



Office of the Medicare Beneficiary Ombudsman

Report to Congress

January 1, 2005 - December 31, 2006

Daniel J. Schrelner
Medicare Beneficiary Ombudsman

MESSAGE FROM THE MEDICARE BENEFICIARY

As the first Medicare Beneficiary Ombudsman, I serve as the advocate within the Centers for Medicare & Medicaid Services (CMS) for the more than 42 million people with Medicare; to listen, understand, and address their issues, and to be their frontline connection to the Medicare program. This is a historic and unique position. This Office exists to give people with Medicare “peace of mind,” to assist the elderly, the disabled, and their representatives to make sure no matter where they access this program, services are there for them.



Our accomplishments have been significant. With a staff of nearly 40-trained Health Insurance Specialists, each day we make sure people get their benefits, understand their health care options, and get the prescription drugs they need. This dedicated staff provides direct support to people with Medicare while assisting in the identification of systemic issues and trends that, once resolved, lead to the improvement of this program.

This office has been an advocate for people with Medicare during the implementation of Medicare Part D, likely the most challenging and significant change in the Medicare program in its 40-year history. These changes have required an Ombudsman to identify and address a host of difficult issues, which could not have been accomplished without the support and assistance of many components within CMS’ Central and Regional Offices. It is a position that will continue to grow in importance as the aging baby-boom population gains access to care.

Through direct personal interaction with people with Medicare, their representatives, and their advocates, I have listened to a broad range of opinions and experiences to understand better the needs of people with Medicare and to develop a vision for the Office of the Ombudsman within CMS. This Office has worked to build awareness and relationships internally within government and externally with State Health Insurance Assistance Programs (SHIPs) and the many advocacy organizations providing guidance and services to people with Medicare.

The focus of this initial report is on the establishment of this Office and its activities for calendar years 2005 and 2006. I know there is much more work to be done. Medicare is one of the single most significant health care programs in the world and I consider it an honor to have the opportunity to contribute to its betterment. To be the Medicare Beneficiary Ombudsman is both a challenging and a rewarding duty. Along with my staff, I am committed to fulfilling this Congressional mandate.

A handwritten signature in cursive script, reading "Daniel J. Schreiner". The signature is written in black ink and is positioned above the printed name and title.

Daniel J. Schreiner
Medicare Beneficiary Ombudsman

EXECUTIVE SUMMARY

The Office of the Medicare Beneficiary Ombudsman (OMO) approaches its legislated tasks with a vision to transform the Medicare program into a leader of high quality services for people with Medicare by ensuring continuous improvement of the Medicare program. The OMO focuses on the manner in which people with Medicare receive assistance with their inquiries and complaints, their grievances and appeals, their ability to make informed decisions about their healthcare coverage, and their access to services. Following an organizational ombudsman model, the Office not only assists individual Medicare beneficiaries but also seeks out and works with other Centers for Medicare & Medicaid Services (CMS) components to address issues whose resolution will improve the Medicare program as a whole. This structure positions the OMO to achieve its mission to provide direct beneficiary assistance, continuously improve the Medicare program through data analysis, evaluate policies and procedures with internal and external partners, and make recommendations on improvements to the administration of the Medicare program through an annual Medicare Beneficiary Ombudsman Report to Congress and the Secretary of Health & Human Services.

To fulfill its mission, the OMO established three goals:

- ***Listen*** to people with Medicare and create opportunities to capture and incorporate their concerns into the development and improvement of all Medicare assistance programs.
- ***Identify*** and facilitate the resolution of systemic issues that affect people with Medicare through a centralized issues tracking mechanism.
- ***Recommend*** solutions for necessary and actionable program improvement based on analysis of trends and information from people with Medicare and their representatives, and escalate systemic issues to CMS Leadership.

With more than 42 million Medicare beneficiaries and a program that is the largest healthcare insurer in the United States, it is necessary for the CMS to contract with numerous business entities to administer the Medicare program. Because every contractor uses unique systems and processes to carry out its contractual obligations, reaching across these various entities to assist people with Medicare in fully exercising their Medicare rights, benefits, and protections became a challenging but necessary endeavor for the Ombudsman's Office. Adding to this challenge is that, historically, the Medicare program has lacked the centralized means to monitor and analyze the range of issues identified by these various entities. In its endeavors to improve the

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administration of Title XVIII, the OMO understood these challenges and worked closely with CMS Regional Office casework staff to act as the beneficiaries' liaison in fostering the resolution of beneficiary issues on two distinct levels: handling individual casework and identifying systemic issues that affect large segments of the Medicare beneficiary population.

