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MEDICARE

Callers Can Access 1-800-MEDICARE Services, but Responsibility within CMS for Limited English Proficiency Plan Unclear

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Highlights

MEDICARE

Callers Can Access 1-800-MEDICARE Services, but Responsibility within CMS for Limited English Proficiency Plan Unclear

Why GAO Did This Study

The Centers for Medicare & Medicaid Services (CMS) is responsible for providing beneficiaries timely and accurate information about Medicare. Receiving nearly 30 million calls in 2007, 1-800-MEDICARE, operated by a contractor, is the most common way members of the public get program information. The help line provides services both to English-speaking and limited English proficiency (LEP) callers. In this report, GAO describes (1) the extent to which access performance standards and targets have been met by the current contractor, (2) the efforts by CMS to provide LEP callers access to help line services and wait times experienced by these callers, and (3) CMS's oversight of callers' access to 1-800-MEDICARE and the information's accuracy. To conduct this work, GAO reviewed documents and analyzed help line data through July 2008. In addition, GAO interviewed agency staff, industry experts, and officials at four federal agencies with high call volume contact centers.

What GAO Recommends

To ensure CMS offices, including those that oversee the operation of 1-800-MEDICARE, are aware of, and take steps consistent with, the Department of Health and Human Services (HHS) LEP Plan when considering the needs of people with LEP, CMS should designate an official or office with responsibility for managing the LEP Plan. In commenting on a draft of this report, CMS generally concurred with our recommendation.

To view the full product, including the scope and methodology, click on GAO-09-104. For more information, contact Kathleen King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The 1-800-MEDICARE contractor met most standards and some targets for the required telephone performance metrics and indicators CMS designed to ensure callers' access—from July 2007 through July 2008. The 1-800-MEDICARE contractor's performance met the standard for each of the three access-related metrics—the average amount of time callers wait to reach customer service representatives (CSR), the percent of unhandled calls, such as abandoned calls, and the percent of calls transferred among CSRs—in 10 of 13 months analyzed. Because of waivers granted by CMS, the contractor was considered by the agency to have met the standards in 12 of 13 months. During that time, the contractor met the target for only one of three access-related indicators—the percent of CSRs answering calls. Other indicators were the average amount of time needed to respond to callers' inquiries and the accuracy of CSR call volume forecasting.

CMS's efforts to provide LEP callers with access have led to shorter average wait times for Spanish-speaking callers, but are not consistent with all elements of the HHS LEP Plan. CMS requires its help line contractor to provide services to Spanish-speaking callers by employing bilingual CSRs and to provide interpretation services for other LEP callers, which the contractor does by using telephone interpreters. In 20 of the 32 months reviewed, Spanish-speaking callers waited less time, on average, to reach a CSR than English-speaking callers. CMS officials with primary responsibility for 1-800-MEDICARE said they were not aware of the LEP Plan when awarding the current contract, and CMS has not identified an office responsible for acting as a point of contact for management of the LEP Plan. Without a responsible office or official, an internal control for federal agencies, CMS staff lack a source of guidance to assist them in taking steps consistent with the LEP Plan when considering the needs of people with LEP. However, CMS has taken steps consistent with some elements of the agency's adopted LEP Plan, such as the element related to oral language assistance, but not others, such as the element identifying the need for complaint mechanisms for language issues.

To oversee 1-800-MEDICARE callers' access to services and accurate information, CMS uses all six commonly used contact center management practices. Based on GAO's review of the literature and interviews with federal agencies and industry experts, these management practices are: (1) clearly defining performance metrics, (2) performing accurate capacity planning, (3) conducting customer satisfaction surveys, (4) ensuring information for CSRs to reference is accurate, (5) evaluating CSRs' interaction with callers, and (6) validating contact center performance reports. These practices are addressed in the current 1-800-MEDICARE contract and reflected in CMS's ongoing contract oversight.

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Abbreviations

BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare & Medicaid Services
CSR	customer service representative
DME	durable medical equipment
FFS	fee-for-service
HHS	Department of Health and Human Services
IVR	Interactive Voice Response System
LEP	limited English proficiency
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
NDW	National Data Warehouse
OBIS	Office of Beneficiary Information Services
OCR	Office for Civil Rights
OEOCR	Office of Equal Opportunity and Civil Rights
TQC	Training, Quality, and Content contractor

United States Government Accountability Office
Washington, DC 20548

December 29, 2008

The Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

The nearly 45 million elderly and disabled Medicare beneficiaries face a complex set of coverage choices. For example, they must choose whether to participate in the original Medicare fee-for-service program or obtain coverage from private health plans that contract with Medicare, and whether to obtain Medicare coverage for outpatient prescription drugs.[1] These choices require them to obtain information about the comparative benefits, costs, and quality of available options. Additionally, once enrolled and receiving services, Medicare beneficiaries may seek additional information about their coverage, such as the status of payments for services or whether their health plan benefits have changed.

The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, is responsible for providing clear, accurate, and timely information about this complex program. In March 1999, CMS implemented a nationwide toll-free telephone help line—1-800-MEDICARE—that beneficiaries, their families, and other members of the public can call to ask questions about Medicare. 1-800-MEDICARE, which is operated by a contractor, is now the most common way beneficiaries and other interested members of the public get information from CMS about Medicare, with the help line receiving more than 30 million calls in

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[1]The original Medicare fee-for-service (FFS) program has two parts: Part A, which covers hospital and other inpatient services, and Part B, which is optional insurance and covers certain physician, outpatient hospital, and other services for beneficiaries who pay monthly premiums. Part B also includes durable medical equipment (DME), such as wheelchairs. As an alternative to FFS, Medicare beneficiaries may obtain coverage from private health plans that participate in the Medicare Advantage program—known as Medicare Part C. Medicare beneficiaries receiving coverage under Medicare FFS or Medicare Part C generally also may obtain coverage for outpatient prescription drugs under Medicare Part D. Medicare Advantage plans also may include drug coverage for beneficiaries.

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2007.[2] The help line operates 24 hours a day, 7 days a week, with calls first answered by an automated system and then routed to a customer service representative (CSR), if requested, for more specific inquiries about Medicare benefits.

The 1-800-MEDICARE help line provides assistance both to English- and non-English-speaking callers—in 2007, approximately 1 million callers of the more than 30 million total callers were assisted in a language other than English. Among non-English-speaking callers, Spanish was the most requested language, representing about 98 percent of all non-English-speaking callers to 1-800-MEDICARE in 2007. HHS, like other federal agencies, is required by Executive Order 13166 to examine the services it provides and develop and implement a system by which people with limited English proficiency (LEP) can meaningfully access federally conducted programs and activities, such as the 1-800-MEDICARE help line. The executive order also requires federal agencies, including HHS, to prepare a plan identifying the steps they will take to ensure meaningful access by people with LEP to such activities.[3]

Since the launch of the help line in 1999, changes to the Medicare program have required CMS to provide more information through 1-800-MEDICARE. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created a voluntary outpatient prescription drug program for Medicare beneficiaries and required information on this new program to be made available through 1-800-MEDICARE.[4] This and other changes to the Medicare program have resulted in increases in the number of calls received by 1-800-MEDICARE. Additionally, while in the past two contractors operated 1-800-MEDICARE, in October 2006 CMS opted to begin using a single contractor in an effort

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[2]CMS also receives inquiries through the mail, e-mail, and its Medicare Web site.

[3]Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*, 65 Fed. Reg. 50121-22 (Aug. 16, 2000). HHS issued an LEP Plan in December 2000 that applied to each of its agencies and programs, including CMS. The executive order further states that these LEP plans are to be consistent with the standards set forth in the Department of Justice guidance, which defines four factors for agencies to consider when forming their agency plans. These factors are: (1) the number or proportion of LEP persons in the eligible service population; (2) the frequency with which LEP individuals come in contact with the program; (3) the importance of the services provided by the program; and (4) the resources available.

[4]Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-2152 (2003) (codified, as amended, at 42 U.S.C. §§ 1395w-101-1395w-152).

to be more efficient, according to CMS officials. This single contractor assumed responsibility for 1-800-MEDICARE operations as of October 30, 2006.[5] CMS monitors the contractor's performance using metrics and indicators with corresponding performance standards and targets.[6]

Given the complexity of Medicare benefits, it is important that callers contacting 1-800-MEDICARE be able to access timely and accurate information as they make health care decisions. You asked us to provide information on the extent to which 1-800-MEDICARE provides timely services to callers, including LEP callers, and how CMS oversees the current 1-800-MEDICARE contractor. In this report, we describe (1) the extent to which performance standards and targets designed by CMS to ensure caller access have been met by the current 1-800-MEDICARE contractor and the extent to which the time a caller waits to reach a CSR has varied, (2) the efforts by CMS to provide LEP callers access to 1-800-MEDICARE services and the wait times experienced by these callers, and (3) CMS's oversight of callers' access to 1-800-MEDICARE and the accuracy of the information provided.

To describe the extent to which performance standards and targets designed by CMS to ensure caller access have been met by the current 1-800-MEDICARE contractor and the extent of efforts by CMS to provide LEP callers access to 1-800-MEDICARE, we reviewed documents related to 1-800-MEDICARE access requirements, including both the prior and current 1-800-MEDICARE contract and other related contracts.[7] We also interviewed staff from the CMS office with primary responsibility for 1-800-MEDICARE. We used these documents and interviews to identify the metrics and indicators and their corresponding standards and targets— criteria used to measure the 1-800-MEDICARE contractor's performance— that we considered to be most closely associated with caller access. In conducting our work, we focused on telephone services provided by 1-800-MEDICARE and did not review requirements for information provided

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[5]A transition period for phasing out operations of the second contractor occurred from October 30, 2006 through May 31, 2007.

[6]The standards are quantitative measures used to assess the contractor's performance on a pass/fail basis. The targets are guidelines used to assess the contractor's performance on a scale of substandard to superior.

[7]In this report, we define the current 1-800-MEDICARE contract as including the original task order awarded to a single contractor and the subsequent modifications to this task order.

through other communication channels, such as e-mail. Using data from CMS's National Data Warehouse (NDW)[8] on calls received by 1-800-MEDICARE, we compared the selected performance metrics and indicators to the contractor's actual performance. We also used these data to examine changes in the amount of time callers waited to reach a CSR. To assess the reliability of the NDW data used, we reviewed CMS documents describing how the data are collected and CMS's efforts to ensure data reliability. We also interviewed CMS officials responsible for collecting and analyzing the data and conducted a series of tests on the data files CMS provided. We determined the data were sufficiently reliable for the purposes of this report and reviewed data for three primary periods:[9]

- *December 2005 through July 2008*. We identified changes during this time period in the amount of time callers, including LEP callers, waited to reach a CSR.[10] This time period encompassed both the prior and current 1-800-MEDICARE contracts.

- *July 2007 through July 2008*. We analyzed data to compare the metrics and indicators implemented in July 2007 of the current 1-800-MEDICARE contract with the actual performance of the 1-800-MEDICARE contractor.[11]

- *September 2007 through July 2008*. We identified differences in the amount of time callers waited to speak to CSRs under the current 1-800-MEDICARE contract, depending on the skill level of staff responding to the calls, the language in which assistance was provided, and the type of calls—general inquiries about the Medicare program or calls about payments for services or benefits, referred to as claims.[12]

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[8]The NDW is a repository for data related to 1-800-MEDICARE, including data on the number of calls received by 1-800-MEDICARE and the amount of time a caller waits to speak with a CSR.

[9]July 2008 data reflect the most current data available at the time of our review.

[10]Data related to the amount of time callers initially waited to speak with CSRs were not available prior to December 2005.

[11]Prior to July 2007, CMS used measures primarily focused on evaluating the 1-800-MEDICARE contractor's performance during the transition of operations from two contractors to the single contractor.

[12]Data identifying differences in the contractor's performance on these three elements were not available prior to September 2007.

To provide additional information on efforts by CMS to provide LEP callers access to 1-800-MEDICARE services, we reviewed Executive Order 13166 and the LEP Plan developed by HHS. We also interviewed staff from the HHS Office for Civil Rights and the CMS Office of Equal Opportunity and Civil Rights.[13] Additionally, we reviewed GAO work related to internal control standards when considering implementation of the LEP Plan. While we reviewed certain 1-800-MEDICARE activities to identify steps consistent with the LEP Plan, we did not review all CMS and 1-800-MEDICARE activities for consistency with the LEP Plan.

To describe how CMS oversees callers' access to, and the accuracy of information provided by, 1-800-MEDICARE, we identified six common oversight practices used by contact centers to ensure both caller access and information accuracy.[14] To identify these practices, we reviewed prior GAO work and federal publications related to contact centers[15] and conducted interviews with four federal agencies that receive inquiries about their services by telephone and with contact center industry experts.[16] We selected federal agency contact centers to interview based on our review of prior related GAO work, selecting those that had annual

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[13]Officials with the HHS Office for Civil Rights (OCR) and CMS Office of Equal Opportunity and Civil Rights (OEOCR) said their primary LEP focus was enforcement of requirements under Title VI of the Civil Rights Act of 1964, Pub. L. No. 88-352, § 601, 78 Stat. 241, 252-253 (1964) (codified, as amended, at 42 U.S.C. §§ 2000d-2000d-7). Executive Order 13166 also requires federal agencies to prepare Title VI guidance for their recipients of federal financial assistance and HHS has issued this Title VI guidance. However, because Title VI requirements and related guidance do not apply to programs conducted by federal agencies, such as 1-800-MEDICARE, they were not included in the scope of our work. In addition to this enforcement role, HHS OCR is responsible for promoting compliance with and enforcement of other federal civil rights statutes that prohibit discrimination on the basis of race, color, national origin, age, disability, and, in some cases, sex and religion. CMS OEOCR also conducts other activities, including managing the agency's equal employment opportunity discrimination complaints and providing relevant information to CMS programs on civil rights issues.

[14]A contact center refers to a customer service center that handles telephone and written inquiries.

[15]See, for example, GAO, *Federal Contact Centers: Mechanisms for Sharing Metrics and Oversight Practices along with Improved Data Needed*, GAO-06-270 (Washington, D.C.: Feb. 8, 2006). For more of the reports we reviewed to identify common practices, see the Federal Contact Center Reports section of the "Related GAO Products" page at the end of this report.

[16]We interviewed officials from the Department of Defense's TRICARE Management Activity, the Department of Education's Office of Federal Student Aid, the Department of the Treasury's Internal Revenue Service, and the Social Security Administration.

call volumes greater than 5 million calls and other characteristics similar to those of 1-800-MEDICARE, such as a comparable population, extended hours, periods of particularly high call volume, and service provision in multiple languages. Using our review of publications and the interviews with our selected federal contact centers, we identified the six common oversight practices, which we then confirmed in interviews with industry experts and an industry publication.[17] To determine whether CMS used these common oversight practices, we reviewed documents related to CMS's oversight of the 1-800-MEDICARE contractor, including meeting minutes, policies and procedures, and contractor evaluations, and interviewed CMS officials. We also conducted a site visit to one of the five 1-800-MEDICARE contact center sites to gain a better understanding of how the centers function.[18] In addition, we reviewed a contract awarded by CMS in December 2007 to a separate contractor—referred to as the Training, Quality, and Content (TQC) contractor—responsible for developing CSR training materials and for conducting quality assurance efforts for 1-800-MEDICARE. We interviewed officials both from CMS and the current 1-800-MEDICARE contractor to determine steps the TQC contractor is taking to assume responsibility for these activities. As the TQC contract was not fully implemented at the time of our review, we could not evaluate its effectiveness.

