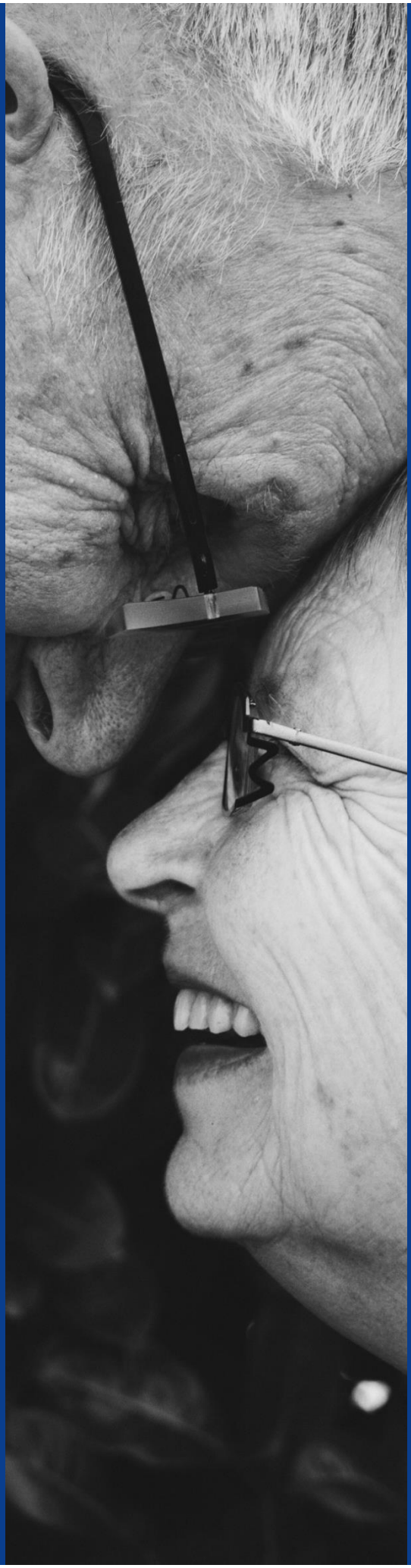


CALENDAR YEAR 2020

Medicare Beneficiary Ombudsman

REPORT TO CONGRESS

CONTENTS

A MESSAGE FROM THE OMBUDSMAN

We are pleased to present this Medicare Beneficiary Ombudsman (MBO) Calendar Year (CY) 2020 Report to Congress and the Secretary of the U.S. Department of Health & Human Services. I am privileged to support the mission of the Centers for Medicare & Medicaid Services (CMS) to protect the health and well-being of millions of Americans by making sure the needs of the populations we serve are considered as CMS develops, implements, and evaluates its programs and policies. My role and objectives as the MBO are to understand the Medicare beneficiary experience and highlight that perspective for policymakers, provide interested parties with relevant information related to the appeals process, and serve as an objective source of information and referrals.

I would like to extend a gracious thank you to Barbara McCoy, CMS Associate Ombudsman, who stepped in to serve as the MBO for the majority of the CY2020 reporting period while I was temporarily assigned to another CMS component. I would also like to acknowledge what a challenging year it was for so many Americans as we grappled with the devastation of the COVID-19 public health emergency (PHE). My heart goes out to all of the impacted Medicare beneficiaries, caregivers, stakeholders, and frontline staff who took on roles and challenges they could have never imagined. Thank you to every person who helped support and continue to care for Medicare beneficiaries during this unprecedented time.

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

- Partnering with advocacy organizations to understand and implement the Special Enrollment Period for Medicare Part C and Part D, as well as the Equitable Relief for Medicare, to ensure that beneficiaries were able to access the care they needed;
- Participating in the 2020 State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP) annual conference;
- Educating partners about updated CMS casework processes; and
- Providing direct assistance with complex inquiries received from partners.

The opportunity to engage with Medicare beneficiaries and stakeholders and analyze inquiry trends helped identify areas for potential improvement, specifically areas related to transitions to Medicare. This will continue to be a focus of mine as we strive to improve our customers' understanding of the Medicare Program.

It is an honor to serve Medicare beneficiaries in this role. I appreciate CMS leadership, my CMS colleagues, and external partners who are dedicated to supporting the Medicare Program and its beneficiaries.

Catherine A. Rippey

Medicare Beneficiary Ombudsman

About the Ombudsman

In 2003, Congress established the Medicare Beneficiary Ombudsman (MBO) to assist Medicare beneficiaries with their inquiries, complaints, grievances, appeals, and requests for information, per Section 1808(c) of the Social Security Act[i]. This position is located in the CMS Offices of Hearings and Inquiries (OHI). This report is being submitted pursuant to Section 1808(c)(2)(C), which requires the Secretary to submit annual reports to Congress that describe the activities of the MBO.