In 2006, CMS named Ombudsman Schreiner as the Agency's National Casework Lead. In this role, the Ombudsman's Office worked closely with CMS Regional Offices and other CMS components to develop a framework for managing CMS' casework and related activities, gathering data about beneficiary concerns and complaints from a wide variety of sources, and analyzing this data to understand and resolve underlying issues. This framework allowed the OMO to implement a process that increased CMS' ability to identify and address beneficiary concerns and the root cause of complaints. The OMO works to identify and understand the impact of those issues that inhibit the Medicare Program from delivering the highest level of service for people with Medicare, and to elevate those issues to CMS Leadership and those components that are directly responsible for resolving the issues. All of this is done in conjunction with the CMS Regional Offices, Office of Beneficiary Information Services (OBIS), and numerous other CMS components.

Also during this report period, the OMO conducted beneficiary-focused outreach activities on three levels: national, regional, and local. The Ombudsman attended and presented at conferences communicating the mission and goals of the OMO with Medicare beneficiaries and their representatives. In addition, the OMO developed working relationships with various Medicare entities and other organizations that serve people with Medicare that research and resolve the beneficiaries' concerns.

Accomplishments

The OMO took a phased approach to the implementation of the Office by first assessing the Medicare Program environment and defining its operation based upon beneficiary needs. Then, the OMO built the processes and tools needed to fulfill those immediate needs. This phased approach allowed the OMO to maintain focus on its vision by identifying achievable targets and creating organizational momentum. During the period of this report, Ombudsman Schreiner and the OMO staff made progress toward fulfilling the legislated charge of Section 923 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) within each of the following major functional work streams.

2005-2006 Report to Congress**Casework Management**

- Worked closely with CMS Regional Offices and other CMS components to formalize and integrate existing CMS processes for casework.
- Improved OMO responses to inquiries and complaints.
- Assumed responsibility for and led the weekly National Casework Call to facilitate communication and information sharing for CMS caseworkers.
- Improved upon the CMS Intranet Casework site devoted to Medicare Part D casework as a primary resource for CMS caseworkers.
- Worked closely with CMS Regional Office casework staff and various CMS subject matter experts to develop CMS caseworker standard operating procedures (SOPs) for specific types of casework.

Outreach

- Conducted outreach and education events for people with Medicare and their representatives.
- Developed facilitation framework for OMO events.
- Established strategic partnerships.
- Developed and facilitated a Technical Assistance Program (TAP) for State Health Insurance Assistance Programs (SHIPs) for providing enhanced assistance to those with mental health needs.

Continuous Quality Improvement

- Developed and implemented issues management processes.
- Developed requirements for a consolidated data collection and reporting mechanism.
- Conducted extensive assessment and evaluation of the Agency's data and systems capabilities for tracking beneficiary inquiries, complaints, grievances, and appeals.

Tracking and Reporting

- Developed a weekly report that provided trends on Medicare Part D casework.

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- Reported to the CMS Administrator on the key Medicare Part D issues impacting casework.

It has been an exciting time for the Ombudsman's Office. Through extensive research and analysis, the OMO determined the staffing model and operational processes needed to fulfill the tasks detailed in MMA 923 and successfully initiated the work of the Office of the Medicare Beneficiary Ombudsman. The OMO created a strong foundation for its long-term plan to identify the needs of people with Medicare and make those needs a stimulus for the continuous improvement to beneficiary service within the Medicare program. Through these endeavors, the OMO and Ombudsman Schreiner have indeed become *a voice for people with Medicare*.

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INTRODUCTION

The Office of the Medicare Beneficiary Ombudsman (OMO) was established in accordance with Section 923 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The OMO's core tasks as authorized by Congress are to:

- Receive complaints, grievances, and requests for information from people with Medicare;
- Provide assistance regarding complaints, grievances, and requests for information;
- Submit an annual report of OMO activities to the Secretary of Health & Human Services and to Congress that includes the Ombudsman's recommendations for improvement in the administration of the Medicare program; and
- Work with insurance counseling programs whenever possible to help provide people with Medicare with the information they need to make informed decisions.

In developing MMA Section 923, Congress recognized the need for an Ombudsman to help people with Medicare understand and exercise their Medicare rights, benefits, and protections. While not acting as an advocate for coverage of new services or increased payments, the Office of the Medicare Ombudsman engages in activities that ensure people with Medicare receive appropriate assistance. The OMO works to ensure that the rights and privileges of people with Medicare are protected, and that the Medicare program as a whole evolves toward a higher standard of service through the implementation of its continuous quality improvement process.

Vision / Mission / Goals

People with Medicare now have access to increasingly affordable and comprehensive health care, additional prescription drug coverage, expanded health plan options, and enhanced preventive care services. While the MMA dramatically expanded the choices open to people with Medicare, this growth brings additional points of contact, more decisions, and potential confusion for some people with Medicare.