Our work did not assess particular issues encountered by callers with visual, hearing, or speech impairments or those with low literacy. In addition, we did not evaluate the accuracy of information callers receive from 1-800-MEDICARE CSRs, the accuracy of information CSRs use to answer beneficiary questions, or the appropriateness of CSR training. We also did not evaluate the effectiveness of the individual management practices CMS uses to oversee callers' access to, and accuracy of information provided by, 1-800-MEDICARE and did not analyze the award process for, or management of, the contract.

We conducted this performance audit from December 2007 through November 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We

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[17]Brad Cleveland. *Call Center Management on Fast Forward.* Maryland: ICMI Press, 2006.

[18]A sixth contact center site is available to accommodate callers during periods of increased call volume.

believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

The 1-800-MEDICARE contractor met most standards and some targets for telephone access-related performance measures—metrics and indicators designed to ensure all callers' access to services—from July 2007 through July 2008. In 10 of the 13 months analyzed, the 1-800-MEDICARE contractor's performance met the standards for each of three required access performance metrics—the average amount of time a caller waits to reach a CSR; the percent of calls that are unhandled, such as abandoned calls; and the percent of calls transferred among CSRs. Because of waivers granted by CMS, the contractor was considered by the agency to have met the standards in 12 of 13 months. For example, the current contractor met the performance metric standard of maintaining a monthly average wait time for all callers of between 5 minutes and 8 minutes, 30 seconds in 12 of 13 months analyzed and, because of a waiver granted by CMS, was considered by the agency to have met the relevant standard for average wait time in all 13 months. However, the contractor met targets for only one of three monthly access-related indicators during that same 13-month period—the percent of CSRs answering calls. Other indicators were the average amount of time needed to respond to callers' inquiries and the accuracy of CSR call volume forecasting. The 1-800-MEDICARE contract does not include metrics or indicators specifically related to the type of call, but the agency expected the contractor to manage wait times to ensure that callers with different types of inquiries had similar wait times. However, during the current contract period, callers experienced differing wait times depending on the type and complexity of the inquiry. For example, callers with more complex inquiries generally experienced longer wait times to reach a CSR. The amount of time callers wait to speak with a CSR has increased since December 2005, but the performance standards related to caller wait time also have varied over time.

CMS's efforts to provide LEP callers with access to 1-800-MEDICARE have led to shorter average wait times for Spanish-speaking callers, but are not consistent with all elements of the LEP Plan. To provide LEP callers with access to 1-800-MEDICARE, CMS requires its help line contractor to provide services to callers in both English and Spanish by employing bilingual CSRs and to provide interpretation services for callers speaking other languages, which the contractor does through a telephone interpretation service. In two-thirds of the months we reviewed— December 2005 through July 2008—Spanish-speaking callers waited, on average, less time to reach a CSR than their English-speaking

counterparts. However, Spanish-speaking callers have recently experienced average wait times that were slightly longer than those of English-speaking callers. CMS officials responsible for 1-800-MEDICARE were not aware of the LEP Plan—developed by HHS for its agencies and programs as required by Executive Order 13166 and adopted by CMS to improve language access—and CMS was not able to identify an office responsible for management of this Plan. Despite this limited awareness, steps CMS has taken to provide access to 1-800-MEDICARE for LEP callers are consistent with some, but not all, of the LEP Plan elements. For example, by requiring its contractor to provide services in multiple languages, CMS has taken a step consistent with the Plan's element related to oral language assistance. However, CMS has not identified a specific office or official with whom LEP callers could register complaints regarding language assistance services, despite a Plan element addressing this issue. Without a responsible office or official—a key internal control for federal agencies—to manage the LEP Plan, CMS staff lack a source of guidance that could assist them in taking steps consistent with the Plan when considering the needs of people with LEP.

CMS uses all six of the commonly used management practices for contact centers we identified to oversee 1-800-MEDICARE callers' access to services and to accurate information. These practices are: (1) clearly defined performance metrics relating to access, (2) customer satisfaction surveys, (3) assurance that information referenced by CSRs to answer callers' inquiries is accurate, (4) evaluation of CSRs' interaction with callers, (5) capacity planning to meet caller demand for services, and (6) validation of contact center performance reports. These practices are addressed in the current 1-800-MEDICARE contract and reflected in CMS's ongoing oversight of the help line. For example, CMS used information collected by customer satisfaction surveys to identify callers' dissatisfaction with the automated system and took steps to improve the system. In addition, CMS identified periods when the 1-800-MEDICARE contractor did not accurately forecast call volume, which is used to determine whether systems and staffing will be sufficient to meet the caller demand for services, and the agency continues to monitor the contractor's performance in this area.

To ensure CMS offices, including those that oversee the operation of the 1-800-MEDICARE help line, are aware of, and take steps consistent with, the HHS LEP Plan when considering the needs of people with LEP, we recommend that CMS designate an official or office with responsibility for managing the LEP Plan. In commenting on a draft of this report, CMS generally concurred with our recommendation.

Background

CMS administers 1-800-MEDICARE through a single contractor that operates the telephone help line 24 hours a day, 7 days a week. CMS initially designed 1-800-MEDICARE to assist beneficiaries in obtaining information about Medicare programs, including Medicare's managed care program, and has since expanded the telephone line to handle increased call volume and additional inquiries, including inquiries about Medicare's prescription drug benefit. Calls are answered by an automated system and, if requested, callers may be routed to a CSR for additional assistance. The contractor trains CSRs to respond to two types of inquiries—(1) general inquiries about the Medicare program (such as general inquiries about prescription drug coverage or beneficiary address changes) and (2) specific inquiries about some Medicare Part A and Part B claims—for both English- and Spanish-speaking callers. CMS uses performance metrics and indicators to oversee and measure the 1-800-MEDICARE contractor's performance. To meet the needs of people with LEP, HHS developed an LEP Plan that identifies steps for its agencies, including CMS, to take to improve access for people with LEP to agency programs and activities, including 1-800-MEDICARE.

Contact Center Operations

CMS administers 1-800-MEDICARE to answer callers' inquiries 24 hours a day, 7 days a week about Medicare eligibility, enrollment, and benefits. CMS initially developed 1-800-MEDICARE to assist beneficiaries and other members of the public in obtaining information about Medicare programs, including Medicare's managed care program, as required by the Balanced Budget Act of 1997 (BBA).[19] In 2003, the MMA required CMS to make information about the Medicare prescription drug benefit available through 1-800-MEDICARE and gave CMS increased flexibility in the administration of Medicare.[20] CMS officials reported that they used this flexibility to transfer responsibility for information about Medicare-related Part A and Part B (including DME) claims calls, which previously had been

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[19]The BBA established Medicare+Choice—now referred to as Medicare Advantage or Medicare Part C—and required that the Secretary of HHS maintain a toll-free number for inquiries on the new program. Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275-327 (1997) (codified, as amended, at 42 U.S.C. §§ 1395w-21, et seq.).

[20]Pub. L. No. 108-173, §§ 101, 911, 117 Stat. 2066, 2071-2152, 2378-2386 (2003) (codified, as amended, at 42 U.S.C. §§ 1395w-101-1395w-152, 1395kk-1). The MMA allowed the Secretary of HHS to expand certain responsibilities of Medicare contractors, including with respect to Medicare Parts A and B claims and beneficiary and provider communications. These Medicare contractors are required to maintain a toll-free line where beneficiaries, providers, and suppliers may obtain information regarding billing, coding, claims, coverage, and other relevant information relating to Parts A and B.

handled by separate Part A and Part B contractors with their own help line numbers, to 1-800-MEDICARE.[21] CMS completed the transition of Part A and Part B claims calls to 1-800-MEDICARE in September 2007.

Each of these initiatives contributed to an increase in the overall volume of calls received by 1-800-MEDICARE. During the period encompassed in our review, overall call volume for 1-800-MEDICARE increased approximately 22 percent, from about 1.6 million calls in July 2005 to more than 2.0 million calls in July 2008. (See fig. 1.) A large increase in volume occurred close to the beginning of the Medicare prescription drug benefit in late 2005 and early 2006. Since that time, monthly call volume has ranged from about 2 million inquiries to slightly more than 3 million.

Figure 1: Total 1-800-MEDICARE Call Volume, July 2005 through July 2008

Source: CMS monthly data.

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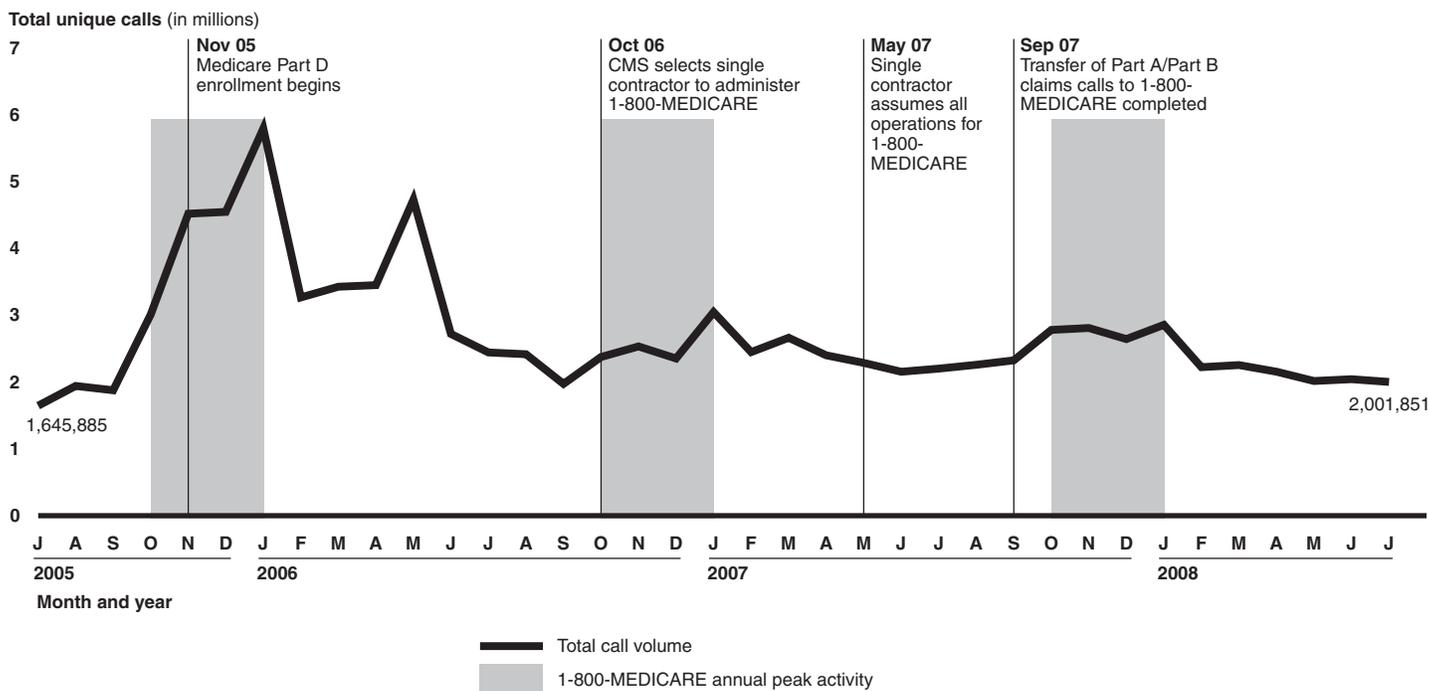
[21]CSRs refer callers with specific inquiries about amounts owed for their deductibles or co-payments related to Medicare's Part C or Part D to the plan in which the beneficiary is enrolled because CSRs do not have access to this information.

Callers to 1-800-MEDICARE receive information from an automated interactive voice response (IVR) system, a CSR, or a combination of both. Calls to the line are initially answered by the IVR, which responds to voice and electronic prompts by the caller.[22] Callers also may use the IVR to obtain assistance in either English or Spanish. Those who do not indicate a language preference in the IVR and wish to speak to a CSR are automatically routed to a CSR for assistance in English. If the IVR cannot address the needs of the caller or if the caller requests to speak to a person, the call is routed to a CSR for assistance. (See fig. 2.)

Figure 2: How Callers Navigate 1-800-MEDICARE's Automated IVR System
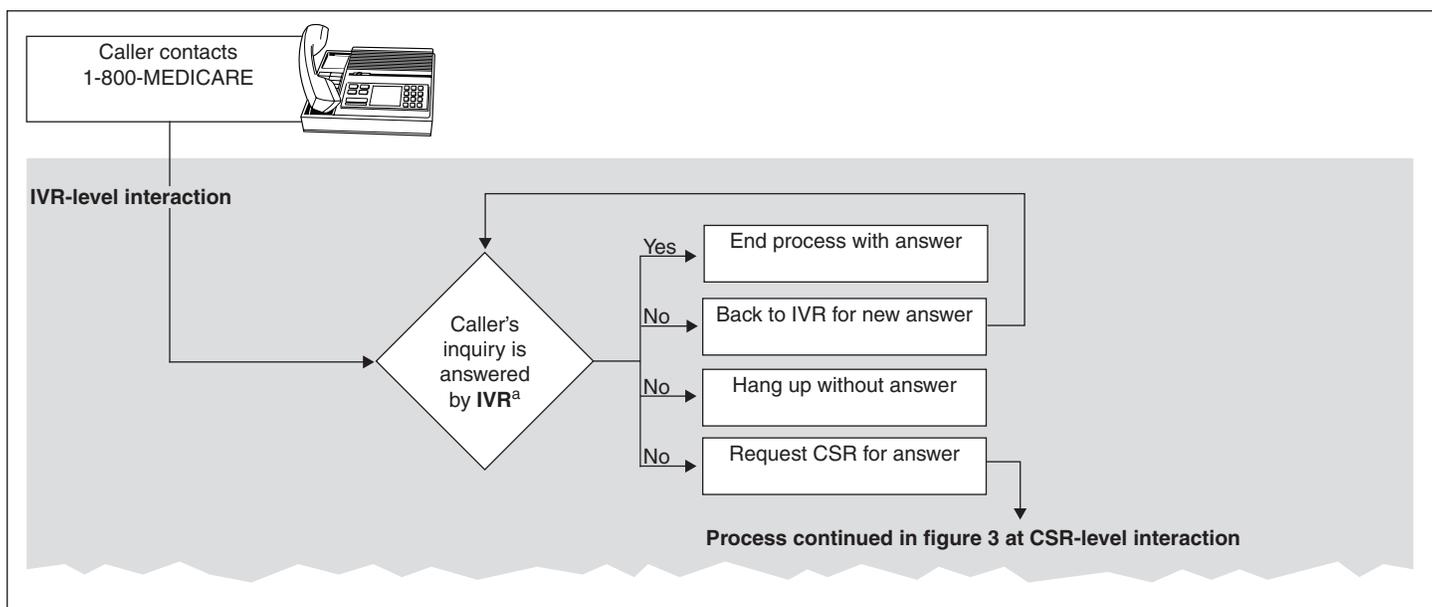
Source: GAO analysis of CMS documents (data); Art Explosion (graphics).

[a]Callers can request assistance in English or Spanish. If callers request assistance in Spanish, they are assisted by a Spanish IVR that is consistent with the IVR available to English-speaking callers. If a caller chooses neither English nor Spanish—for example, a caller who speaks neither language— the IVR routes that caller directly to a CSR for assistance in English.

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[22]Prior work by the HHS Office of the Inspector General reported on concerns raised by callers about difficulties in using the 1-800-MEDICARE IVR. See Department of Health and Human Services, Office of Inspector General, *1-800-MEDICARE: Caller Satisfaction And Experiences*, OEI-07-06-00530 (Washington, D.C.: September 2007).