The MBO's day-to-day work includes supporting CMS customer service and administration efforts by receiving and responding to beneficiary and stakeholder inquiries and complaints, working with partners to provide outreach and education to beneficiaries, and providing recommendations for improving the administration of Medicare.

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

Barbara McCoy joined CMS in 2009 and has worked in a variety of positions, including grants management, outreach and education, and casework for both Medicare and the Marketplace. She also worked at the Administration for Community Living (ACL). Prior to joining federal service, she worked at the Virginia Department for the Aging as the State Health Insurance Assistance Program (SHIP) Director and in direct practice in hospitals and nursing homes as a social worker.

IMPROVING STAFF RESILIENCE

The MBO and CMS customer-facing representatives interact with a variety of external customers, including Medicare beneficiaries, their representatives, and advocacy and stakeholder organizations. It is through those interactions that the MBO gains valuable insights about the Medicare beneficiary experience to share throughout the agency. Working in the field of health care can often present complicated customer experience situations. CMS representatives strive to provide exemplary service to their customers despite the challenges sometimes encountered in this type of work. In order to provide high-quality customer service, the MBO recognizes the need for staff to be supported with resilience and self-care tools.

In an effort to support the mental health and well-being of CMS staff, the MBO and fellow OHI colleagues developed a program to enhance personal resilience in times of change. Resilience has been defined by the American Psychological Association (APA) as "the human ability to adapt in the face of tragedy, trauma, adversity, hardship, and ongoing significant life stressors."[ii] Just as someone would address physical injuries, it is imperative to seek support, alleviate symptoms of pain, and take steps to ensure recovery when faced with emotional or psychological challenges. To address those needs, the CMS Human Resilience Training program for customer-facing staff consists of a combination of instructor-led coursework, breakout sessions, and recorded training modules to help attendees gain the knowledge they need to be more resilient, including the valuable practice of using real-life scenarios encountered by customer-facing staff.

In order to promote these key concepts, a cohort of CMS staff from various components became trainers for this material. These individuals meet regularly to

facilitate a community of practice and are prepared to share their knowledge and train other CMS staff on human resilience topics and techniques. The MBO anticipates this project will improve CMS employee resilience and job satisfaction; improve their ability to adapt and respond to customers; and ultimately improve the quality of customers' experiences with CMS staff.

Researching Beneficiary Concerns

In 2020, the MBO conducted research into several beneficiary concerns to better understand the challenges that beneficiaries face when transitioning to Medicare. Below are a couple examples of topics researched in CY2020.

Access to skilled nursing facilities for beneficiaries transitioning to Medicare

In 2019, the MBO became aware of an issue regarding coverage of skilled nursing facility (SNF) stays for newly entitled Medicare beneficiaries. Medicare provides SNF coverage for beneficiaries with Medicare Part A who are determined to be in need of skilled care and have a qualifying inpatient hospital stay of at least three days, among other requirements.[iii] The MBO was informed of a denied claim for a beneficiary who was covered by another insurer during their inpatient hospital stay but became entitled to Medicare while receiving care in a SNF. In this instance, the SNF claim was denied because this individual was not covered by Medicare during the entirety of the inpatient hospital stay, and Medicare does not consider hospitalization prior to Medicare entitlement as a qualifying stay.

To understand the number of Medicare beneficiaries who were affected by this issue, the MBO requested an analysis of claims for SNF care that Medicare had rejected or denied[iv] because the qualifying stay requirement was not met. The analysis found that:

- A total of 1,505 newly enrolled Medicare beneficiaries had rejected or denied SNF claims due to inaccurate or missing qualifying inpatient stays between October 1, 2016, and September 30, 2019.[v] Since Medicare did not cover the cost of SNF care in these instances, beneficiaries may have been responsible for paying out-of-pocket for their care.
- Of the affected beneficiaries, 56% were exactly 65 years old, 39% were under the age of 65, and 5% were older than 65. This distribution indicates that this issue primarily affects beneficiaries first transitioning to Medicare due to age or disability.

While the number of beneficiaries affected by this issue was nominal, these findings suggest that the three-day qualifying inpatient stay requirement can contribute to rejected and denied SNF claims and that the current policy to not take into consideration an inpatient hospital stay prior to Medicare enrollment may lead to costly coverage gaps for beneficiaries who require SNF care during the time of their initial enrollment into Medicare.

The MBO is continuing to monitor this issue and keep CMS abreast of the effect of the SNF coverage requirement on newly eligible Medicare beneficiaries.