Given the size, diversity, and evolution of the Medicare program, it is almost inevitable that some people with Medicare experience a gap between their needs and the service provided. These gaps occur largely due to lack of access to information, inability to

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comprehend fully the Medicare program information that is available to them, and/or unintended breakdowns in program operations. To provide timely and proactive assistance to the largest number of people with Medicare, the Centers for Medicare & Medicaid Services (hereafter called CMS or the Agency) must identify the issues causing such gaps. With this aim, the OMO framed the following vision, mission, and goals.

The OMO's *vision* is to be the beneficiary advocacy model for providing customer service and critical information to ensure continuous improvement of the Medicare program.

The OMO's *mission* is to provide direct beneficiary assistance and continuously improve the Medicare program through analyzing data on complaints, inquiries, grievances, and appeals; evaluating policies and procedures with multiple internal and external partners; and making annual recommendations through the Office of the Medicare Beneficiary Ombudsman Report to the Secretary of Health & Human Services and to Congress on improvements to the administration of the Medicare program.

The OMO's *goals* are to:

- *Listen* to people with Medicare and create opportunities to capture and incorporate their concerns into the development and improvement of all Medicare assistance programs.
- *Identify* and facilitate the resolution of systemic issues that affect people with Medicare through a centralized issues tracking mechanism.
- *Recommend* solutions for necessary and actionable program improvement based on analysis of trends and information from people with Medicare and their representatives, and escalate systemic issues to CMS Leadership.

From the OMO's vantage point within the Agency, the Ombudsman brings the views and needs of people with Medicare to the forefront of the decision-making process. Ombudsman Schreiner will continue to be committed to making the beneficiary the central and critical component to the improvement of the entire Medicare program.

MMA 923

The primary legislative responsibility for the OMO is beneficiary assistance. The OMO fulfills this mandate on two levels:

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- **Individual Casework** includes concerns, requests, and complaints submitted by an individual Medicare beneficiary or their representative. These may be submitted to CMS by telephone, fax, e-mail, or letter. People with Medicare and their representatives may also voice their concerns in person at CMS partnership and outreach events. The OMO, CMS Regional Offices, and State Health Insurance Assistance Programs (SHIPs) all play a key role in facilitating individual casework.
- **Systemic Issues** are recurring or program problems affecting large segments of the Medicare beneficiary population. These issues are identified through the various outreach, education, and issue identification processes that the OMO has involvement.

With over 42 million people with Medicare, it is imperative to focus the OMO's time and effort on those issues whose resolution and enhancement have wide-ranging impact for large numbers of beneficiaries. During the period of this report, the OMO:

- Identified the functions and strategies necessary to execute the intent of MMA 923;
- Developed several channels for communication with the Medicare community, such as the Ombudsman web page, www.cms.hhs.gov/center/ombudsman.asp;
- Identified and implemented a methodology to document, track, and resolve the concerns voiced by people with Medicare; and
- Developed a process for the OMO to identify, elevate, and track issues through to resolution.

BACKGROUND: THE MEDICARE LANDSCAPE

The OMO functions in a complex environment. Much of the first year was devoted to researching the myriad beneficiary service components and their associated functions and practices within the Medicare program. This information formed the basis for the selection of an appropriate organizational model and formulation of an effective strategy to fulfill the OMO's congressional charge.

The scope and complexity of the Medicare program is attributable to:

- ***Size & Numbers.*** The Medicare program is the largest health care insurer in the United States and one of the largest in the world. It offers coverage to more than 42 million individuals who are eligible for benefits under Title XVIII of the Social Security Act. The many benefits and the number of entities involved in the administration of the Medicare program make facilitating beneficiary service issues a real challenge.
- ***Coverage Options.*** People with Medicare can choose to have their health care and prescription drugs covered in numerous ways under the Medicare program. These options include the Original Medicare Plan under Part A and Part B; a Medicare Advantage (MA) Plan under Part C; and/or Medicare Prescription Drug Coverage under Part D.
- ***Representatives and Advocates.*** Because of the nature of the Medicare program, many groups closely scrutinize it. These entities include the White House, the Congressional offices (535 offices), Office of Inspector General (OIG), Government Accountability Office (GAO), and numerous Medicare beneficiary advocacy groups.
- ***Contractors and Grantees.*** MMA Section 911 directed CMS to institute contractor reform with the goal of improving the administration of the Medicare program. The reconfiguration of how the Agency handles claim inquiries will bring changes to beneficiary service delivery in the coming years. As with any major business process modification, these conversions pose the potential for new beneficiary service issues.

The OMO will continue to track the many annual changes in the Medicare program, including CMS' progress in completing the claim-processing conversions before the end of 2011. *Figure 1* on page 5 summarizes contractor conversions currently underway.

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CMS Contractor Reform Initiative			
Current Fee-For-Service Medicare Environment		Future Medicare Administrative Environment	
27	Fiscal Intermediaries (FIs)	15	Medicare Administrative Contractors (MACs)
20	Carriers		
47	Beneficiary Claims Call Centers	1	Beneficiary Contact Center
4	Durable Medical Equipment Regional Carriers (DMERCs)	4	Durable Medical Equipment Medicare Administrative Contractors (DME MACs)
4	Regional Home Health Intermediaries (RHHIs)	4	Home Health MACs

Figure 1: CMS expects to complete the contractor reform initiative in 2011.