CSR Assistance	1-800-MEDICARE classifies incoming calls to CSRs into two types of requests:

- Inquiries about general Medicare issues, such as general inquiries about prescription drug coverage or beneficiary address changes.

- Specific inquiries about claims for Medicare Parts A and B. To provide assistance with these claims inquiries, 1-800-MEDICARE CSRs are able to access certain Part A and Part B claims data.[23]

  Newly hired CSRs initially receive training to provide services related to general Medicare inquiries and, as they become more proficient, receive additional training to respond to claims inquiries. The 1-800-MEDICARE contractor hires additional, temporary CSRs to handle anticipated increases during 1-800-MEDICARE's annual peak period from October through mid-January; these CSRs are trained to handle general Medicare inquiries.[24]

  The IVR routes callers with general Medicare or specific claims inquiries to CSRs according to complexity. The approximately 2,600 CSRs[25] responding to these calls are grouped into two skill levels, or "tiers," based on their training and experience. (See fig. 3.)

- *Tier 1 CSRs*, who made up the majority of CSRs as of January 1, 2008, receive training to respond to simple inquiries about Medicare and claims. Tier 1 CSRs handle the majority of 1-800-MEDICARE inquiries. Between September 2007 and July 2008, Tier 1 CSRs handled over 15.1 million calls—95 percent of the approximately 15.9 million calls handled by CSRs. Approximately 11.8 million of these Tier 1-handled calls were general Medicare inquiries while approximately 3.3 million were claims inquiries.

- *Tier 2 CSRs* receive training to assist callers with more complex general Medicare and claims inquiries. For example, callers wishing to enroll in a Medicare Advantage plan would speak to a Tier 2 CSR. These CSRs also can respond to calls at the Tier 1 level if needed. Between September 2007

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[23]CSRs do not have access to information about amounts owed for callers' deductibles or copayments for Medicare's Part C or Part D plans.

[24]Events that affect volume during this period include the annual mailing of the *Medicare & You* handbook and annual beneficiary enrollment in Medicare Advantage plans and prescription drug plans.

[25]The 2,600 CSRs were employed as of January 1, 2008, by the 1-800-MEDICARE contractor.

and July 2008, Tier 2 CSRs handled about 800,000 calls—5 percent of all calls handled by CSRs. Approximately 523,000 of these calls were general Medicare inquiries, while approximately 273,000 were claims inquiries.

Particularly complex inquiries, about 1 percent of all calls received, may be referred by Tier 1 or Tier 2 CSRs to a reference center staffed by CSRs with additional training above the level of the Tier 2 CSRs.[26]

Figure 3: How Callers Navigate 1-800-MEDICARE's CSR-Level Interaction
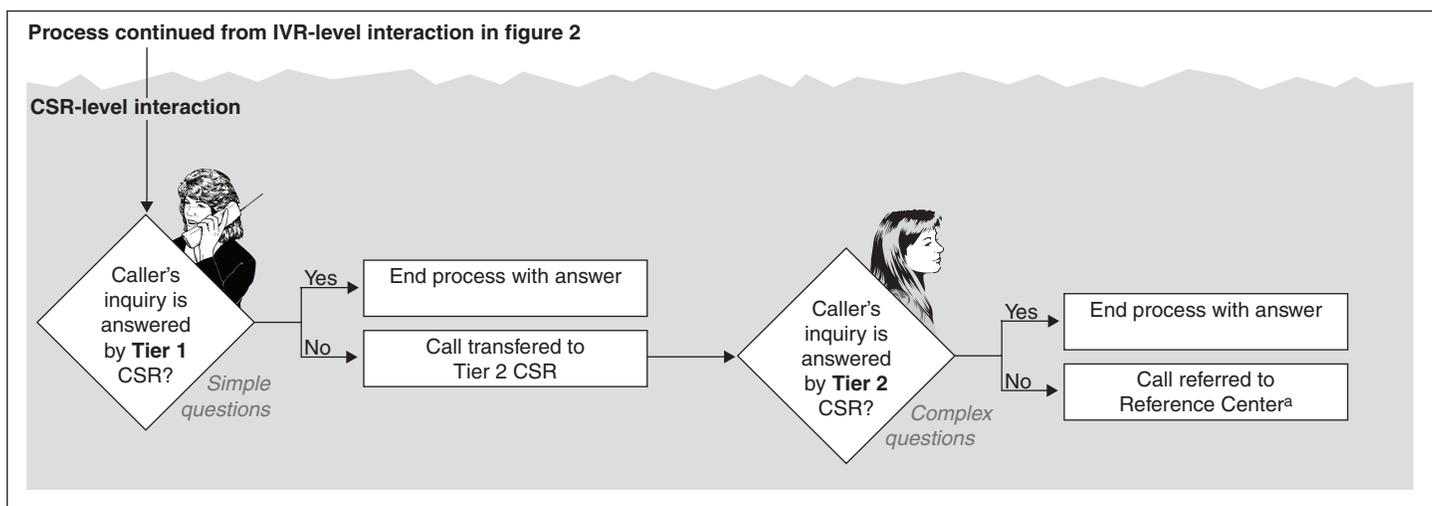
Source: GAO analysis of CMS documents (data); Art Explosion (graphics).

[a]Callers are not transferred to the reference center. Rather, Tier 1 and Tier 2 CSRs provide information on callers' inquiries to Reference Center staff, who will research the issue and contact the caller.

To provide responses to callers, CSRs in Tier 1 and Tier 2 use defined "scripts"—standard language explaining elements of the Medicare program—that they access using desktop computer software. CSRs listen to a caller's inquiry and then enter related keywords into this system to generate a list of suggested scripts that could be used to answer the inquiry. The CSRs then select the script they consider best suited to answer the inquiry and read either excerpts or the entire script to the

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[26]As of January 1, 2008, CSR staffing also included Tier 2 Senior Representative CSRs who assist Tier 1 and Tier 2 CSRs. Additional CSRs also are dedicated to responding to written and e-mail correspondence. These CSRs are also trained and available to respond to calls during periods of high call volume.

caller.[27] CSRs may also consult other information sources if appropriate. For example, CSRs sometimes use tools available on the Medicare Web site to help beneficiaries select a prescription drug plan.[28] CMS requires CSRs to read scripts in an effort to ensure that all callers receive consistent information from 1-800-MEDICARE—regardless of the expertise of the CSR—and that information being shared is easily understood by the caller.[29]

1-800-MEDICARE Contract and Related Contracts

In October 2006, CMS awarded a single performance-based contract[30] for the operation of its 1-800-MEDICARE contact centers valued at approximately $496 million over the life of the contract. This contract consisted of an initial 7-month transition period, during which the current 1-800-MEDICARE contractor assumed full responsibility for 1-800-MEDICARE help line operations, and 2 additional years, referred to as "option years."[31] The contractor is reimbursed for its costs and receives a fixed base fee. In addition, the contractor can earn an "award fee"—a percent of the total contract amount—based on its performance in meeting specific metric standards and indicator targets that CMS identified as being particularly important to providing services to callers and controlling contract costs. The current metrics and their standards were put in place as of July 2007.[32] Using the standards and targets, CMS evaluates the contractor's performance three times a year. For each

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[27]CSRs use scripts to the extent possible when answering claims inquiries, though some claims information (e.g., specific claims amounts) may vary by caller.

[28]The Medicare Web site is *www.medicare.gov.*

[29]Prior GAO work has raised concerns about the ability of both CSRs and callers to understand scripts for commonly asked questions. See GAO, *Medicare: Accuracy of Responses from the 1-800-MEDICARE Help Line Should Be Improved,* GAO-05-130 (Washington, D.C.: Dec. 8, 2004).

[30]Performance-based contracts specify the desired outcomes and allow the contractors to determine how best to achieve those outcomes, rather than prescribe the methods to be used. Performance-based contracts can encourage contractors to be innovative and to find cost-effective ways of delivering services. See GAO-06-270.

[31]CMS has exercised its option to extend this contract for two additional years. Accordingly, the current 1-800-MEDICARE contract extends from October 30, 2006, through May 31, 2009.

[32]Prior to July 2007, CMS used measures primarily focused on evaluating the 1-800-MEDICARE contractor's performance during the transition of operations from two contractors to the single contractor.

evaluation period, CMS can decide to award all, part, or none of the available award fee amount depending on the contractor's performance.

The current performance metrics quantify and measure the caller experience with 1-800-MEDICARE. Several metrics are specifically related to telephone access, such as the average amount of time callers wait after indicating that they want to speak to a CSR until their calls are answered by the CSR.[33] The 1-800-MEDICARE contractor must meet the specific standards for these performance metrics in order to be awarded up to 15 percent of the award fee. Each evaluation period is 4 months long. If the contractor does not meet a performance metric standard during any month in an evaluation period, that month's portion of the award fee is withheld at the end of that evaluation period.

CMS also has designed several performance indicators that it considers when measuring the performance of the 1-800-MEDICARE contractor. Several of these indicators are specifically related to telephone access, such as the average amount of time a CSR talks to a caller. These performance indicators do not have fixed standards against which the contractor's performance is measured; rather, CMS has established performance targets and compares the contractor's actual performance against these targets, using a scale ranging from substandard to superior, to determine the contractor's award fee. According to CMS officials, the purpose of the targets is to provide a baseline for planning and management of contact center activities. The performance indicators, when combined with other contract elements, account for up to 45 percent of the award fee. CMS also considers the contractor's performance related to program management and communication, contract compliance, and fiscal responsibility when determining the award fee. These elements, when combined, account for up to 40 percent of the award fee.[34]

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[33]CMS has categorized the performance metrics into two "bundles," one related to telephone access and another related to other communication channels, such as responses to e-mail and written inquiries.

[34]The element related to program management and communication accounts for 20 percent of the award fee while the elements related to contract compliance and fiscal responsibility account for 10 percent each. We considered the program management and communication indicators related to access and accuracy as part of our review of CMS oversight of 1-800-MEDICARE; however, the performance indicators for contract compliance and fiscal responsibility were not related to access or oversight of access and accuracy and therefore were considered outside the scope of our review.

In addition to the main 1-800-MEDICARE contract, CMS has awarded four additional contracts to individual companies for other activities directly related to the support of 1-800-MEDICARE:

- A contract with a telephone company to manage the phone lines used by 1-800-MEDICARE. This company also ensures that calls to CSRs are routed to the next available CSR with the skill set to assist the caller.

- A contract to support and maintain the desktop application used by CSRs, including software CSRs use to access scripts.

- A contract to manage the NDW, a central data repository that captures, aggregates, and integrates data on 1-800-MEDICARE from multiple sources.

- A contract—referred to as the TQC contract—to conduct activities that include training, development of the scripts used by CSRs, and quality assurance, such as evaluation of CSR calls.[35]

Access to Services for Persons with LEP

As required by Executive Order 13166, HHS has developed a plan that identifies the necessary steps for the department and its agencies intended to ensure access to timely, quality language assistance services by eligible LEP persons to its programs and activities, such as 1-800-MEDICARE. The HHS LEP Plan, issued in December 2000, identifies seven elements designed to help each HHS agency, program, and activity to meet the department's goal of providing "access to timely, quality language assistance services to [LEP] persons." For example, the Plan includes elements related to oral language assistance services and efforts to assess accessibility and the quality of language assistance activities. (See app. I for a list of the seven LEP Plan elements.) The Plan reflects HHS's overall goals for improving language access for individuals and includes strategies for improving technical assistance for language access services. HHS officials said that the Plan provides a "road map" for addressing HHS's goals, while allowing individual operating divisions and agencies, including CMS, some flexibility in implementing the Plan's elements.

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[35]CMS awarded the TQC contract in December 2007. According to CMS officials, elements of the TQC contract were continuing to be implemented during the period encompassed in this review.

The 1-800-MEDICARE Contractor Met Most Standards and Some Targets Designed to Ensure Caller Access, but Average Wait Times under the Current Contract Varied by Type and Complexity of Inquiry

The current 1-800-MEDICARE contractor met most standards and some targets for telephone access-related performance metrics and indicators—measures designed to ensure all callers' access to services—from July 2007 through July 2008. In 10 of 13 months we analyzed, the current 1-800-MEDICARE contractor's performance met the standards for each of the required access-related performance metrics. Because of waivers granted by CMS, the agency considered the contractor to have met the relevant standards in 12 of the 13 months. While generally meeting the required standards for the three access-related performance metrics, the 1-800-MEDICARE contractor consistently met the target for only one of the three access-related performance indicators we analyzed. However, the amount of time callers waited to access services has varied depending on the type and complexity of callers' inquiries. The amount of time callers waited to speak with a CSR has increased since December 2005, but the performance standards related to caller wait time also have varied over time.

Overall, the Current 1-800-MEDICARE Contractor Met CMS Monthly Access-Related Performance Standards

In 10 of 13 months we analyzed (July 2007 through July 2008), the current 1-800-MEDICARE contractor's performance met the standards for all three telephone access-related performance metrics required under its contract with CMS.[36] Because of waivers granted by CMS, the contractor was considered by the agency to have met the relevant standards in 12 of the 13 months. Implemented in July 2007, the performance metrics and their associated standards were designed to measure, on a monthly basis, the 1-800-MEDICARE contractor's ability to ensure callers can access services and to determine the contractor's award fee during each evaluation period, which occur three times a year.[37] The metrics, described below in table 1, are: (1) the average wait time (also referred to by CMS as the average speed of answer), (2) the percentage of unhandled CSR calls, and (3) the percentage of transfers.

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[36]We analyzed metrics for incoming calls only. CMS has also developed performance metrics related to services other than incoming calls, including web chats and responding to e-mails.

[37]The standard for one metric, average wait time, was modified in August 2008. All data in this report are through July 2008.

Table 1: Required Monthly Access-Related Performance Metrics and Standards, July 2007 through July 2008

Performance metric	CMS Definition of Performance Metric	Performance Standard	Contractor Performance
Average wait time	The average amount of time callers wait until their calls are answered by a CSR[a]	July 2007 through September 2007, between 7 and 8 minutes, 30 seconds October 2007 through July 2008, between 5 and 8 minutes, 30 seconds[b]	Met standard in 12 of 13 months; received waiver for one month when standard not met[c]
Unhandled CSR calls[d]	The percentage of callers indicating they want to speak with a CSR but who are unable to because the call is abandoned, disconnected, or delayed because of high call volumes	Percentage of unhandled calls standard varies with the average wait time—for example, if the average wait time standard is between 7 and 8 minutes the unhandled call standard is 40 percent or less; if the average wait time standard is between 3 to 4 minutes, the related unhandled CSR call standard would be 20 percent[e]	Met standard in 11 of 13 months; received waiver for one month when standard not met[f]
Transfers	The percentage of calls transferred from one CSR to another CSR	20 percent or less	Met standard in 13 of 13 months

Source: GAO analysis of CMS data and 1-800-MEDICARE contract.

Note: Prior to June 2007, CMS had contract metrics related to performance but, according to CMS officials, the contractor was primarily measured on activities related to the transition period, rather than on those metrics. CMS began using performance metrics in June 2007, with the current metrics implemented in July 2007.

[a]The average wait time performance metric averages the time callers wait before CSRs answer their calls on a monthly basis. Wait times for individual calls may be lower or higher than the monthly average.

[b]Effective August 2008, CMS revised its average wait time standard. The new standard requires the contractor to have an average wait time between 1 minute and 5 minutes.

