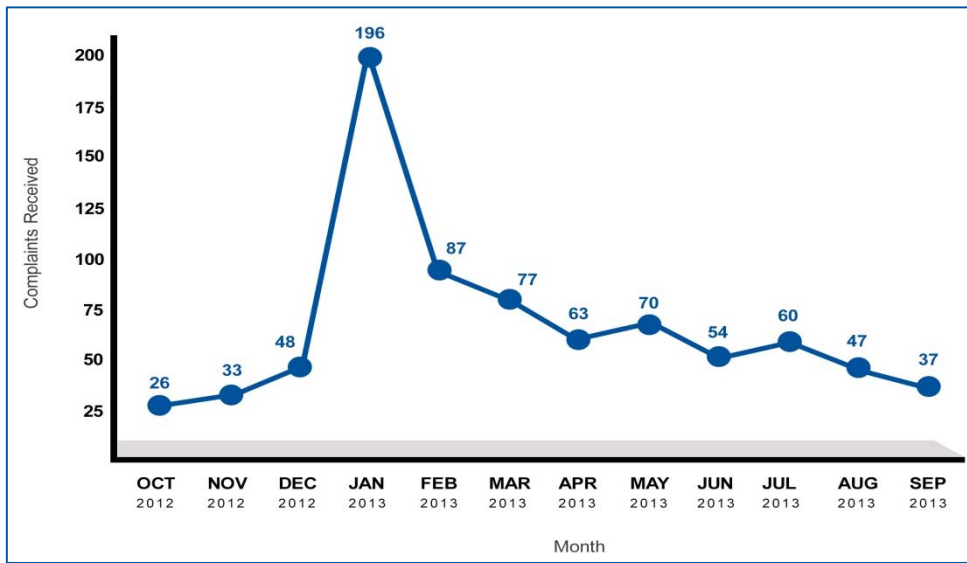
FIGURE B-4. TOP THREE COMPLAINTS BY DATA SOURCE FY 2013
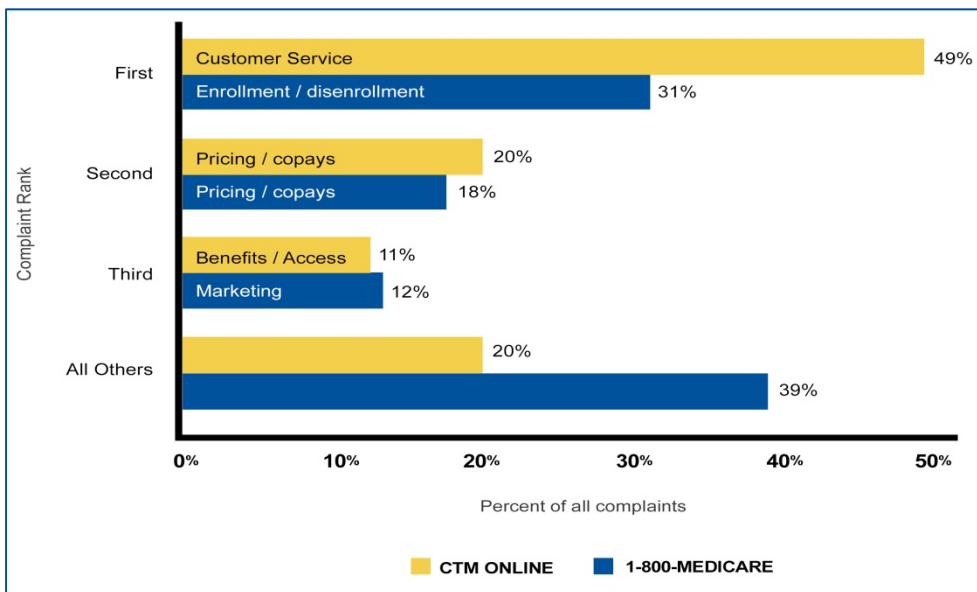
In addition to complaint categories, the CTM also contains information about the "issue level" of complaints (immediate need, urgent, routine), and the dates that complaints were filed and resolved. The majority of online complaints was not related to beneficiaries at risk of running out of their medication and was, therefore, considered routine.

Based on an initial review, CMS' implementation of an online complaint form enhanced complaint resolution for beneficiaries and CMS partners by improving the consistency, reliability, and usefulness of complaint information reported via the online form.