During this reporting period, 1,233 Medicare entities served as points of contact for people with Medicare. People with Medicare must often work with many of these entities, and it is not always obvious to the beneficiary which organization is the appropriate point of contact. Figure 2 shows the primary beneficiary service entities within the Medicare environment.

Medicare Beneficiary Service Entities			
Entity Type	Number of Entities	Entity Type	Number of Entities
CMS Central Office (CO)	1	End-Stage Renal Disease (ESRD)	18
CMS Regional Office (RO)	10	Medicare Prescription Drug Plan (PDP)	563
Fiscal Intermediary (FI)	27	State Health Insurance Assistance Program (SHIP)	54
Carrier	20	Qualified Independent Contractor (QIC)	6
Durable Medical Equipment Regional Carrier (DMERC)	4	Independent Review Entity (IRE)	2
Regional Home Health Intermediary (RHHI)	4	Managed Care Organization	458
Quality Improvement Organization (QIO)	53	Program Safeguard Contractor (PSC)	12
Coordination of Benefits Contractor (COBC)	1	Beneficiary Contact Center (1-800-MEDICARE)	1

Figure 2: 16 primary entity types comprised of 1,233 individual entities provide services to people with Medicare.

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- **Multiple Channels for Accessing Services.** People with Medicare may contact a variety of entities for assistance with inquiries, grievances, complaints, and appeals. They may use any of the following channels:
 - Telephone: 1-800-MEDICARE or other toll-free numbers;
 - Internet: e-mail via www.medicare.gov, www.MyMedicare.gov or www.cms.hhs.gov;
 - Mail; or
 - In person at outreach events or an office location.
- **Number of Contacts.** During 2006, the Medicare program received in excess of 98 million total contacts. *Figure 3* provides contact detail for several of the numerous beneficiary services components that handle contacts from diverse segments of the beneficiary population regarding a variety of issues.

Contacts to the Medicare Program for Selected Beneficiary Service Components		
Service Component	Source of Data	2006 Total Volume
1-800-MEDICARE	Office of Beneficiary Information Services (OBIS)	37,480,603
CMS Central Office (CO)	OMO/Division of Ombudsman Casework and Trends Management (DOCTM)	412,484
CMS CO and ROs (Part D complaints)	CBC/New York Regional Office	605,986
End-Stage Renal Disease (ESRD) Networks	Office of Clinical Standards and Quality (OCSQ)	4,677
Fiscal Intermediaries (FIs) and Carriers	Office of Financial Management (OFM)	57,802,177
Quality Improvement Organizations (QIOs)	Office of Clinical Standards and Quality (OCSQ)	62,373
State Health Insurance Assistance Programs (SHIPs)	Office of External Affairs (OEA)	1,460,953
Medicare Advantage (MA) Plans (level 2 and 3 appeals)	Center for Beneficiary Choices (CBC)	24,555
Prescription Drug Plans (level 2 and 3 appeals)	Center for Beneficiary Choices (CBC)	13,487
Survey and Certification	Center for Medicaid and State Operations (CMSO)	67,755

Figure 3: Contacts to the Medicare Program for selected beneficiary service components on behalf of people with Medicare in 2006.

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The numbers shown on page 7 do not include all beneficiary contacts to the Medicare program. However, they do illustrate the variables the OMO needed to take into account when assessing opportunities to improve service to people with Medicare.

- ***Diverse Systems and Procedures.*** The OMO is committed to working with all of the entities and through the multiple channels of communication to identify systemic issues and facilitate solutions that reduce potential confusion and barriers to service. The OMO gathered information from a number of program sources to correlate and analyze data and facilitate trending and analysis of the Medicare program's provision of beneficiary services.

Currently, each entity type listed on page 7 in *Figure 2* has its own operating and reporting structure, performance standards, and data storage and tracking systems. The OMO made progress in gathering and aggregating data to bring CMS closer to consolidated tracking and reporting of beneficiary needs for assistance and associated issues. A comprehensive tracking, data analysis, and reporting function will facilitate program-wide issue identification and trending.

- ***Changes to the Program.*** The implementation of Medicare Part D was one of the most significant changes to Medicare since its inception in 1965. In 2006, Ombudsman Schreiner directed much of the OMO staff efforts toward assisting people with Medicare and their representatives with their questions and concerns about Medicare Part D. Medicare Part D issues also predominated in the OMO's issue identification and national casework activities.

Each of these factors added to the complexity of the OMO's task of assessing and initiating improvements in the service delivered to people with Medicare. To fulfill this charge within the available resources of time, money, and staff added another layer of complexity to the task. Thus, the OMO's first challenge was to create an organizational structure that would optimize available resources.