[c]Because of this waiver, CMS did not consider the contractor's performance on this metric for that month when determining overall performance or in determining an award fee.

[d]Data on unhandled calls are collected by the NDW.

[e]The current 1-800-MEDICARE contract includes several possible unhandled call time standards, all dependent on the average wait time standard. CMS officials said that the agency included a range of unhandled CSR call standards in the contract to facilitate future changes to the metrics.

[f]Because of this waiver, CMS did not consider the contractor's performance on this metric for that month when determining overall performance or in determining an award fee.

Average wait time. The 1-800-MEDICARE contractor met the overall monthly average wait time performance standard—between 5 minutes and 8 minutes, 30 seconds each month—in 12 of the 13 months (from July 2007 through July 2008) we analyzed and, because of a waiver granted by CMS, was considered by the agency to have met the relevant standard in all 13 months. (See fig. 4.) CMS granted the waiver for one month's wait time standard for multiple reasons, including to account for the interruption of normal 1-800-MEDICARE contact center operations because of flooding in

the Midwest. During the 13-month period we studied, the average wait time ranged from a low of less than 6 minutes in July 2008 to a high of more than 8 minutes in September 2007.[38] For the 5 months (October 2007 to February 2008) encompassing the most recent annual coordinated election period and a portion of the open enrollment period[39]—when call volume to 1-800-MEDICARE typically increases—the contractor's monthly average wait time for all calls was between 6 minutes, 30 seconds and 7 minutes.

Figure 4: 1-800-MEDICARE Contractor's Average Wait Time, July 2007 through July 2008
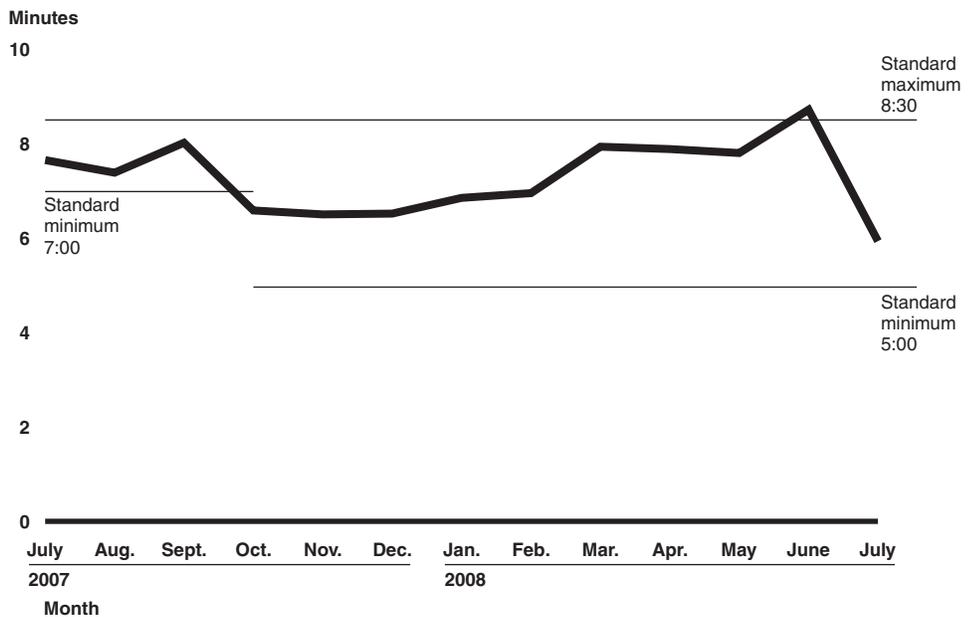
Source: CMS monthly data.

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[38]This excludes June 2008, the month in which the contractor received a waiver for the average wait time metric and standard.

[39]Medicare beneficiaries generally may change or disenroll from either Medicare Advantage plans or prescription drug plans during the annual coordinated election period, which begins on November 15 and ends on December 31 of each year. Beneficiaries may also change or disenroll from most Medicare Advantage plans once during the open enrollment period, which begins on January 1 and ends on March 31 of each year.

CMS's monthly average wait time standard during the time period we analyzed allowed longer wait times than were typical at two of the four federal agencies we interviewed that use this metric for their contact centers.[40] These two agencies used average wait time as a performance metric, with performance standards ranging from 4 minutes, 30 seconds to 5 minutes, 30 seconds.[41] CMS officials said they recognized that the 1-800-MEDICARE average wait time performance standard was long, but said that they selected it based on what could be reasonably achieved within the current budgeted amount available for the 1-800-MEDICARE contract. CMS officials also said that they believed that the budget would not allow for a standard that was more comparable to standards used in the contact center industry. However, CMS officials reported that in August 2008, they began requiring the contractor to meet an average wait time standard of between 1 minute and 5 minutes. CMS officials said that in order to better serve callers, they and the 1-800-MEDICARE contractor implemented processes and improved technologies that have increased the efficiency of the help line. For example, CMS and the contractor implemented new staffing initiatives to ensure that 1-800-MEDICARE has the necessary CSRs available to answer calls.

Unhandled CSR call rate. The 1-800-MEDICARE contractor met its unhandled CSR call rate standard, keeping the number of unhandled calls within the required standards, in 11 of the 13 months we analyzed and, because of a waiver granted by CMS, was considered by the agency to have met the standard in 12 of 13 months. (See table 2 below.) The unhandled CSR call metric provides CMS with data on the extent to which callers abandon their calls while waiting for a CSR to answer the call,[42] and CMS officials said that they expect the number of abandoned calls to

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[40]An industry expert we interviewed also noted that CMS's average wait time performance standard was relatively long, although performance standards are usually based on the level of service an agency can afford to purchase with its contact center budget.

[41]The other two federal agencies we interviewed used a performance metric defined as the percentage of calls answered within a designated timeframe, with a standard of answering 80 percent or more calls within 20 seconds.

[42]The calculation of this metric includes callbacks, an option in which basic caller information is taken and the caller is contacted at a later time. CMS may exercise this option when call volumes cause average wait times to reach a threshold of 20 minutes. Two types of callbacks can occur to help reduce average wait times: (1) CMS can program the IVR to provide callers with the option to receive a callback from a CSR within 48 hours or (2) the 1-800-MEDICARE contractor's CSRs can offer to call back callers within 48 hours.

decrease with shorter average wait times.[43] CMS granted the waiver for one month's unhandled CSR call rate standard because of changes during that month in its expectations of the contractor's performance. Though the performance metric standard was not changed, CMS encouraged the contractor to keep its average wait time below 8 minutes. To do this, the contractor increased the number of callbacks—instances in which callers are called back within 48 hours rather than remaining on hold. Because CMS includes callbacks in the unhandled CSR call metric, in this month the contractor exceeded the unhandled CSR call standard. An expert in federal call centers indicated that the unhandled call rate standard used by CMS was high compared to some other federal agencies, but that these performance standards are usually based on what level of service an agency can afford to purchase with its contact center budget.

Table 2: 1-800-MEDICARE Contractor's Unhandled CSR Call Performance, July 2007 through July 2008

| Month	Unhandled CSR call rate	Average wait time	Unhandled CSR call rate performance standard, based on average wait time	Did contractor meet the unhandled CSR call rate performance standard?
July 2007	40.61%	7:39	40% or less	No
August 2007	38.57%	7:23	40% or less	Yes
September 2007	38.45%	8:01	45% or less	Yes
October 2007	35.00%	6:35	35% or less	Yes
November 2007	37.61%	6:30	35% or less	Waiver[a]
December 2007	26.82%	6:31	35% or less	Yes
January 2008	29.73%	6:51	35% or less	Yes
February 2008	25.81%	6:57	35% or less	Yes
March 2008	29.41%	7:56	40% or less	Yes
April 2008	27.38%	7:53	40% or less	Yes
May 2008	26.08%	7:48	40% or less	Yes
June 2008	28.48%	8:43	45% or less	Yes
July 2008	20.39%	5:56	30% or less	Yes

Source: GAO analysis of CMS 1-800-MEDICARE contract and evaluation data.

[a]Because of the waiver granted for this month, CMS did not consider the contractor's performance on this metric for that month when determining overall performance or in determining an award fee.

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[43]As wait times to reach a CSR increase, callers may be more likely to abandon calls.

Transfer rate. Transfers from one CSR to another occurred for no more than 20 percent of calls in each of the 13 months of data we analyzed, meeting the contractually required performance standard. While CMS officials said that they expect some transfers to occur normally, they also said a monthly transfer rate that exceeds 20 percent may imply that CSRs are inappropriately transferring callers. CSRs transferred nearly 13 percent of calls in July 2007, but the transfer rate increased to just under 20 percent by October 2007. Since October 2007, the transfer rate has generally decreased, with the lowest percentage of transferred calls of the 10 months we studied occurring in June 2008. (See fig. 5.)

Figure 5: 1-800-MEDICARE Contractor's CSR Transfer Rate, July 2007 through July 2008
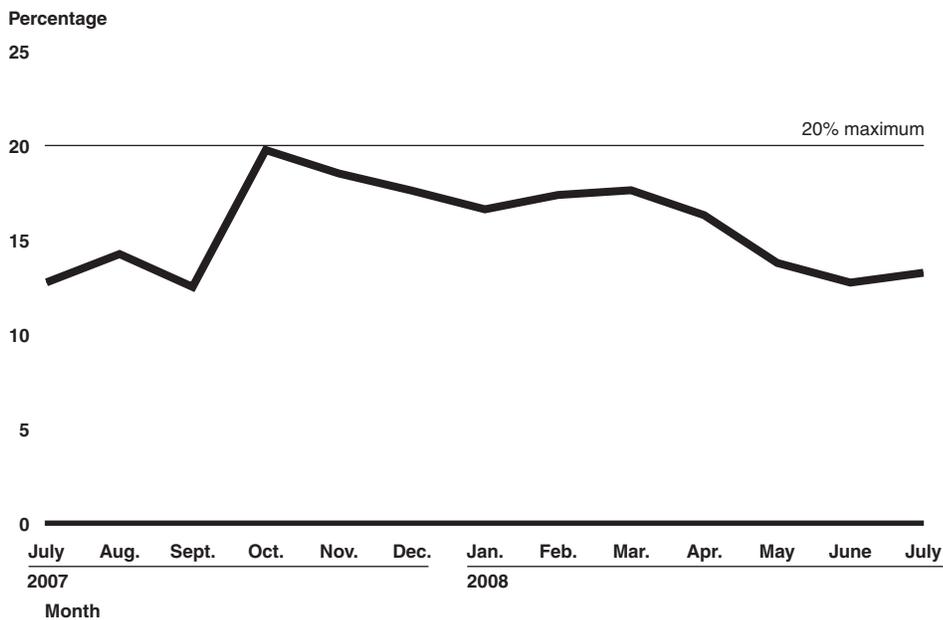
Source: CMS monthly data.

CSRs can transfer calls to other CSRs for various reasons, including transferring a call from a Tier 1 CSR to a Tier 2 CSR if the complexity of a caller's inquiry requires a greater degree of training. According to CMS officials, most transfers occur between Tier 1 and Tier 2 CSRs, although transfers can also occur between two Tier 1 CSRs. For example, a caller may have a general Medicare inquiry answered initially by a Tier 1 CSR, but then raise a claims-related inquiry that may be better answered by another Tier 1 CSR with additional training.

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The Current 1-800-Medicare Contractor Consistently Met Performance Targets for One of Three Monthly Access-Related Performance Indicators

In addition to the three required performance metrics, CMS also established several performance indicators and associated targets for the 1-800-MEDICARE contractor to meet in order to receive a portion of its award fee. Three of the indicators are particularly related to callers' telephone access: (1) the average amount of time CSRs spend assisting callers, referred to as average handle time;[44] (2) agent occupancy—the percentage of CSRs answering calls; and (3) forecasting of call volume going to CSRs.[45] (See table 3 for more information on these selected performance indicators.)

Table 3: Selected Access-Related Performance Indicators, July 2007 through July 2008

Performance indicator name	CMS definition of performance indicator	Performance indicator target	Contractor performance
Average handle time	The average amount of time CSRs take to respond to callers' inquiries, including talk time, hold time, and after-call work time	• July 2007— 9.5 minutes • August 2007— 9 minutes • September 2007 and beyond— 8 minutes	Met target in 0 of 13 months
Agent occupancy	The percentage of CSRs answering calls (versus those not available to answer calls, such as CSRs in training)	80 percent	Met target in 13 of 13 months
CSR call volume forecast	The percentage difference between actual CSR call volume and forecasted CSR call volume	< 10 percent variance	Met target in 4 of 13 months

Source: GAO analysis of CMS data and 1-800-MEDICARE contract.

Notes: Prior to June 2007, CMS had metrics related to performance but according to CMS officials, the contractor was primarily measured on activities related to the transition period, rather than on those metrics. CMS began using performance metrics in June 2007, with the current metrics being implemented in July 2007.

CMS, in the current 1-800-MEDICARE contract, also specifies access-related performance indicators and associated targets related to the availability of 1-800-MEDICARE's network and information systems. CMS officials told us, as of August 2008, that they were working with the 1-800-MEDICARE contractor to ensure the contractor understands the required data reporting for each of these performance indicators.

[44]This measure also includes any time a CSR spends to complete work related to a call after the call is completed.

[45]CMS's current 1-800-MEDICARE contract specifies about 20 performance indicators and associated targets; we reviewed only indicators related to telephone access.

The 1-800-MEDICARE contractor met its performance target in each of the 13 months between July 2007 through July 2008 for one performance indicator—agent occupancy—but had varying experience in meeting its targets for the average handle time and CSR call volume forecasting.

- For agent occupancy, the 1-800-MEDICARE contractor met its performance target—to have 80 percent or more of its CSRs answering calls—in each of the 13 months of data we analyzed. During these 13 months, the 1-800-MEDICARE contractor's agent occupancy ranged from 83 percent to 89 percent.

- For average handle time, the 1-800-MEDICARE contractor did not meet its performance target—most recently set at 8 minutes—in any of the 13 months analyzed. Average handle time peaked in December 2007 at 11 minutes, 18 seconds and then decreased each month, reaching an average handle time of 8 minutes, 59 seconds in July 2008. CMS officials said that, because there are many factors that could affect call length, they consider average handle time in conjunction with other metrics and indicators to determine if the contractor is managing CSRs' time effectively.

- The 1-800-MEDICARE contractor met its CSR call volume forecasting target—having a variance of less than 10 percent between its forecasted CSR call volume and actual CSR call volume—in 4 of the 13 months of data we analyzed.

Callers' Average Wait Times during the Current Contract Period Varied by Type and Complexity of Inquiry

During the current contract period, callers with claims inquiries or complex inquiries who needed assistance from a Tier 2 CSR generally experienced longer wait times than other callers. Although the current 1-800-MEDICARE contract does not have an average wait time metric or indicator specifically related to the type of call, CMS's evaluation reports have noted that the agency expected the contractor to manage wait times by type of call to ensure that a caller with a claims inquiry does not wait longer than a caller with a general Medicare inquiry.

Wait times varied by type of call. Callers waited, on average, less time to have general Medicare inquiries answered than to have calls about claims inquiries answered in all but 1 of the 11 months we analyzed under the current contract. During that month—December 2007—the difference between wait times for these two types of calls was 1 second. (See fig. 6.) During the time period we reviewed—ending July 2008—callers with general Medicare inquiries waited between 5 minutes and 8 minutes, 30 seconds on average—a time that matches the performance standard for

all calls during that period—in 10 of the 11 months we analyzed. In contrast, claims callers were within that range in only 5 of the 11 months with the longest waits in the first two months of this period—almost 18 minutes in September 2007 and just over 11 minutes in October 2007. In September 2007, about 48 percent of callers disconnected before a CSR could answer their calls. Beginning in November 2007 and continuing through July 2008, average wait times for callers with claims inquiries were more closely aligned with that of callers with general Medicare inquiries. (For more information on differences in average wait times by type of claims call, see app. II.)