Enrollment challenges for formerly incarcerated individuals

In 2020, the MBO requested an overview of the Medicare and Medicaid enrollment challenges facing individuals who were recently released from federal or state prison (re-entrants), as Medicare and Medicaid generally do not pay for items and services given to a beneficiary while they are incarcerated in a correctional facility, and enrollment periods were limited for this population. As the number of formerly incarcerated individuals eligible for Medicare rapidly increases, providing resources and assistance to this population so that they can obtain Medicare coverage and, when possible, avoid late enrollment penalties, is a critical aspect of the re-entry process.[vi]

Research on this issue highlighted that:

- Incarcerated individuals and elderly re-entrants should sign up, if possible, for Medicare Part A and Part B during the initial enrollment period (IEP) to avoid penalties and gaps in coverage.
- Both currently incarcerated individuals and re-entrants should be made aware of the Medicare Savings Programs (MSPs), which can be used to assist with premiums, coinsurance, and deductibles, including late enrollment penalties. These are especially important programs for beneficiaries without a 10-year qualifying work

history, who must also pay Medicare Part A premiums.[vii]

- States are playing a prominent role in increasing access to federal benefit programs for recently incarcerated individuals, including Social Security benefits. State efforts have contributed to increased enrollment in Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) using targeted enrollment strategies, such as the SSI/SDI Outreach, Access, and Recovery (SOAR) program, which connects re-entering individuals with a representative to work with one-on-one to navigate the application process.[viii]
- States are also facilitating coordination efforts between their correctional facility information systems with Medicaid eligibility systems to improve data sharing.
- Additionally, some state Medicaid programs are using peer supports to establish relationships with potential enrollees in jails and prisons to connect inmates with Medicaid prior to or upon re-entry.[ix]

With these highlights in mind, the MBO is exploring ways to connect with partners to assist re-entrants with Medicare enrollment.

Looking ahead

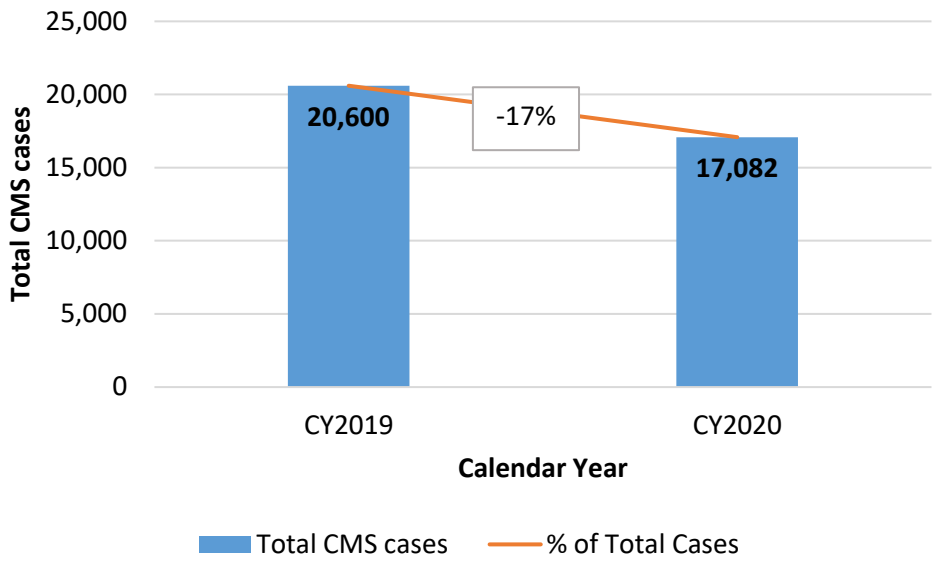
The MBO will continue to work on efforts to strengthen CMS staff customer service for Medicare beneficiaries and provide CMS staff with the tools and resources they need to stay resilient in light of increasing demands on the agency. This will include supporting CMS as it continues to implement customer service enhancements to improve the beneficiary experience related to direct premium billing. The MBO will also continue to focus on improving the transition to Medicare for newly enrolled beneficiaries.

DATA HIGHLIGHT: ENROLLMENT, ENTITLEMENT, AND ELIGIBILITY CASES, CY2020

The total count of cases[1] from beneficiaries, beneficiary representatives, advocacy groups, and Congressional offices decreased by 17% from CY2019 to CY2020, as shown in Figure 1.[x] This may have been due to decreased non-emergency healthcare utilization among Medicare beneficiaries during the COVID-19 pandemic.

[1] Cases are defined as communications submitted to CMS that require a CMS response to a specific issue from the public, other agencies, Medicare beneficiaries, etc.