Organizational Ombudsman Model

After researching various types of ombudsman offices, the OMO chose to structure itself on an organizational ombudsman model. The Office chose this model because of the need to maximize the resources available through CMS and avoid duplication of existing services.

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An organizational ombudsman:

- Provides information in a confidential manner;
- Serves as a communication channel for handling complaints;
- *Facilitates issue resolution;*
- *Helps an organization work for change;*
- Fosters fairness, equity, justice, equality of opportunity, and respect;
- Promotes respect for those who are or who see themselves as less powerful than others; and
- Is a designated neutral party within an organization that usually reports at or near the top of the organization.

Working from within an organization presents unique challenges and opportunities. However, based on the organizational ombudsman model, the OMO has fulfilled MMA 923 by:

- Assisting the Medicare beneficiary population through the identification of systemic issues and engaging in efforts to facilitate resolution of those issues,
- Handling complaints by resolving individual and systemic issues that directly impact people with Medicare,
- Reporting annually to the Secretary of Health & Human Services and Congress the activities of the Office and providing recommendations for improvements in the administration of the Medicare program, and
- Championing beneficiary issues within existing Medicare program policies.

Organizational Change within CMS

Since its inception, the Office of the Medicare Ombudsman has reported directly and primarily to the CMS Office of the Administrator (OA). Ombudsman Schreiner met with CMS Leadership on an ongoing basis to share findings, make informal recommendations, and provide updates on the status or progress of improvements to the processes and systems through which people with Medicare receive services.

While the OMO reported directly to the OA, restructuring within CMS during 2006 moved the OMO from its original position in the Center for Beneficiary Choices (CBC) to the Office of External Affairs (OEA). This change was part of a larger restructuring within CMS aimed at strengthening its administration of the Medicare program,

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principally the administration of Medicare Advantage Plans under Part C and Prescription Drug Coverage under Part D.

In its transition to OEA, the OMO moved from a CMS component focused on internal policy and processes to a CMS component focused on external outreach and communication. The OMO’s move to OEA placed it in a public-facing entity with the collective responsibility of advising the CMS Administrator and other Agency components on anything that might affect the delivery of beneficiary services to people with Medicare. The move also put the OMO in a position to draw upon OEA’s public relations and communications capabilities to reach out to more Medicare beneficiaries. Figure 4 depicts OEA’s current organization.