Figure 6: Monthly Average Wait Time for Callers with General Medicare Inquiries and Callers with Claims Inquiries, September 2007 through July 2008
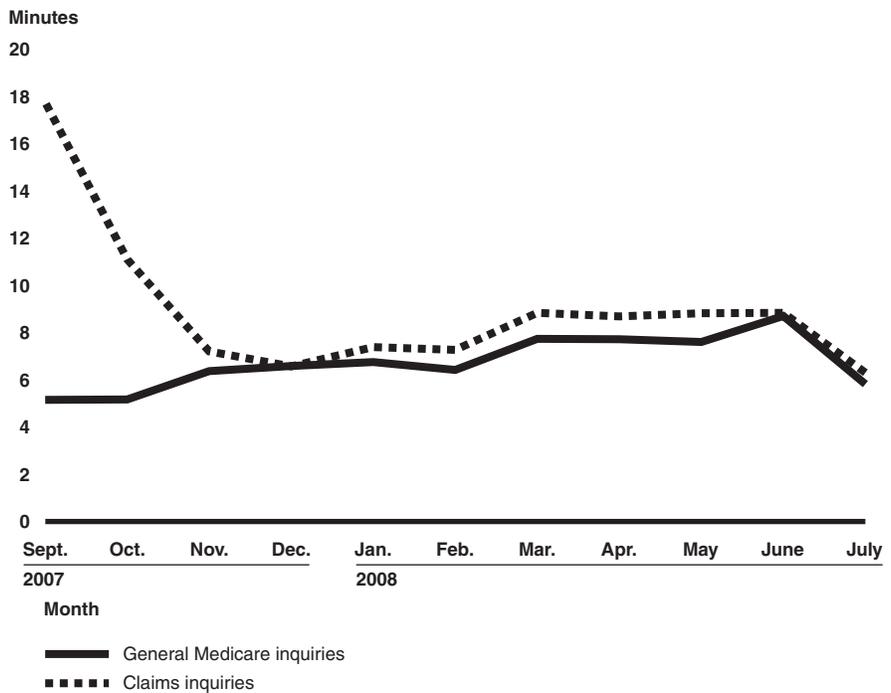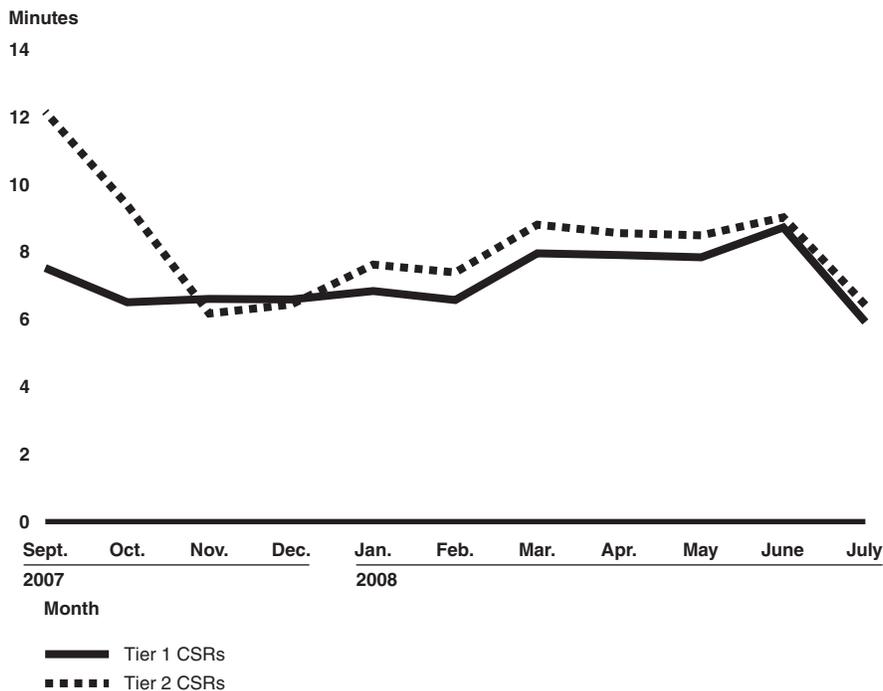

Source: CMS monthly data.

Wait times varied by complexity of calls. Between September 2007 and July 2008, callers generally waited longer, on average, to speak with a Tier 2 CSR—a CSR with additional training to respond to more complex calls— than to speak with a Tier 1 CSR. (See fig. 7.) The average wait time for a Tier 1 CSR was between 5 minutes and 8 minutes, 30 seconds—a time that matched the performance standard for all calls during that period—in 10 of 11 months we reviewed. In contrast, callers waited more than

8 minutes, 30 seconds to speak with a Tier 2 CSR in 5 of 11 months we reviewed. During the first two months of this period, the average wait time for callers needing to speak with a Tier 2 CSR was much longer—more than 12 minutes in September 2007 and 9 minutes in October 2007. Beginning in November 2007 through July 2008, average wait times for callers needing to speak to a Tier 2 CSR were more closely aligned with that of callers needing to speak to a Tier 1 CSR. (For more information on differences in average wait times by complexity of inquiry, see app. II.)

Figure 7: Monthly Average Wait Time for Tier 1 and Tier 2 CSRs, September 2007 through July 2008
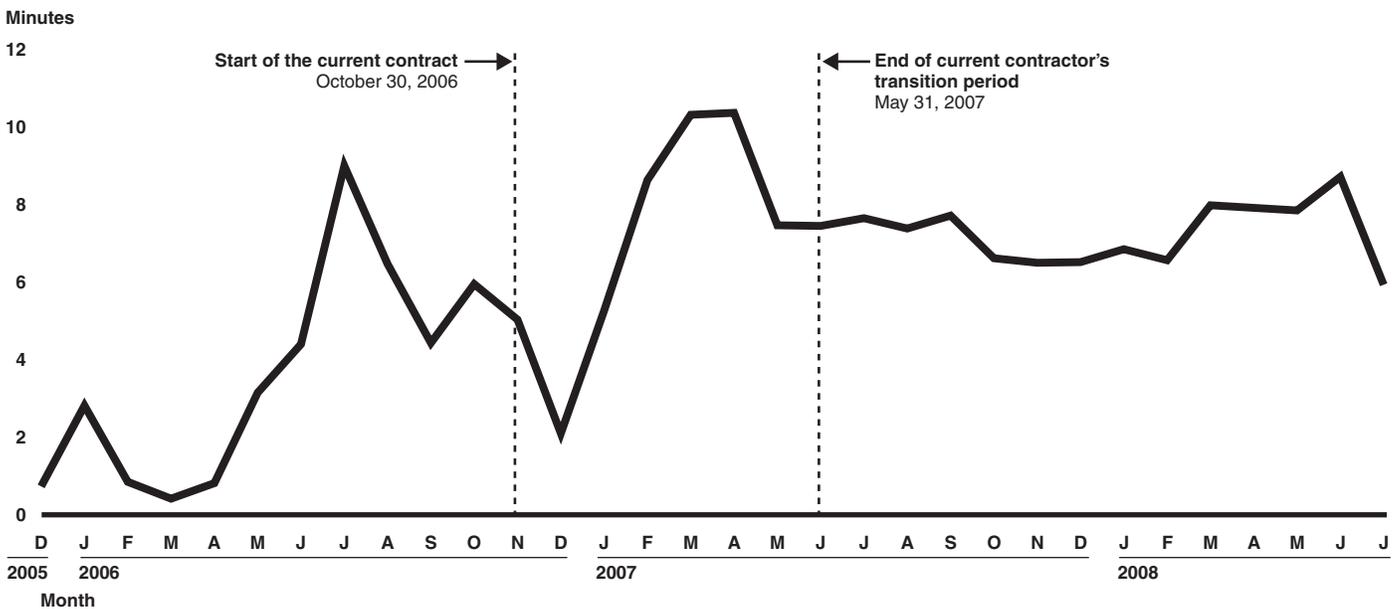

Source: CMS monthly data.

Since Late 2005, Callers' Average Wait Times Have Increased

CMS's performance standards for caller wait times have varied since December 2005, and, since that time, callers have waited longer, on average, to have their calls answered by a CSR. (See fig. 8.) The varying performance standards have allowed for a very short caller wait time, such as requiring 80 percent of calls to be answered in 30 seconds, while at other times allowing for a longer wait time, such as requiring that 80 percent of calls be answered in 10 minutes. During the current contract period, CMS's performance standards have consistently allowed for a

longer average caller wait time. From December 2005 to October 2006, when two contractors operated 1-800-MEDICARE, the average wait time in 8 of 11 months was below 5 minutes—the minimum average wait time standard under the current contract period through July 2008.[46] During the transition period of the current 1-800-MEDICARE contract, October 30, 2006 through May 31, 2007, the average wait time ranged from a low of 2 minutes, 6 seconds to a high of 10 minutes, 22 seconds. From the end of the transition period through July 2008, the monthly average wait times have been at or above 6 minutes, 30 seconds in all but one month, though they have not varied as widely as in prior periods we reviewed.

Figure 8: Monthly Average Wait Time, December 2005 through July 2008

Source: CMS monthly data.

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[46]Effective August 2008, CMS revised its average wait time standard to a new minimum of 1 minute.

Efforts to Provide LEP Callers Access to 1-800-MEDICARE Have Led to Shorter Wait Times for Spanish-speaking Callers, on Average, but Are Not Consistent with All LEP Plan Elements

CMS has made efforts to provide LEP callers with access to services through 1-800-MEDICARE by requiring the contractor to provide services in either English or Spanish and to provide interpretation services for callers speaking other languages. To meet these requirements, the contractor uses CSRs who are bilingual in English and Spanish and a telephone interpretation service to assist callers who speak other languages. Spanish-speaking callers waited less time on average to reach a CSR than their English-speaking counterparts in almost two-thirds of the months we reviewed—from December 2005 through July 2008.[47] Officials from the Office of Beneficiary Services (OBIS)—the CMS office with primary responsibility for 1-800-MEDICARE—said they were not aware of the HHS LEP Plan when awarding and assigning the current 1-800-MEDICARE contract and CMS has not identified an office responsible for acting as a point of contact for its management of the LEP Plan. Nonetheless, steps CMS has taken to provide services to LEP callers are consistent with some elements of the HHS LEP Plan adopted by the agency without modification, such as the element related to oral language assistance, but not others, such as the Plan's element for assessing quality and accessibility, which identifies the need for complaint mechanisms for language issues.

1-800-MEDICARE Provides LEP Callers with Access to Services and Spanish-speaking Callers Frequently Experience Shorter Average Wait Times to Reach a CSR than English-speaking Callers

As required by CMS, the 1-800-MEDICARE contractor provides callers with service in either English or Spanish and provides interpretation services for callers speaking other languages. The 1-800-MEDICARE contractor uses CSRs who are bilingual in English and Spanish to provide services to Spanish-speaking callers. As of January 1, 2008, slightly more than 7 percent of all CSRs at 1-800-MEDICARE were bilingual. Bilingual CSRs complete the same training required of CSRs who are not bilingual and must successfully handle test calls in both English and Spanish prior to answering 1-800-MEDICARE calls. Like CSRs who speak only English, bilingual CSRs use scripts, translated into Spanish, to provide assistance to callers.

To meet CMS's requirement that the contractor ensure "real-time phone translations" for callers who speak neither English nor Spanish, the 1-800 contractor subcontracts with a "language line"—a telephone interpretation

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[47]Because callers who speak neither English nor Spanish are assisted by English-speaking CSRs using a telephone interpretation service, data for this population are included with data for English-speaking callers.

service. Through this language line, English-speaking CSRs have access to interpretation services in more than 150 languages. According to the 1-800-MEDICARE contractor, the language line provider uses internal certification and assessment to assure the quality of its interpreters.[48] The number of languages for which CSRs have requested assistance has increased over time, from 40 languages in 2005 to 73 as of March 2008. The language line also is used to provide interpretation services for Spanish-speaking callers if the wait for a bilingual CSR exceeds 20 minutes. In these cases, Spanish-speaking callers are transferred to non-Spanish-speaking CSRs who then use the language line to assist these callers. According to CMS officials, the cost of language line interpreters and the additional length of time required to connect and handle the call using the language line increases the costs of these calls. Calls needing Spanish interpretation accounted for the majority of calls to the language line during the time period we reviewed, growing from 60 percent of all calls to the line in 2005 to 80 percent of all calls in 2007. However, while the use of the language line for Spanish interpretation has increased, in most months we reviewed more than 90 percent of all Spanish-speaking callers to 1-800-MEDICARE were assisted by bilingual 1-800-MEDICARE CSRs.

Spanish-speaking callers who speak with bilingual CSRs frequently experienced shorter average monthly wait times to reach a CSR than their English-speaking counterparts. (See fig. 9.) Spanish-speaking callers waited less time, on average, in slightly more than 60 percent of the months we reviewed (20 of 32), which encompassed parts of both the prior and current contract.

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[48]The language line certifies their interpreters and is affiliated with multiple professional interpretation and translation associations, such as the American Translators Association.

Figure 9: Monthly Average Wait Time for English- and Spanish-speaking Callers, December 2005 through July 2008

English-speaking callers

•••• Spanish-speaking callers

Source: CMS monthly data.
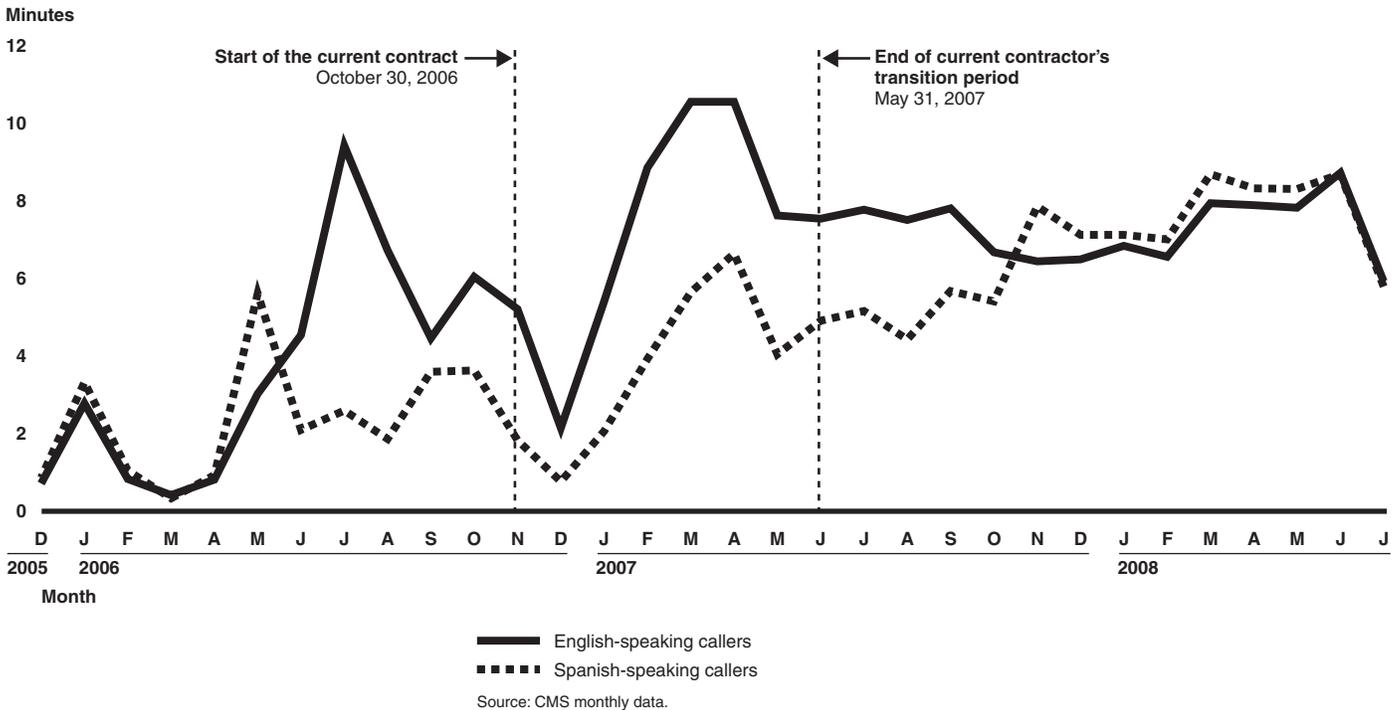
While the current 1-800-MEDICARE contract does not have metrics specifically focused on call language, the average wait time experienced by Spanish-speaking callers under the current contract, beginning at the end of October 2006, was consistent with CMS's performance standard for overall average caller wait times as of July 2008 in almost two-thirds of the months we reviewed.[49] However, Spanish-speaking callers have recently waited slightly longer, on average, than their English-speaking counterparts. In addition, while Spanish-speaking callers with simple claims inquiries have experienced shorter average wait times than English-speaking callers, they have waited, on average, longer for all general Medicare inquiries and more complex claims inquiries. (For more information on differences in average wait times by caller language, see app. II.)