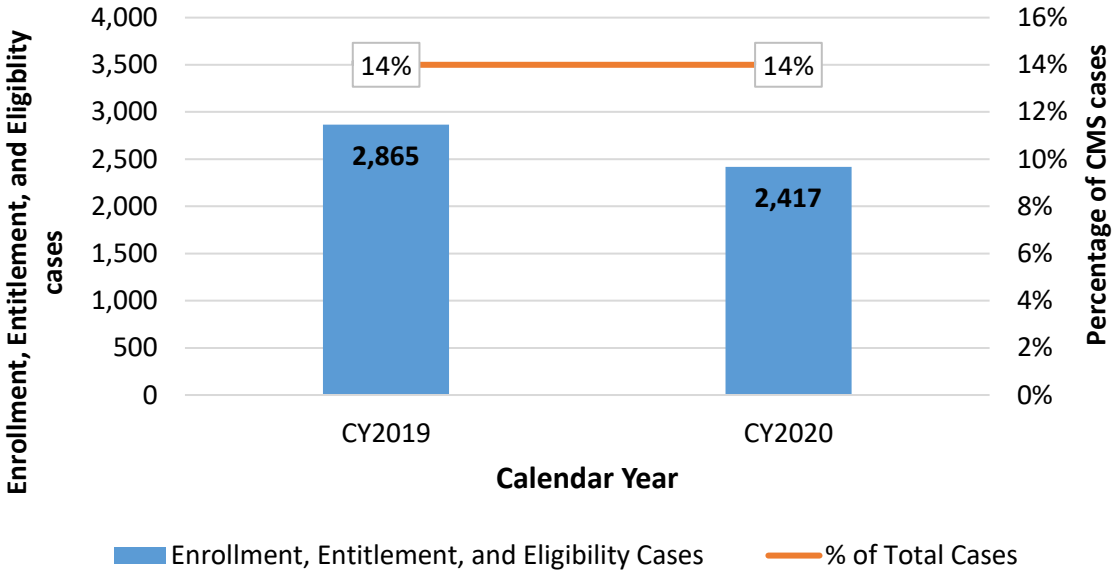
Figure 1: Beneficiary-Related Casework, CY2019–CY2020



Source: Medicare Administrative Issue Tracker and Reporting of Operations (MAISTRO)

While the total volume of casework in CY2020 decreased from CY2019, the percentage of cases related to Enrollment, Entitlement, and Eligibility remained consistent to the previous year, as seen in Figure 2.

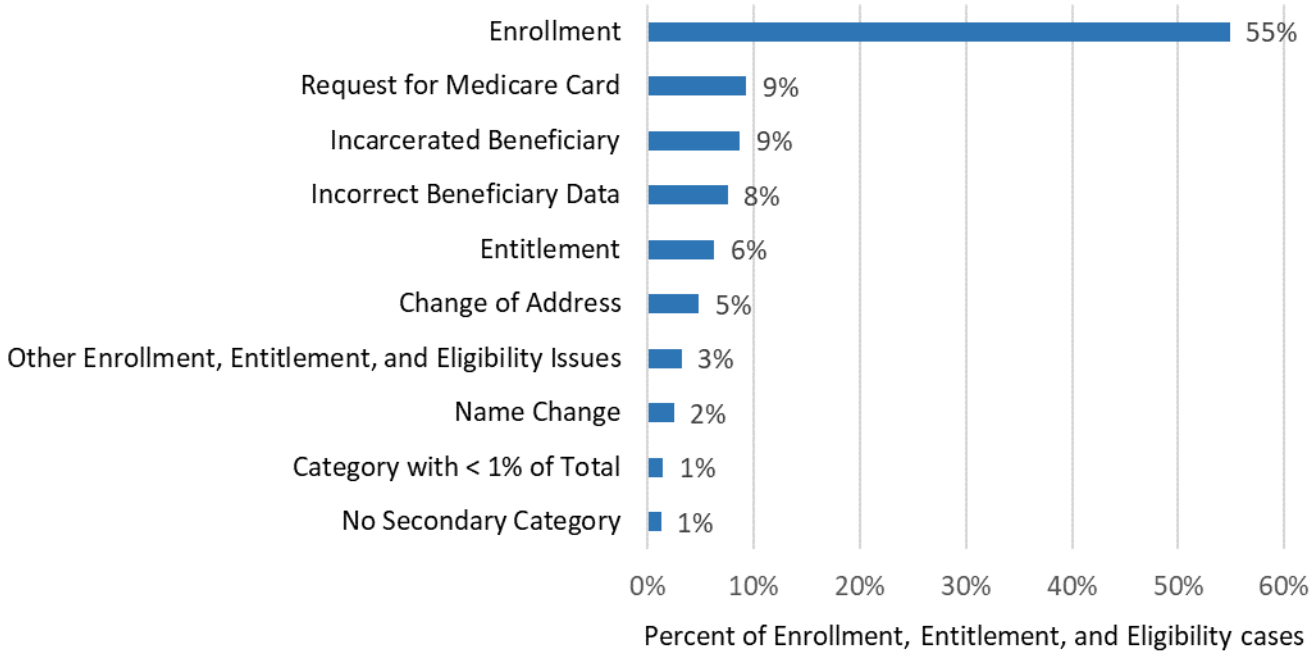
Figure 2: Enrollment, Entitlement, and Eligibility Cases, CY2019–CY2020



Source: MAISTRO

Within the CY2020 Enrollment, Entitlement, and Eligibility cases, over half (55%) were categorized under the secondary category of "Enrollment," as seen in Figure 3. The next most common secondary category involved requests for Medicare cards (9.2%), followed by cases related to incarcerated beneficiaries (8.7%), and cases concerning incorrect beneficiary data (8%).