OEA Organizational Chart

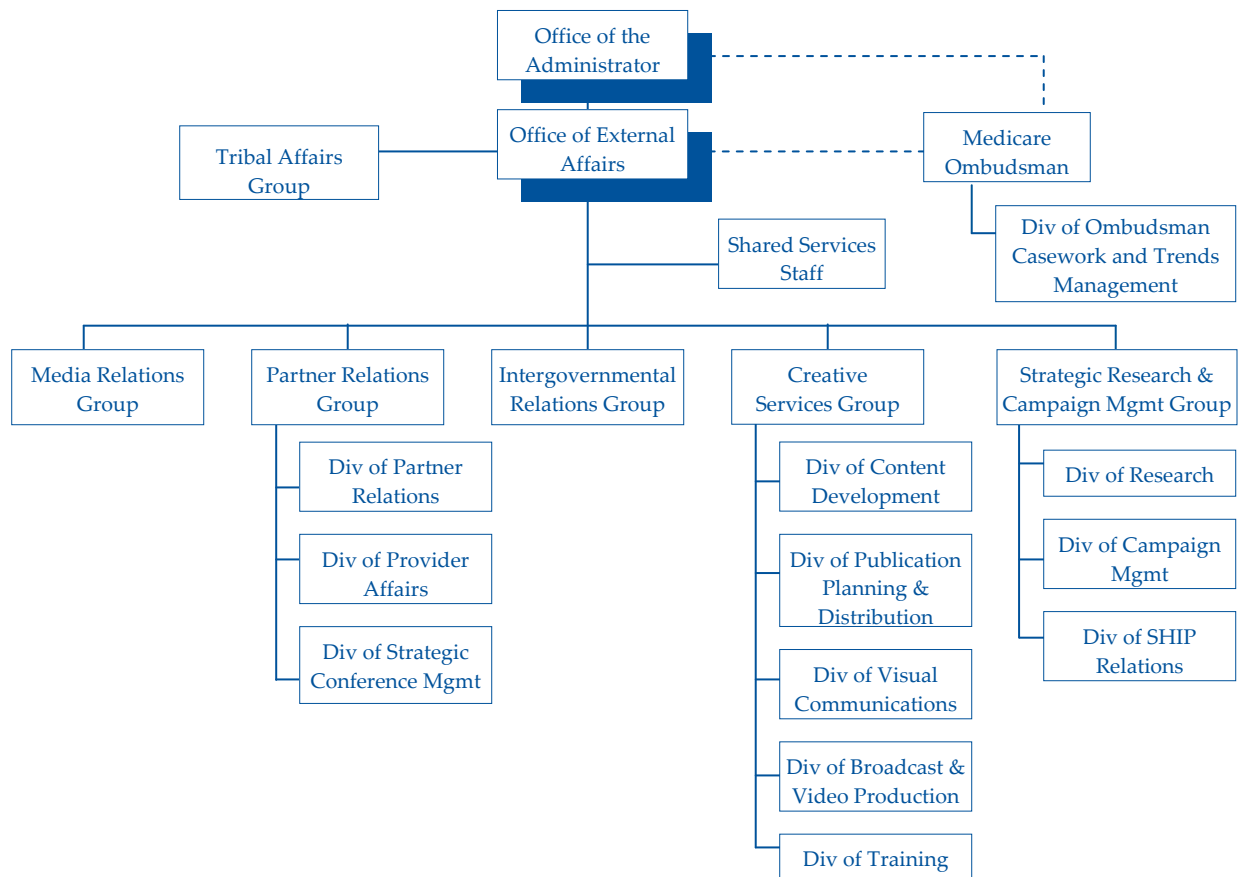
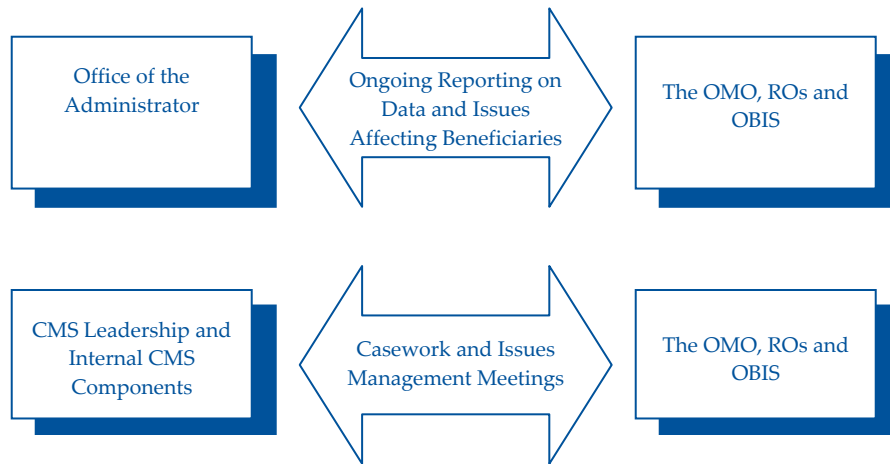


Figure 4: Reorganization strengthened Medicare Program administration and allowed the OMO to focus on external outreach and communication.

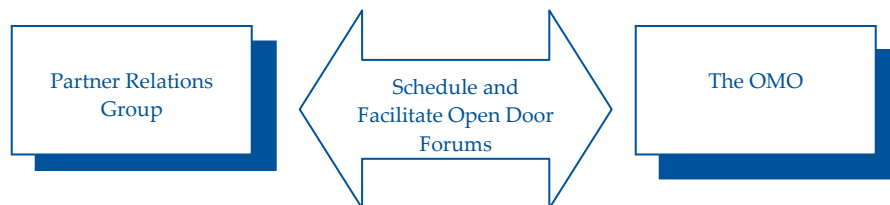
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It must be noted that the reorganization did not alter the OMO’s relationship with the OA. Ombudsman Schreiner continued to update the Administrator regularly on issues affecting the beneficiary population. Through the OA, the OMO also coordinated with CMS Leadership, Regional Offices (ROs), and Office of Beneficiary Information Services (OBIS) to manage beneficiary inquiries and issues as outlined in the following two diagrams.



While the OMO’s responsibilities to the OA continued unchanged, the reorganization placed the OMO in a new proximity to OEA groups that collaborate in the development and dissemination of current and accurate information to external parties, such as people with Medicare, CMS partners, and beneficiary advocacy groups to name a few. These mutually beneficial relationships are described in the diagrams below.

- Improved the OMO's opportunities for public visibility and expanded its ability to reach people with Medicare by leveraging existing partnership and outreach mechanisms through the Partner Relations Group. The Partner Relations Group manages CMS activities to better hear and interact with providers and other stakeholders, including patient advocacy outreach, interested in the delivery of quality health care for Medicare and Medicaid beneficiaries. The OMO’s outreach activities, in turn, gave the Partner Relations Group more information on Medicare service as well as a model and methodology to get in-depth information about specific issues and populations.



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- Improved the opportunities to mitigate potential negative impacts to Medicare beneficiaries through collaboration with the Strategic Research & Campaign Management Group, which manages aspects of the SHIP program including assistance.



These benefits were especially noteworthy since they allowed the OMO to better align itself with CMS' strategic objectives.