[49]In just over three-quarters of the months between the end of October 2006 and July 2008 where the average wait time was outside the performance standard range, the wait times were less than 5 minutes.

CMS Did Not Consider the LEP Plan When Determining Service Provision, Although Steps Taken Are Consistent with Some Plan Elements

Officials from OBIS—the CMS office with primary responsibility for 1-800-MEDICARE—said they were not aware of the LEP Plan when awarding and assigning the current contract for operation of the help line.[50] Rather, they relied primarily on industry best practices when determining how to require the 1-800-MEDICARE contractor to provide LEP services.[51] In addition, while officials from HHS's OCR and CMS's OEOCR said CMS chose to adopt the HHS LEP Plan as issued—although HHS allowed its agencies flexibility to modify it—officials from multiple CMS offices were unable to identify an office or official responsible for acting as the central point of contact responsible for the agency's management of the Plan.[52] A key factor in meeting standards for internal control in federal agencies is defining and assigning key areas of authority and responsibility—such as a point of contact for an agency-wide plan—and communicating that information throughout the organization.[53] Without an office or official responsible for management of the Plan, staff lack a source of guidance that could assist them in taking steps consistent with the Plan to provide services to people with LEP.

Although CMS officials did not consider the LEP Plan when determining how services for LEP callers to 1-800-MEDICARE would be provided, steps they have taken to implement language services are consistent with some—but not all—elements of the Plan.[54] In particular, by requiring its

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[50]Services have been available in Spanish since 1-800-MEDICARE began in 1999, pre-dating the HHS LEP Plan and the current contract. Services for callers who speak neither English nor Spanish were added in 2003.

[51]CMS officials provided the 1-800-MEDICARE contractor with a limited number of LEP information resources from HHS and other federal agencies related to LEP populations, such as a language planning and self-assessment tool developed by the Department of Justice. However, they noted that were not aware of the extent of information about services for LEP callers available from other HHS and CMS offices.

[52]Officials from both HHS's OCR and CMS's OEOCR stated that their offices do not focus on LEP issues within federally conducted programs, such as 1-800-MEDICARE.

[53]Standards for internal control in the federal government state that agency management is responsible for establishing and maintaining a control environment that sets a positive attitude toward internal control and conscientious management, including an organizational structure with clearly defined areas of authority and responsibility. See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999) and GAO, *Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

[54]Because OBIS officials said that they were not aware of the HHS LEP Plan, we did not conduct an exhaustive review of all 1-800-MEDICARE activities that may relate to elements of the Plan.

contractor to provide services to all LEP callers, CMS has taken a step consistent with the LEP Plan element stating that "each agency, program, and activity… will arrange for the provision of oral language assistance in response to the needs of LEP customers, both in face-to-face and telephone encounters."[55] In addition, the LEP Plan states that agencies, activities, and programs will implement mechanisms to assess the LEP status and needs of current and potential customers. To do this, CMS officials said they and the contractor regularly review the frequency with which LEP callers contact the 1-800 line to determine appropriate bilingual CSR staffing levels. In addition, CMS officials noted that this information could be used to determine whether CSRs who speak languages other than English and Spanish should be made available to callers.

However, CMS has not taken steps consistent with other Plan elements related to 1-800-MEDICARE. For example, CMS officials did not identify, and did not require the contractor to identify, a specific official or office to allow LEP callers to register concerns or complaints regarding language assistance services provided by 1-800-MEDICARE, as indicated by the LEP Plan element for assessing accessibility and quality.[56] In addition, while CMS considers the number and languages of LEP callers currently using 1-800-MEDICARE, consistent with the LEP Plan's element related to the assessment of needs and capacity, neither the number nor proportion of Medicare-eligible or Medicare-enrolled LEP beneficiaries is specifically considered when planning how 1-800-MEDICARE language services will be provided. The LEP Plan also directs agencies to develop policies and procedures for each Plan element, to designate staff responsible for implementing these policies and procedures, and to provide staff with training on them. However, given that CMS staff within OBIS were not aware of the existence of the LEP Plan until our review, no uniform CMS policies and procedures had been used to implement any elements of the LEP Plan for 1-800-MEDICARE, nor had training specific to the LEP Plan occurred.[57]

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[55]Because 1-800-MEDICARE does not provide services in-person, the plan element regarding face-to-face oral language assistance is not applicable.

[56]While no office or official specific to language access complaints has been identified, callers can register general complaints about services provided by 1-800-MEDICARE through the line.

[57]While no CMS policies and procedures exist related to the Plan, the 1-800-MEDICARE and TQC contractors have developed standard operating procedures—as required by their contracts with CMS—which include procedures related to LEP callers.

CMS Uses Common Management Practices to Oversee Callers' Access to Services and to Accurate Information from 1-800-MEDICARE

CMS uses all six of the management practices we identified as commonly used by contact centers to oversee 1-800-MEDICARE callers' access to services and to accurate information.[58] (See table 4 for a description of these six common oversight practices.) These practices are addressed in the current 1-800-MEDICARE contract and reflected in CMS's ongoing oversight of the help line. For example, CMS awarded some of the available award fee to the 1-800-MEDICARE contractor for meeting certain performance metrics and used CSR feedback to improve the oversight of information CSRs provide to beneficiaries. In addition, CMS used customer satisfaction surveys to identify areas for improvement, including the IVR, and worked with the contractor to improve call volume forecasting in an effort to ensure appropriate staffing levels to meet callers' needs.

Table 4: Six Common Management Practices Used to Oversee Callers' Access to Services and to Accurate Information

Management practice	Description of management practices
Clearly defined performance metrics relating to access	Selects quantifiable, clearly defined units to measure aspects of performance that affect a caller's access to information or services.[a]
Customer satisfaction surveys	Surveys callers' satisfaction with the service received from the contact center, including, to a limited extent, callers' opinions about whether the information received was accurate.
Assurance that information referenced by CSRs to answer callers' questions is accurate	Takes steps to ensure the information used by CSRs to respond to callers' inquiries is accurate, including scripts and organizational internet resources.
Evaluation of CSRs' interaction with callers	Reviews information provided during calls to evaluate how well CSRs handled the inquiry; the evaluation typically uses a score sheet that allows the reviewer to rate the CSRs in multiple areas, such as courtesy, accuracy of information provided, timeliness, and completeness.
Capacity planning to meet caller demand for services	Uses quantitative or judgmental methods to predict the number of calls that will come into a contact center—or workload—in future time periods. A contact center's workload determines the resources, including staff, information technology, and corresponding funding, needed to meet the demand for services.
Validation of contact center performance reports	Validates the data provided in contractor-prepared reports to ensure accuracy; these reports, which could be provided daily, weekly, monthly, or quarterly, include operational information such as the contact center's workload volumes, handling times, and results of the contractor's contact monitoring.

Source: GAO analysis based on prior GAO reports, literature on industry practices, discussions with federal agencies and industry experts.

[a]The current 1-800-MEDICARE contract uses the terms "metrics" and "indicators" with corresponding standards and targets to refer to quantifiable, clearly defined units used to measure callers' experience with 1-800-Medicare.

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[58]CMS also has mechanisms to oversee contract elements not related to access and accuracy, such as security issues and financial oversight. The scope of our review did not include an examination of these mechanisms.

Clearly defining performance metrics and indicators. The performance metrics and indicators that CMS officials said they designed to encourage improved performance and correct identified problems are clearly defined in the 1-800-MEDICARE contract.[59] The current 1-800-MEDICARE contract identifies each metric and indicator, provides a definition for these measures, and sets a standard or target for each measure. CMS uses these measures to evaluate contractor performance three times a year and to provide an award fee if the contractor performs at or above set levels. Because the contractor did not meet all standards and targets for any evaluation period as of May 2008, CMS has awarded only part of the possible award fee to date, in accordance with the award guidance in the 1-800-MEDICARE contract.[60] Award fees are based on a scoring system, in which a percentage of the award fee is distributed depending on CMS's rating of the contractor's performance, ranging from the lowest rating, substandard, to the highest rating, superior.[61] CMS rated the contractor as good or very good from the start of the current contract through May 2008.

CMS also uses the performance metrics and indicators on a continuous basis to monitor and evaluate callers' ability to access information from 1-800-MEDICARE. For example, CMS officials said they receive updates from the contractor on the average wait times—a measure of caller access—through daily e-mails. If callers' average wait time exceeds 5 minutes, CMS officials receive e-mail notification every half hour. During that time, CMS officials said the contractor also notifies them of actions it is taking to improve caller wait times.

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[59]We analyzed metrics and indicators for incoming calls only. CMS has also developed performance metrics related to services other than incoming calls, including CSR responses to Web chat and to e-mails.

[60]The first evaluation period encompassed the entire 7-month contract transition period and, as such, was longer than the standard 4-month period and did not use the current contract performance metrics and indicators. It ran from October 30, 2006 to May 31, 2007.

[61]If the contractor's performance is rated as substandard or satisfactory, the contractor receives no award fee. If its performance is rated as good, the contractor can receive between 0 and 50 percent of the award fee. If the contractor's performance is rated as very good it can receive between 51 and 90 percent of the award fee and if its performance is rated as superior it can receive between 91 and 100 percent of the award fee.

Customer satisfaction surveys. CMS officials said they use the results of customer satisfaction surveys to gain insight into callers' experiences with 1-800-MEDICARE services and to identify opportunities for improving services. In June 2008, the TQC contractor assumed responsibility for conducting a customer satisfaction survey of 20 percent of randomly selected 1-800-MEDICARE callers.[62] The TQC contractor will provide CMS with the results from this survey on an ongoing basis; however, initial results were not available as of May 2008. Prior to June 2008, CMS required the 1-800-MEDICARE contractor to call back randomly selected beneficiaries who contacted 1-800-MEDICARE and administer a customer satisfaction survey developed by CMS. CMS officials said they used the information from the surveys to make changes to 1-800-MEDICARE. For example, based on survey participant concerns about the IVR, which is used by 18 to 20 percent of callers to resolve their inquiries, CMS officials indicated they made changes to the IVR prompts to make them easier to follow. CMS officials said that they anticipate future callers to 1-800-MEDICARE will be more willing to use technologies such as the IVR to obtain information. However, as of November 2008, only limited testing and focus groups had been conducted to confirm this anticipated trend.[63]

Ensuring accurate information. To ensure that beneficiaries receive consistent and accurate program information, CSRs are required to use scripts approved by the agency and CMS, and contractor officials reported taking steps designed to make correct scripts easier for CSRs to identify and to make scripts easier to understand.[64] In April 2008, the TQC contractor began developing content for 1-800-MEDICARE scripts, which previously had been developed by the 1-800-MEDICARE contractor and

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[62]The TQC customer satisfaction survey begins after a caller completes his or her inquiry and allows the caller to provide feedback about the IVR system, their interaction with the CSR, or both, depending on the services the caller accessed.

[63]The HHS Office of the Inspector General recommended that CMS reevaluate their investment in the IVR due to low rates of customer inquiries resolved with the technology. See OEI-07-06-00530.

[64]In prior work related to contact centers, GAO has noted that the information CSRs use to assist callers should be electronically searchable so that CSRs can expeditiously provide correct and complete responses. In addition, GAO has noted that 1-800-MEDICARE CSRs and callers have had difficulty understanding scripts, and recommended that scripts be revised as needed and be pretested to ensure that CSRs can effectively use them to accurately answer callers' inquiries. See GAO, *Medicare: Call Centers Need to Improve Responses to Policy-Oriented Questions from Providers*, GAO-04-669 (Washington, D.C.: July 16, 2004) and GAO-05-130.

reviewed by CMS. The TQC contractor employs staff with expertise in Medicare who develop and revise scripts as needed. CMS reviews and approves all scripts before making them available to CSRs. According to CMS officials, in August 2008 the TQC contractor began quarterly script reviews for accuracy as well as legislative, program, or policy changes. In addition to reviews conducted by the TQC contractor, CMS officials said that they have used the results of customer satisfaction surveys and call evaluations to assess how well scripts meet the needs of callers and how easy scripts are for CSRs to find. CMS can also access a computer application that captures CSR feedback on scripts, including how easy scripts are to understand, an issue identified in previous GAO work.

Evaluating CSR interaction with callers. To assess whether callers receive consistent and accurate information from 1-800-MEDICARE, CMS requires both the 1-800-MEDICARE contractor and the TQC contractor to evaluate CSRs' interactions with callers through call monitoring. The 1-800-MEDICARE contractor listens to four calls a month for each CSR, evaluating the CSRs' performance on customer service skills identified by CMS, including tone, using scripts appropriately, and completeness of information provided. CMS officials said they designed the 1-800-MEDICARE contractor's call evaluation process for contractor supervisors to coach CSRs on their performance and to help improve CSRs' ability to use software to find appropriate scripts. The 1-800-MEDICARE contractor has reported on the required evaluations monthly. Using these evaluation reports, CMS officials said, they worked with the 1-800-MEDICARE contractor to identify and correct trends or issues with scripts, software, or CSR training. For example, CMS used the call evaluation process to determine the reasons why callers may need to be transferred to a more experienced CSR or place another call to 1-800-MEDICARE. This analysis was part of the "First Call Resolution Initiative," an effort to increase the number of callers who have their inquiries resolved with one phone call rather than many.[65] However, in its evaluation of the 1-800-MEDICARE contractor for the period ending May 2008, CMS reported that it observed callers receiving poor service from CSRs who received perfect call evaluation scores from the 1-800-MEDICARE contractor for those calls. CMS noted the 1-800-MEDICARE contractor needed to improve

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[65]This initiative is a part of CMS's response to a recommendation that CMS should ensure callers' inquiries are fully answered during their first call to 1-800-MEDICARE, made by the HHS Office of the Inspector General. See OEI-07-06-00530.

consistency between actual CSR call evaluation scores and the quality of service callers receive.