Figure 3: Secondary Categories for Enrollment, Entitlement, and Eligibility Cases, CY2020



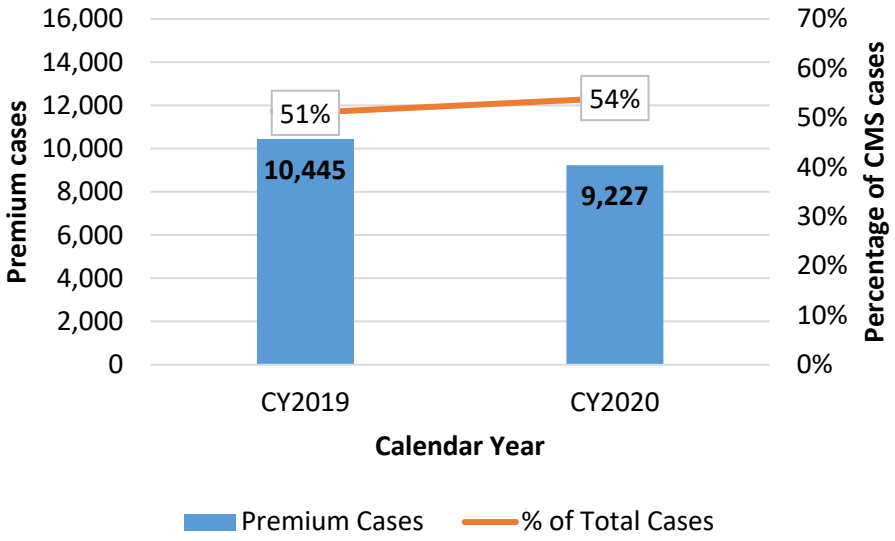
Source: MAISTRO

Among cases with a secondary category of "Enrollment," the most common tertiary category was "Withdrawal/Refusal of Part B" (47%), followed by "General Enrollment Period/Special Enrollment Period" (34%), and "Termination" (9%). This tertiary categorization was similar to how "Enrollment" cases were categorized in CY2019.

Medicare premium cases

In CY2020, Medicare premium cases were the most common type of case submitted by beneficiaries, beneficiary representatives, advocacy organizations, and Congressional offices, representing 54% of CMS cases submitted by these groups. While the overall volume of premium casework declined from CY2019 to CY2020, the percentage of total cases that were related to premiums increased slightly from 51% to 54%, as seen in Figure 4.

Figure 4: Medicare Premium Casework, CY2019–CY2020



Source: MAISTRO

Within the CY2020 premium cases, the most common secondary category was “Direct Premium Billing” (85%), followed by “Termination/Reinstatement” (6.6%), and “Third Party Billing-State” (3.6%). These secondary categories were also the most common secondary categories in CY2019.

Customer Accessibility Resource Staff Activities in CY2020

During CY2020, the Customer Accessibility Resource Staff (CARS) within OHI continued to support CMS's essential functions to enhance beneficiary services and access to information in compliance with Section 504 of the Rehabilitation Act. During this reporting period, CARS continued to improve the accessibility of external CMS communication materials by collaborating with CMS components and key stakeholders, as well as with CMS policy subject matter experts and leadership, to identify opportunities for improvement related to accessibility. CARS worked to ensure people, external to CMS, with disabilities had an equal opportunity to participate in CMS services, activities, programs, and other benefits, including exploring expanding the availability of auxiliary aids and services to improve CMS's posture on external communications to individuals with disabilities.

Throughout this reporting period, CARS coordinated with the CMS Office of Communications (OC) to launch a direct marketing email campaign to promote awareness of the availability of accessible formats and accessibility of other CMS resource materials. To create operational efficiency and reduce burden for CMS employees, CMS launched a 2020 Accessibility Awareness Training, which combined two previously separate, required trainings into one consolidated package covering Sections 501, 504, and 508 of the Rehabilitation Act of 1973. CARS collaborated with the Office of Information Technology (OIT) and the Office of Equal Opportunity and Civil Rights (OEOCR) to develop this new training to help employees understand how the requirements of Sections 501, 504, and 508 apply to their respective roles and responsibilities, as well as to understand basic concepts around accessibility and reasonable accommodations.