One of the CMS strategic objectives is a multi-faceted campaign to help people with Medicare become more confident and informed consumers. Even before the move to OEA, the OMO began a series of outreach and education events to *listen* to people with Medicare, and *identify* the areas in which people with Medicare have difficulty accessing available resources. The OMO's position within OEA provides a unique opportunity to *recommend* communication methods and service processes that ensure people with Medicare have the information they need to make the most of their Medicare benefits.

The OMO's role, goals, and placement within OEA and OA nurture and facilitate the Ombudsman's efforts to assist people with Medicare and to be *a voice for Medicare beneficiaries* within the Agency.

The following section describes the functions and strategies necessary for the OMO to fulfill its mission of assisting people with Medicare.

FULFILLING THE LEGISLATION

When Congress passed MMA 923 and created the position of the Medicare Beneficiary Ombudsman, CMS first assembled a team to analyze the needs and requirements of the OMO. As with any new program, it was not possible to fulfill the tasks detailed in MMA 923 and establish the Office during the same short span of time. On March 22, 2005, CMS hired Daniel J. Schreiner as the first Medicare Beneficiary Ombudsman. Ombudsman Schreiner brought together a team of Medicare and beneficiary service experts to implement the Office of the Medicare Beneficiary Ombudsman.

The OMO took a phased approach to the implementation of the Office. This phased approach allowed the OMO to maintain focus on the end-state vision by creating achievable targets while building organizational momentum. The phases are outlined below.

Year One: Assess

In its first year of existence, the OMO creatively balanced resource allocation and expertise to construct the necessary infrastructure for the work of the Office. Program research and gap analyses resulted in recommendations regarding office processes and appropriate staffing to enable consumer assistance and continuous improvement of the Medicare program.

To lay the groundwork for the infrastructure, the OMO led the activities of two independent consultants for an in-depth, current-state analysis of Medicare processes and systems. Those efforts provided a clearer picture of how:

- People with Medicare interact with the Medicare program and resulted in recommendations for categorizing the issues brought forward by beneficiaries, and framing the staff and infrastructure of the OMO.
- Medicare entities capture and store data and resulted in recommendations for establishing a data and information gathering mechanism.

These assessment activities enabled the Office to define its vision, mission, and goals, to develop the operational framework, and to support the strategic planning activities that would set year two's Build phase in motion.

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Year Two: Build

Second-year activities were the product of CMS' ongoing strategic planning and implementation efforts from year one's Assess phase. The OMO's approach focused on ensuring that people with Medicare receive appropriate services in a timely and efficient manner. The elements of this approach were:

- ***Functional Statements*** that focused on the four core tasks detailed in MMA 923,
- ***Work Streams*** that provided a framework to support the alignment of multiple distinct tasks, and
- A ***Staffing Model*** that enabled performance of work stream activities.

Functional Statements

Ombudsman Schreiner committed to making the people with Medicare the central and critical component to the improvement of the entire Medicare program. To fulfill the four core tasks outlined in MMA 923, the OMO developed functional statements that clearly detail the Office's purpose and role.

The majority of the OMO's functional statements focus on its primary MMA 923 responsibility: assisting people with Medicare. The Office fulfilled this charge by apportioning the functions to work streams.

Work Streams

Work streams are a management tool that help link strategic plans to service and process improvements. The OMO's functional statements map the activities involved in serving as *a voice for Medicare beneficiaries*. The OMO developed and implemented work streams that enable the execution of these functions. They align multiple, distinct tasks in support of strategic goals and provide a bridge between strategy and operations. The OMO's work streams are:

- ***Casework Management***: the conduit for the OMO to receive requests from and assist people with Medicare;
- ***Outreach***: the channel for the OMO's beneficiary education efforts; and
- ***Continuous Quality Improvement***: the process for execution of improvement strategies through tracking and analyzing data.

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Based on the functional statements and the corresponding work streams, the OMO identified the roles and responsibilities needed to fulfill the obligations of the Office as outlined in MMA 923. The OMO's last step in its strategy for fulfilling the MMA 923 legislation was the creation of the Office's staffing model.

Staffing Model

Ombudsman Schreiner framed the OMO staffing model keeping in mind the organizational ombudsman model and the four core tasks delineated in MMA 923. During the time of this report, the OMO revised the original staffing model to maintain alignment with the Agency's reorganization as discussed in the Report subsection, Organizational Change within CMS. One result of the Agency's reorganization was the reassignment of the Division of Beneficiary Inquiry Customer Service (DBICS) and the Division of Beneficiary Inquiry Trends Analysis (DBITA) to the OMO. These divisions now comprise the Division of Ombudsman Casework and Trends Management (DOCTM) and report directly to Ombudsman Schreiner.

The current OMO staffing model outlined on page 15 in *Figure 5* aligns operationally with the OMO's goals and allows the OMO's staff to coordinate their efforts for maximum efficiency.