In addition, since April 1, 2008, CMS has required the TQC contractor each month to monitor and evaluate 600 randomly selected calls in English and 225 randomly selected calls in Spanish. This call sample is designed to allow CMS to generalize trends that emerge from this sample to the call volume of 1-800-MEDICARE as a whole. CMS officials said they anticipate analyzing any trends identified from this call monitoring to note areas for improvement to the 1-800-MEDICARE help line. CMS officials also said that they will use the results of the TQC scores as part of the 1-800-MEDICARE contractor's regular performance evaluation and resulting award payment beginning in October 2008.[66] In addition, CMS officials reported monitoring calls themselves and meeting weekly with the 1-800-MEDICARE and TQC contractors to listen to and rate recorded calls as a group. CMS officials said that these meetings help to ensure that the contractors understand the standard of service CMS expects callers to receive. CMS officials also planned to perform similar evaluations on calls for which customer satisfaction survey information is available—a practice identified by an industry expert as a method to improve contact center service.

Capacity planning. CMS officials said they work with the 1-800-MEDICARE contractor to create short- and long-term call volume forecasts and to determine whether systems and staffing can handle call volume, taking into account Medicare's annual coordinated election and open enrollment periods when inquiries peak. CMS requires the 1-800-MEDICARE contractor to produce call volume forecasts that are accurate within 10 percent of actual call volumes for the forecasted period. CMS oversight of the contractor's forecasting efforts has identified significant differences between the long-term forecasts and actual monthly volume of calls going to CSRs—forecasting up to 35 percent more calls than were actually received by CSRs for the performance period ending January 2008 and causing projected staffing costs for this period to be overstated.[67] In its evaluation of the performance period ending January 2008, CMS notified

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[66]The evaluation period starting October 1, 2008 will also coincide with the anticipated increased call volume associated with Medicare's annual coordinated election and open enrollment periods.

[67]An industry expert indicated that call volume forecasts should not differ from actual call volume more than 25 percent to be worthwhile in producing the forecasts.

the contractor that performance in this area needed to improve and stated that it wanted the contractor to identify methods of ensuring consistent and accurate forecasts. However, CMS noted that when the forecasted call volume was not realized, the 1-800-MEDICARE contractor adjusted its staffing so that only the number of CSRs needed to meet the performance standard related to average wait times were available. In its evaluation for the period ending May 2008, CMS noted a significant improvement in long-term forecasting and indicated that the 1-800-MEDICARE contractor had a better understanding of events that affected call volume throughout the year.

To ensure that 1-800-MEDICARE systems, such as phone lines and desktop software, are available to handle forecasted call volumes, CMS requires the 1-800-MEDICARE contractor to notify the agency of systems outage incidents that affect callers' access. In the evaluation period ending January 2008, CMS identified inconsistencies in the outage reporting process, which caused key information to be omitted from reports about systems outage incidents. In its evaluation for the period ending May 2008, CMS noted some improvement in reporting systems outage incidents, but indicated that the 1-800-MEDICARE contractor needed to improve the consistency of its reporting practices in the future. CMS officials said they are working with the contractor to address this issue and reported finalizing a process for reporting systems outages in early November 2008.

Validation of contractor reports. CMS officials said they validate contractor reports—many of which are used to determine contract award fees—by analyzing data captured by 1-800-MEDICARE computer systems and having regular meetings with their contractors. To ensure the integrity of data collected by 1-800-MEDICARE systems, CMS collects and stores these data in the NDW, which is managed by a separate contractor. CMS officials compare data from the NDW on the actual call center performance to reports submitted by the 1-800-MEDICARE contractor, such as the long-term call volume forecasts. Using this method of validating reports, CMS determined that the 1-800-MEDICARE contractor's forecasting reports were inaccurate and required the contractor to improve in this area, which the contractor did over the next evaluation period. In addition to validating contractor reports through the NDW, CMS officials said they used weekly and monthly status reports, meetings with contractors, and visits to 1-800-MEDICARE contractor sites to monitor contractor performance between periodic evaluations.

Conclusions

To date, the current 1-800-MEDICARE contractor has met most of CMS's performance standards and some of the performance targets designed to ensure callers' access to services from the help line. In addition, by employing all six commonly used management practices to oversee 1-800-MEDICARE callers' access to services and accurate information, CMS gains valuable data to assess the contractor's performance and identify areas for improvement. In particular, the new TQC contract provides CMS with an opportunity to continue to improve both access to, and accuracy of, information.

However, while callers with LEP can access services through 1-800-MEDICARE, CMS has not taken steps to ensure that officials throughout the agency, including within OBIS, are fully aware of the LEP Plan, which HHS designed to be a "road map" for providing appropriate services to this population. By not identifying an official point of contact responsible for management of the Plan, CMS is lacking a key internal control measure—a clearly defined area of responsibility that has been communicated agencywide. While CMS has taken steps to ensure access for LEP callers to 1-800-MEDICARE, a clearly identified office or official responsible for the Plan could provide guidance in areas where steps consistent with the LEP Plan have not been taken and could work to ensure consistent use of the Plan across the agency.

Recommendation for Executive Action

To ensure CMS offices, including those that oversee the operation of the 1-800-MEDICARE help line are aware of, and take steps consistent with, the HHS LEP Plan when considering the needs of people with LEP, CMS should designate an official or office with responsibility for managing the LEP Plan.

Agency Comments and Our Evaluation

We provided CMS with a draft of this report for its review and comment. The agency provided written comments, which we addressed as appropriate and which have been reprinted in appendix III. The current 1-800-MEDICARE contractor stated that the report was factually accurate and provided oral technical comments, which we incorporated as appropriate. The Social Security Administration and the departments of Defense, Education, and Treasury told us they had no comments on the draft report.

In responding to our draft, CMS stated that it has taken steps to implement our recommendation. More specifically, CMS has identified an official responsible for the development of an LEP Plan for the agency that, when

finalized, is intended to define responsibility for ensuring consistent and reliable LEP tracking and reporting. CMS also noted that the report identified issues related to accurate forecasts and wait times experienced by callers for general Medicare and claims calls. The agency reiterated that these issues were affected by the transition, completed in 2007, of claims calls previously answered by FFS contractors to 1-800-MEDICARE. CMS also stated that its intent is to try to fully answer callers' questions rather than focusing exclusively on reducing average handle time—the average amount of time CSRs take to respond to callers' inquiries. Additionally, CMS stated that while it has not specifically evaluated the number or proportion of LEP beneficiaries who are Medicare eligible and enrolled, it continues to review demand and consider other opportunities to best serve LEP callers. Finally, CMS noted that some information regarding the 1-800-MEDICARE contractor's operations and contract with the agency are considered proprietary.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services and others. The report also will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.

Sincerely yours,

Kathleen M. King
Director, Health Care

Appendix I: Elements of the Department of Health and Human Services' Limited English Proficiency Plan

Element	Element description
Assessment: needs and capacity	"Each agency, program, and activity of the HHS [Department of Health and Human Services] will have in place mechanisms to assess, on a regular and consistent basis, the LEP [limited English proficiency] status and language assistance needs of current and potential customers, as well as mechanisms to assess the agency's capacity to meet these needs according to the elements of this [HHS LEP] plan."
Oral language assistance services	"Each agency, program, and activity of HHS will arrange for the provision of oral language assistance in response to the needs of LEP customers, in both face-to-face and by telephone encounters."
Written translations	"Each agency, program, and activity of HHS will provide vital documents in languages other than English where a significant number or percentage of the customers served or eligible to be served has [LEP]. These written materials may include paper and electronic documents such as publications, notices, correspondence, web sites and signs."
Policies and procedures	"Each agency, program, and activity of HHS will have in place specific written policies and procedures related to each of the plan elements and designated staff who will be responsible for implementing activities related to these policies."
Notification of the availability of free language services	"Each agency, program, and activity of HHS will proactively inform LEP customers of the availability of free language assistance services through both oral and written notice, in his or her primary language."
Staff training	"Each agency, program, and activity of HHS will train front-line and managerial staff on the policies and procedures of its language assistance activities."
Assessing accessibility and quality	"Each agency, program, and activity of HHS will institute procedures to assess the accessibility and quality of language assistance activities for LEP customers."

Source: HHS LEP Plan.

Appendix II: Average Caller Wait Time by Type and Complexity of Call and Language of Caller, September 2007 through July 2008
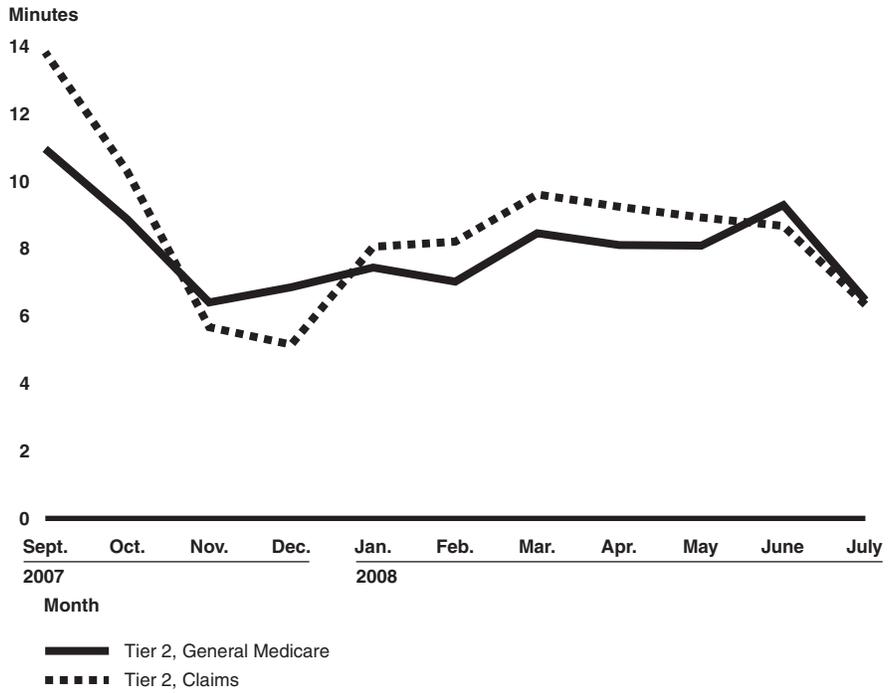
This appendix provides more detailed information on the average wait times experienced by callers depending on the type of inquiry—general Medicare and claims—and complexity of their call or the language in which they need assistance for the period September 2007 through July 2008 of the current contract.[1]

Wait Times by Type and Complexity of Calls

Figures 10 and 11 provide information on differences in average wait times experienced by callers depending on their type of inquiry—general Medicare and claims—and the complexity of their inquiry. While simple inquiries may be resolved by Tier 1 CSRs, inquiries of greater complexity may require the assistance of a Tier 2 CSR. Figures 12 through 14 compare the wait times for callers with simple inquiries to callers with complex inquiries by type of claims inquiry—Medicare Part A, Part B, and, within Part B, durable medical equipment (DME).[2]

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[1]All tables within this appendix reflect the average wait time standard of between 5 minutes and 8 minutes, 30 seconds required by CMS's contract with the 1-800-MEDICARE contractor as of July 2008. Effective August 2008, CMS lowered its average wait time standard to between 1 minute and 5 minutes.

[2]Medicare guidance defines DME as equipment that serves a medical purpose, can withstand repeated use, is generally not useful in the absence of an illness or injury, and is appropriate for use in the home. DME includes items such as wheelchairs, hospital beds, and walkers. CMS tracks information on calls related to DME separately from Part B calls.

Figure 10: Monthly Average Wait Times for General Medicare and Claims Inquiries by Tier 1 CSRs

Source: CMS monthly data.

**Figure 11: Monthly Average Wait Times for General Medicare and Claims Inquiries
by Tier 2 CSRs**

Minutes

Tier 2, General Medicare

Tier 2, Claims

Source: CMS monthly data.

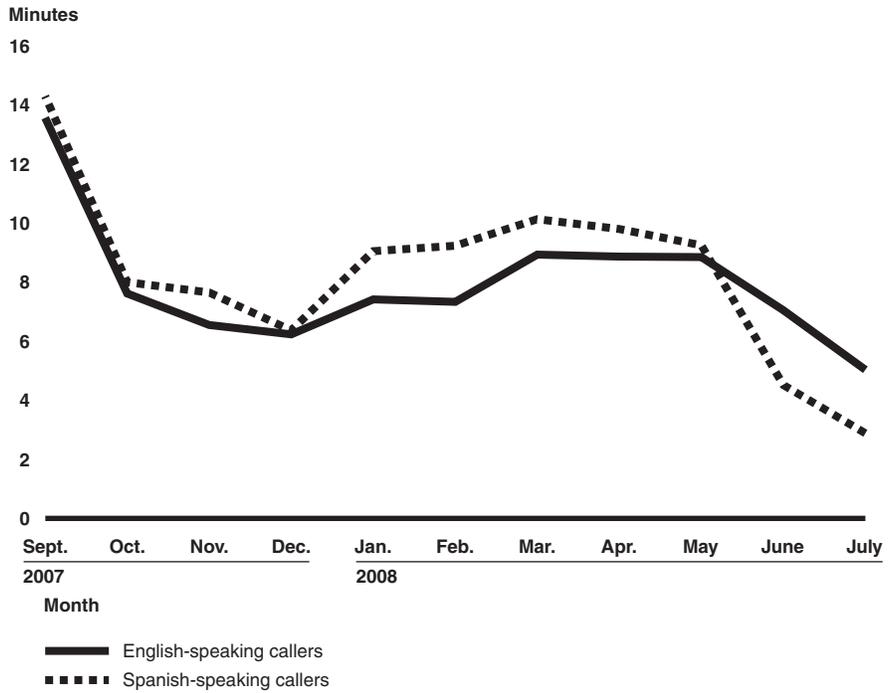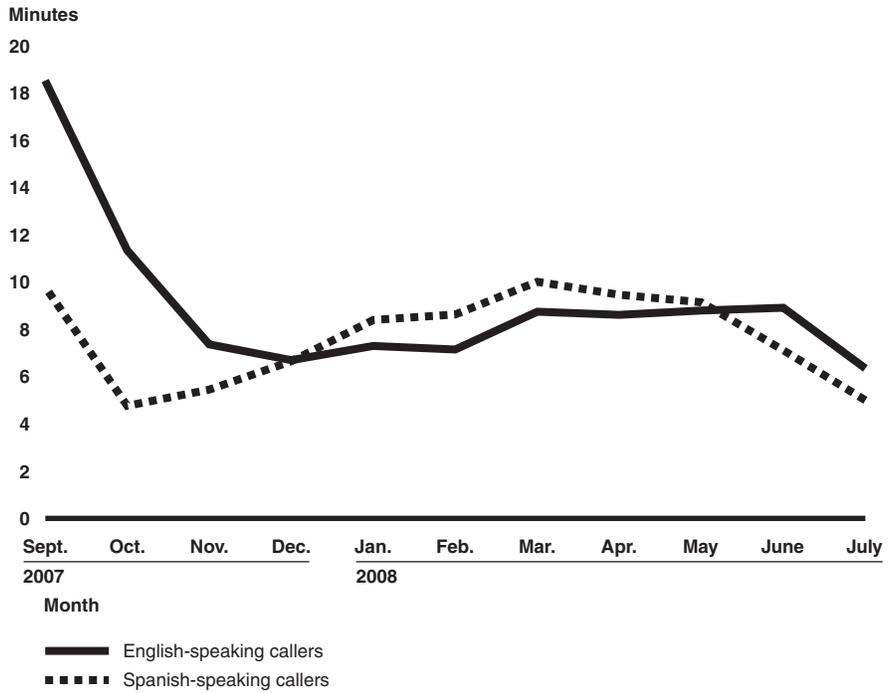**Figure 12: Monthly Average Wait Time for Tier 1 and 2 CSRs Responding to Part A
Inquiries**
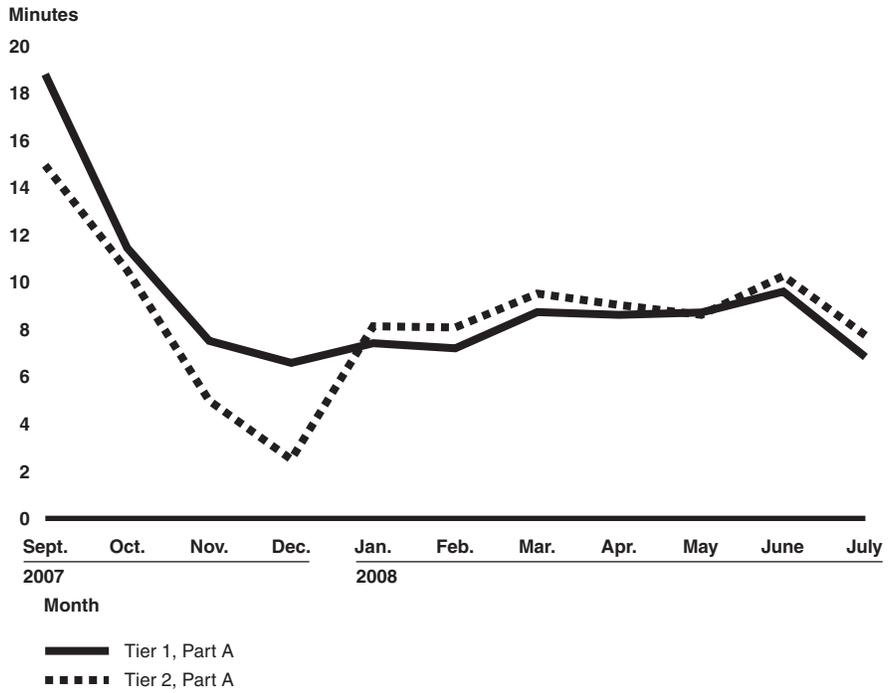
Source: CMS monthly data.