The MBO worked collaboratively with CARS throughout the reporting period to initiate the Resiliency and Self-Care Program, including the launch of the Human Resilience virtual trainings, "Enhancing Personal Resiliency in Times of Uncertainty and Change," and "Psychological Body Armor." Additionally, the MBO leveraged feedback from CARS to help ensure Medicare information is available in multiple formats to meet customer needs.

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

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

APPENDIX: CENTER FOR MEDICARE, MEDICARE PARTS C & D ONLINE COMPLAINT DATA, CY2020

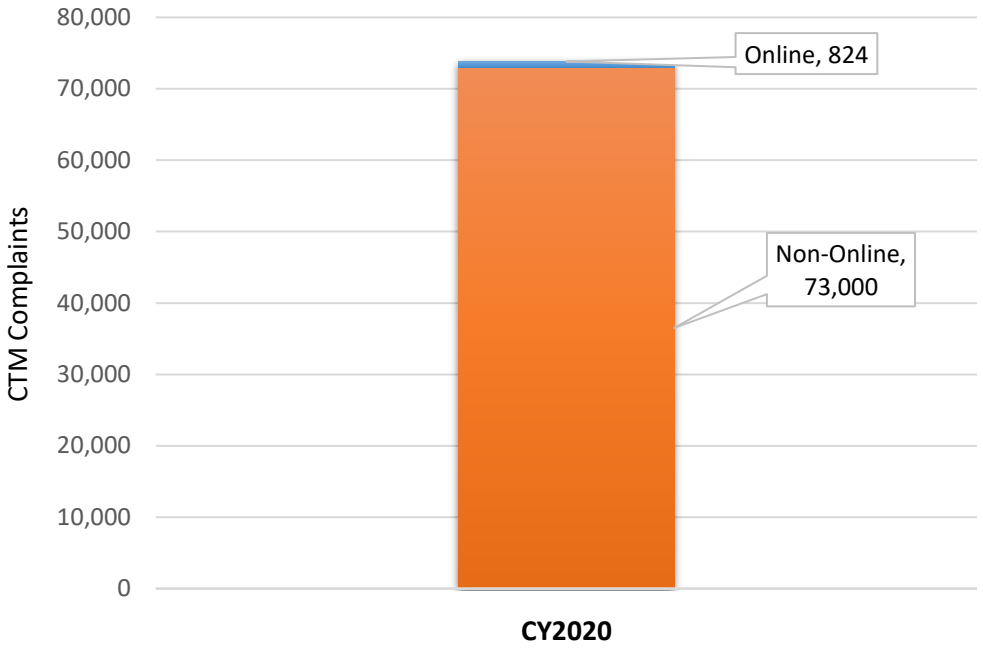
Among other customer service tasks, CMS operates the Complaint Tracking Module (CTM), CMS's mechanism for collecting complaints about Medicare Part C (Medicare Advantage [MA]) and Part D Prescription Drug Plans (PDPs). One of the CTM's functions is to support the online electronic complaint form for Medicare Parts C and D, which is called the "Improved Medicare Prescription Drug Plan and MA–PD Plan Complaint System," and is required by law.[xii] The electronic complaint form for Part D drug plans must be displayed in a prominent location on the Medicare.gov and MBO websites.[xiii] The electronic complaint form was created and posted in December 2010 and can be found at https://www.medicare.gov/MedicareComplaintForm/home.aspx. CMS is required to provide an analysis of complaints registered through this system in an annual Report to Congress.[xiv] Such reports would include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints. This appendix fulfills the CMS reporting requirement for CY2020 and provides CTM data including the general use of the electronic complaint form, and differences in complaint category types.

The online complaint form is widely accessible to all Medicare providers, beneficiaries, and their caregivers. As a result, a variety of inquiries and complaints are submitted. 1-800-MEDICARE customer service representatives review each inquiry and complaint and log those determined to be true complaints into CTM.[xv] CMS also requires MA plan and PDP sponsors to address and resolve complaints that have been logged in CTM.[xvi] To determine whether sponsors are resolving complaints in a timely manner, CMS requires that sponsors provide information on the status and resolution timeframes for notifying beneficiaries. This allows CMS to monitor the status of complaints and work with sponsors who fail to comply with requirements for the complaints process.

CY2020 DATA ANALYSIS AND RESULTS

During CY2020, CMS received 6,155 online submissions; 824 (approximately 13%) of these submissions were determined to be true complaints related to Parts C and D. The remaining 5,331 inquiries were resolved by the 1-800-MEDICARE call center. Online complaints represented 1% of all (73,824) CTM complaints received during the reporting period, as shown in Figure 5 on the following page.