Figure 13: Monthly Average Wait Time for Tier 1 and Tier 2 CSRs Responding to Part B Inquiries

Minutes

Tier 1, Part B	(solid line)
Tier 2, Part B	(dotted line)
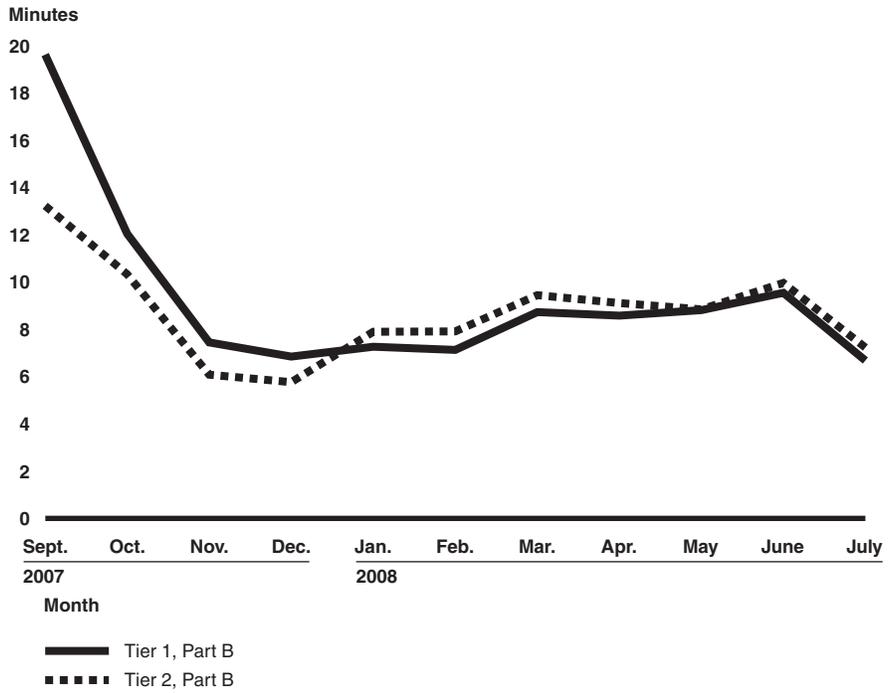
Source: CMS monthly data.

Figure 14: Monthly Average Wait Times for Tier1 and Tier 2 CSRs Responding to DME Inquiries
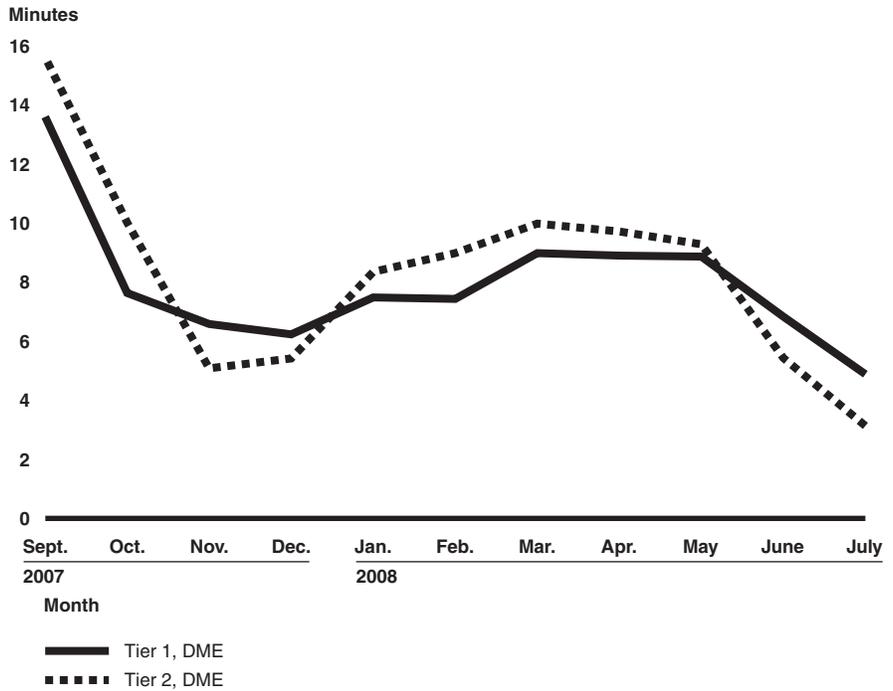
Source: CMS monthly data.

Wait Times by Language of Caller

Figures 15 through 18 provide information on differences in average wait times experienced by callers depending on the language in which they are assisted. The information provided compares the wait times of English- and Spanish-speaking callers for each type of inquiry, by complexity level.

**Figure 15: Monthly Average Wait Times for Tier 1 CSRs Responding to English- and
Spanish-speaking Callers' General Medicare Inquiries**

Minutes

[Line graph showing monthly average wait times in minutes from Sept. 2007 through July 2008. The y-axis ranges from 0 to 10 minutes. Two lines are plotted: a solid line for English-speaking callers and a dotted line for Spanish-speaking callers.]

Month

━━━━ English-speaking callers

▪▪▪▪▪ Spanish-speaking callers

Source: CMS monthly data.

**Figure 16: Monthly Average Wait Times for Tier 2 CSRs Responding to English- and
Spanish-speaking Callers' General Medicare Inquiries**

Source: CMS monthly data.

Figure 17: Monthly Average Wait Times for Tier 1 CSRs Responding to English- and Spanish-speaking Callers' Claims Inquiries

Source: CMS monthly data.

**Figure 18: Monthly Average Wait Times for Tier 2 CSRs Responding to English- and
Spanish-speaking Callers' Claims Inquiries**

Source: CMS monthly data.

DEPARTMENT OF HEALTH & HUMAN SERVICES   OFFICE OF THE SECRETARY

Assistant Secretary for

Legislation

Washington, DC 20201

DEC 0 9 2008

Kathleen M. King
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. King:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "MEDICARE: Callers Can Access 1-800-MEDICARE Services, but Responsibility Within CMS for Limited English Proficiency Plan Unclear" (GAO 09-104).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES   Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: DEC   9 2008

TO: Vincent J. Ventimiglia, Jr.
            Assistant Secretary for Legislation
            Department of Health and Human Services

FROM: Kerry Weems
            Acting Administrator
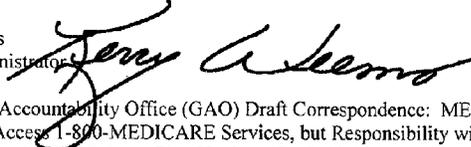
SUBJECT: Government Accountability Office (GAO) Draft Correspondence: MEDICARE:
            Callers Can Access 1-800-MEDICARE Services, but Responsibility within CMS
            for Limited English Proficiency Plan Unclear (GAO-09-104)

Thank you for the opportunity to review and comment on the GAO Draft correspondence,
"MEDICARE: Callers Can Access 1-800-MEDICARE Services, but Responsibility within CMS
for Limited English Proficiency Plan Unclear" (GAO-09-104). We are very pleased to see the
results confirm our belief that we provide a quality service to callers, that our contract oversight is
effective and that we service all callers appropriately, regardless of the caller's disability or
language preference. In this draft correspondence, the GAO described (1) the extent to which
performance standards and targets designed by the Centers for Medicare & Medicaid (CMS) to
ensure caller access have been met by the current 1-800-MEDICARE contractor and the extent to
which the time a caller waits to reach a customer service representative(CSR) has changed; (2)
efforts by CMS to provide limited English proficiency (LEP) callers access to 1-800-MEDICARE
services and the wait times experienced by these callers, and (3) CMS oversight of callers' access
to 1-800-MEDICARE and the accuracy of the information provided.

We appreciate the effort GAO put into reviewing our processes, procedures and the large amounts
of data associated with operating the 1-800-MEDICARE helpline. It is our goal to provide timely
and accurate information to a population comprised of the aged, the disabled, their families and
caregivers. We appreciate the professionalism and courtesy extended to CMS by the auditors who
analyzed an enormous amount of contractual and operational data to reach their finding. We
understand that this was a detailed audit requiring extensive research and coordination between
CMS and GAO and we believe that both entities worked collaboratively and transparently as a
team to ensure that all opportunities for improvement were identified.

Below is our response to the GAO recommendation as well as additional comments.

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GAO Recommendation

To ensure CMS offices, including those that oversee the operation of the 1-800-MEDICARE help line, are aware of, and take steps consistent with, the Department of Health and Human Services'(HHS) LEP Plan when considering the needs of people with LEP, CMS should designate an official or office with responsibility for managing the LEP Plan.

CMS Response

As to the specific recommendation for appointing an official responsible for managing LEP programs, CMS has identified Tasha Richburg in the Office of Equal Opportunity and Civil Rights (OEOCR) as the officer responsible for the development of the CMS LEP Plan. OEOCR will coordinate with the HHS Office for Civil Rights (OCR) to develop the CMS LEP Plan. The draft CMS LEP Plan will be vetted throughout the Agency before the final draft is submitted to OCR for approval. Once approved, the CMS LEP plan will serve as the internal control measure that will clearly define the area of responsibility used to ensure consistent and reliable LEP tracking and reporting.

Other Comments

1) Forecasting Targets – We are pleased that GAO recognized the considerable improvement already made in this area and we are confident that as we gain more experience with our changed environment, we will continue to improve our forecasting model. We would like to note that during the months associated with this report, there were major changes occurring to our program and process. We were transitioning the fee-for-service (FFS) contractors' claims calls into the Beneficiary Call Center (BCC) as well as transitioning from the 1-800-MEDICARE contract to the BCC contract. With all of the changes occurring, it took a longer time than we anticipated to fully understand the effects on forecasting call volumes.

2) Average Speed of Answer (ASA) differences by line of business – GAO noted a significant difference between the ASA of the claims lines of business and General Medicare line of business for September and October 2007. It is important to note that the transition of FFS contractors' claims lines of business into the BCC was completed in September 2007, a full year ahead of schedule. We are pleased that GAO recognized a marked service improvement only 1 month after the end of transition of the claims volumes into the BCC. It is also important and most notable that this marked improvement was accomplished during our annual enrollment period, the highest call volume months of the year.

3) Average Handle Time (AHT) –AHT is a performance indicator in the contract. The AHT for a call is used by the contractor to project the number of CSRs needed to handle the anticipated call volume. CMS makes an effort to be as efficient as possible with calls and did target many areas for improvement including a reduction in AHT. However, CMS' guidance to the contractor and the CSRs was and continues to be that they shall fully answer questions and not just work to reduce AHT. Contrary to some industry practices, we have made the business decision that fully answering a caller's questions is paramount and while we

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obviously need to manage AHT it is not a metric we attempt to drive down aggressively from an operational standpoint.

4) We are pleased that the GAO acknowledged that we do service all callers to the best of our ability regardless of their language preference. While it is true that we have not specifically evaluated the number or proportion of Medicare-eligible or Medicare-enrolled LEP beneficiaries when planning how language services will be provided, we have gathered data on an ongoing basis related to language use for planning purposes and the result is that the next largest number of LEP calls received at the BCC (after English and Spanish) is Russian with a rate of 0.1 percent. While it would not be financially or operationally prudent to add another standard language to our CSR base to address a call volume of less than one tenth of one percent, we will continue to evaluate incoming call patterns and look for opportunities to improve the service we provide the beneficiaries. In addition, we are proud of our ability to service over 70 languages via our language line and believe that we go well beyond the basic requirements in our efforts to fully service LEP beneficiaries.

5) There are several references in the GAO report that contain Vangent proprietary information that should be removed from the report before publication. These include:

- Specific references to the exact award fee amounts. The Vangent evaluations and award fee scores are considered proprietary.
- The exact amount of fee. This is considered proprietary, as it is part of the bid strategy when the contract is competed.
- Detailed number of CSRs as of January 1 and specifically the number of tier 2 CSRs. This is considered proprietary as competitors can use these detailed data to reverse engineer the Vangent rates.

Once again, we appreciate the efforts of the GAO and the professionalism exhibited by the staff responsible for this study. We are committed to improving our service wherever possible and we will continue to work in partnership and keep you apprised as we implement the Report's recommendation.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Acknowledgments

In addition to the person named above, Karen Doran, Assistant Director; Jennie F. Apter; Hernan Bozzolo; Eleanor M. Cambridge; Emily R. Gamble Gardiner; Barbara A. Hills; Martha R.W. Kelly; Ba Lin; Lisa S. Rogers; and Hemi Tewarson made key contributions to this report.

Related GAO Products

Medicare-Related Reports

Medicare: Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved. GAO-06-654. Washington, D.C.: May 3, 2006.

Medicare: Accuracy of Responses from the 1-800-MEDICARE Help Line Should Be Improved. GAO-05-130. Washington, D.C.: December 8, 2004.

Medicare: Call Centers Need to Improve Responses to Policy-Oriented Questions from Providers. GAO-04-669. Washington, D.C.: July 16, 2004.

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Tax Administration: 2007 Filing Season Continues Trend of Improvement, but Opportunities to Reduce Costs and Increase Tax Compliance Should be Evaluated. GAO-08-38. Washington, D.C.: November 15, 2007.

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