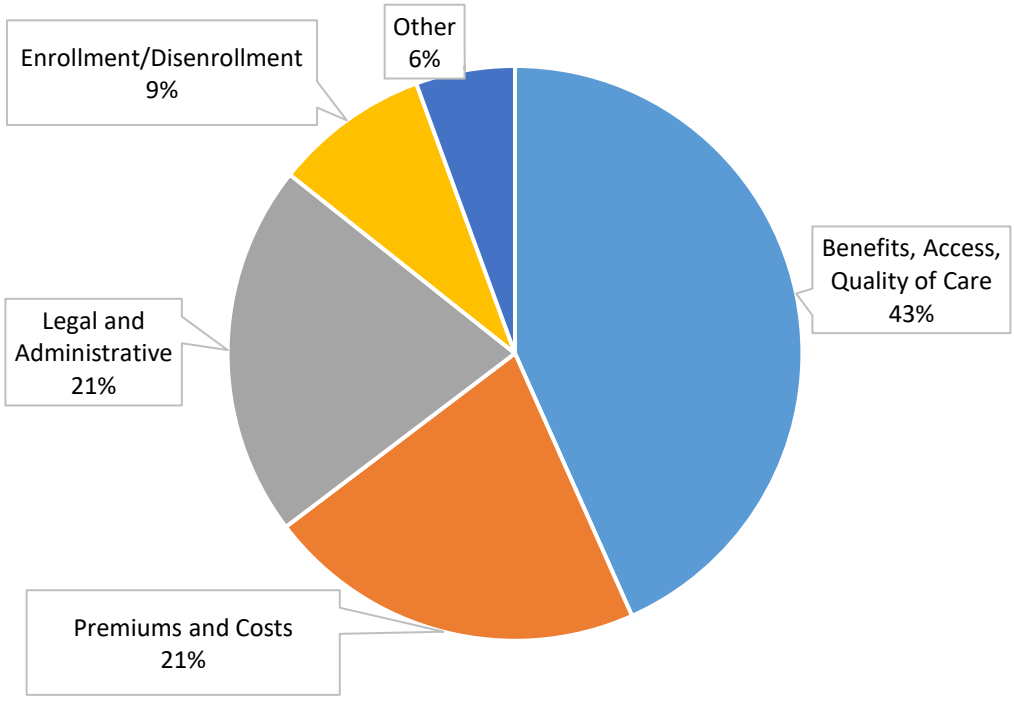
Figure 5: Total CTM Complaints by Submission Method, CY2020



Source: Complaint Tracking Module

Complaints are categorized in CTM for casework and resolution. Most of the true online complaints reported during CY2020 were related to (1) benefits, access, and quality of care; (2) premiums and costs; (3) legal and administrative issues; and (4) enrollment and disenrollment, as shown in Figure 6. These top four complaint categories accounted for approximately 94% of all true complaints in CY2020.

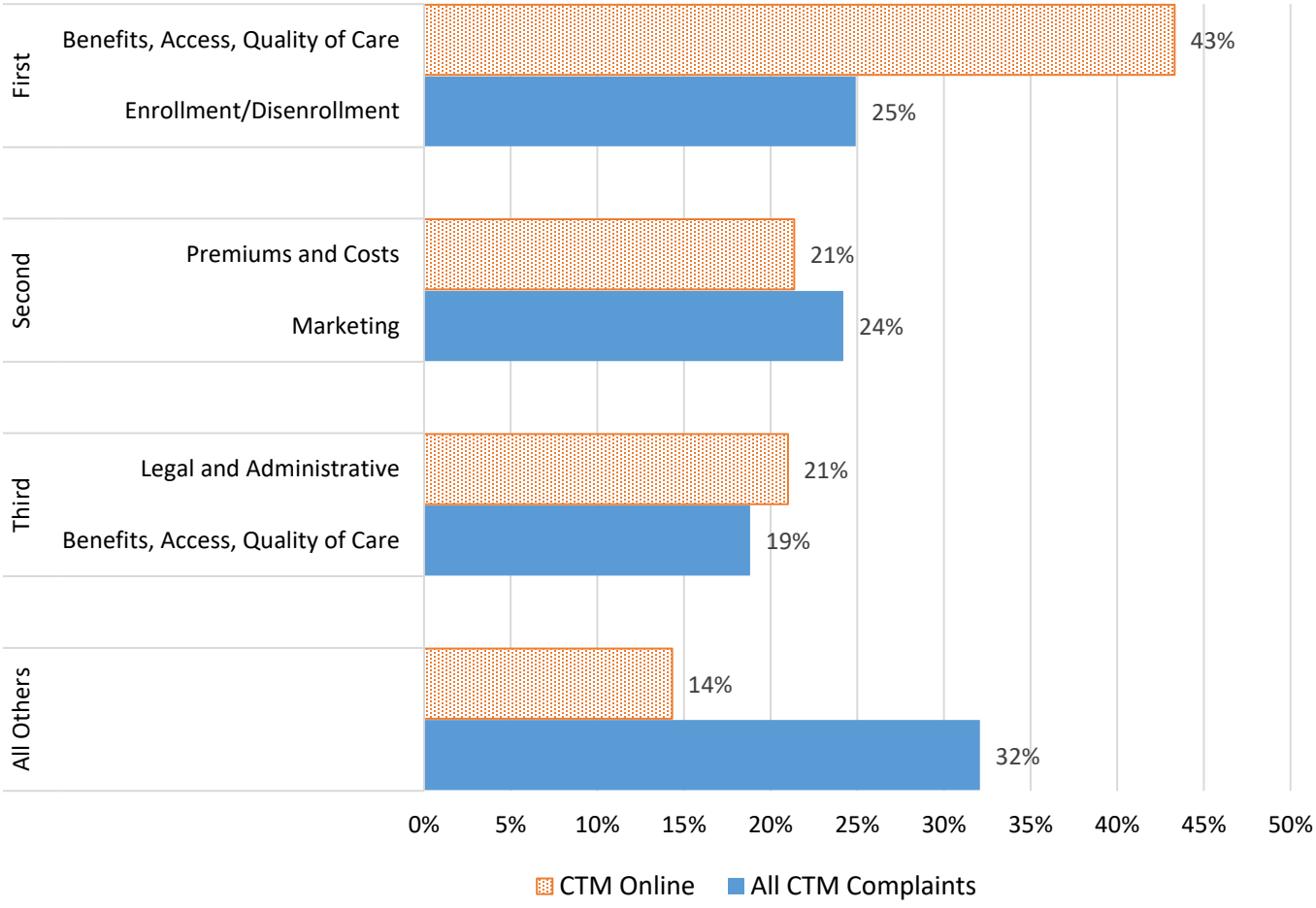
Figure 6: Online CTM Complaints by Category, CY2020



Source: Complaint Tracking Module

The top complaint categories among the CTM online complaints differed from the top categories among all CTM complaints, as shown in Figure 7. While nearly half of all online complaints related to benefits, access, or quality of care, fewer than one in five of all CTM complaints fell into that category. Enrollment and disenrollment issues were the most common reason for all CTM complaints, comprising approximately one quarter of total complaints, whereas just 9% of online complaints fell into that category.

Figure 7: Top Categories for Online and All CTM Complaints, CY2020



Source: Complaint Tracking Module

CMS Accessibility & Non-discrimination for Individuals with Disabilities Notice

Non-Discrimination Notice

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

CMS Accessible Communications

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

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

1. Call us:

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

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

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

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

4. Send us a letter:

    Centers for Medicare & Medicaid Services

    Offices of Hearings & Inquiries

    7500 Security Boulevard, Room S1-13-17

    Baltimore, MD 21244-1850

    Attn: Customer Accessibility Resource Staff

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

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

How to File a Complaint:

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

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

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

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

In writing: Send information about your complaint to:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

CMS Accessibility & Compliance with Section 508

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

Additional Information

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

REFERENCES

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

[ii] Newman, R. (2005). APA's resilience initiative. Professional Psychology: Research and Practice, 36(3), 227–229. https://doi.org/10.1037/0735-7028.36.3.227.

[iii] Social Security Act § 1861(i), 42 CFR § 409.30.

[iv] A rejected claim is not considered fully adjudicated by Medicare and is sent back to the provider or supplier due to failing certain requirements. A denied claim is considered fully adjudicated, meaning Medicare has made a final decision not to pay for the claim. A beneficiary cannot be charged for a rejected claim, but may be liable for a denied claim.

[v] Data were obtained from the Integrated Data Repository (IDR) on February 11, 2020.

[vi] Feinberg et al. (2018). "Aging, Reentry, and Health Coverage: Barriers to Medicare and Medicaid for Older Reentrants." Office of the Assistant Secretary for Planning and Evaluation. Accessed on January 10, 2020. Available at https://aspe.hhs.gov/system/files/pdf/260296/Reentry.pdf.

[vii] Ibid.

[viii] Ibid.

[ix] Medicaid and the Criminal Justice System. (2018). The Medicaid and CHIP Payment and Access Commission (MACPAC). Accessed on June 2, 2020. Available at https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf.

[x] Data were obtained from the Medicare Administrative Issue Tracker and Reporting of Operations (MAISTRO) system, where caseworkers record FFS case details, on January 14, 2021. Date was generated based on "Component Received Date." Inquirer types other than beneficiaries, beneficiary representatives, advocate groups, and Congressional offices were excluded. Cases are defined as communications submitted to CMS that require a CMS response to a specific issue from the public, other agencies, Medicare beneficiaries, etc.

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

[xii] 42 U.S.C. 1395w-154(a).

[xiii] 42 U.S.C. 1395w-154(b).

[xiv] 42 U.S.C. 1395w-154(c).

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

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

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

[xviii] Ibid.