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The OMO Staffing Model

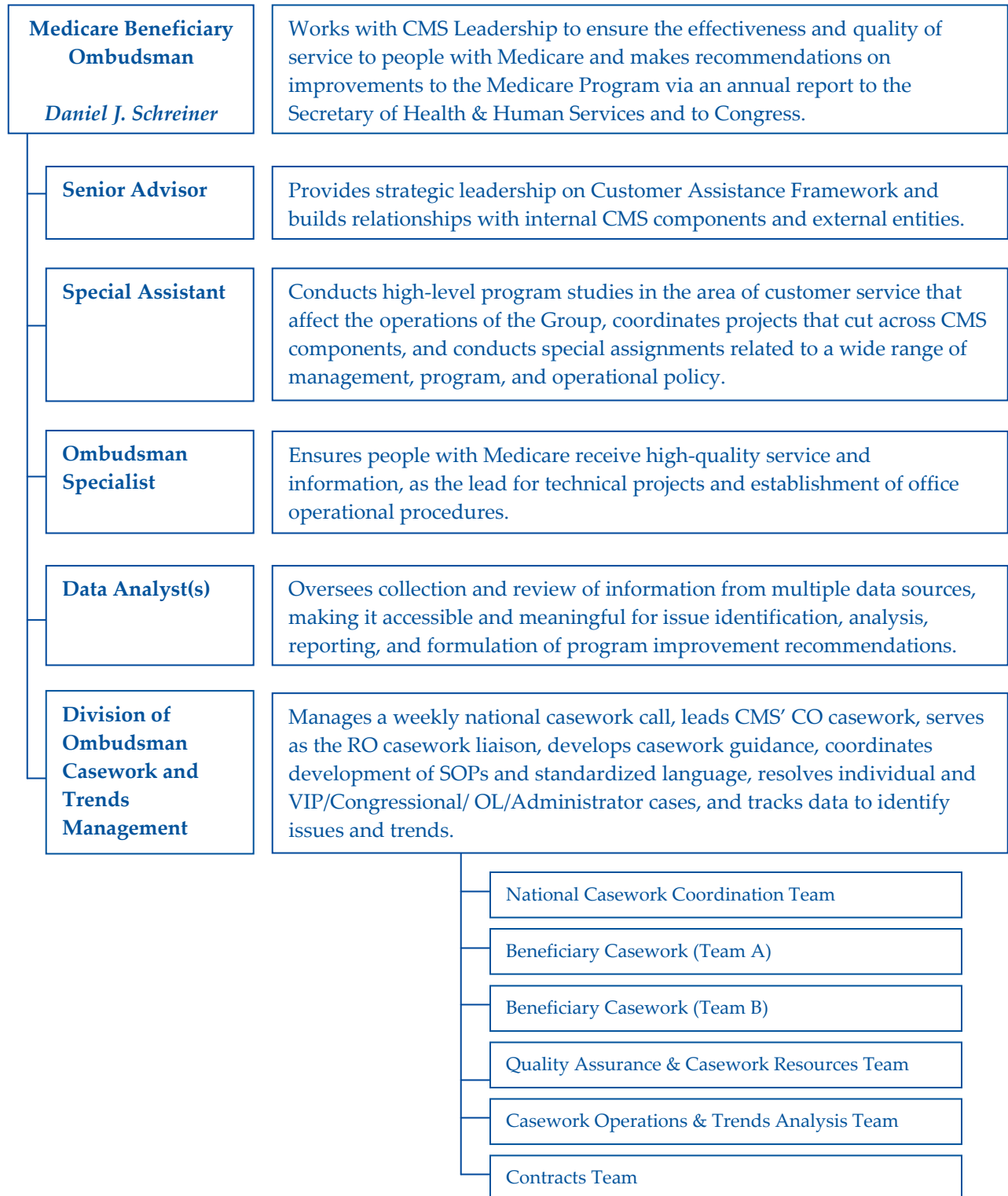


Figure 5: The OMO staffing model enables fulfillment of the MMA 923 mandate.

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The OMO built on what it learned in the Assess phase and used the strategies listed above to make sure its infrastructure enabled its ability to fulfill its mission.

The OMO's first major opportunities to identify and work closely with others to address systemic beneficiary service issues were presented during the initial implementation of Part D. Issues involving Part D continue to hold a major focus for the Agency and the OMO with regard to casework and beneficiary services.

Case Review 1**Toll-Free Numbers Improve Access to New Medicare Program Information**

During the OMO's assess phase, Ombudsman Schreiner attended a meeting with representatives from Medicare Advantage Plans (MAP) to listen to their concerns and better understand their needs. He learned that many people with Medicare were referred to Regional Offices (ROs) for assistance and issue resolution. The MAP representatives expressed concern regarding the number of Part D enrollment telephone calls the ROs would soon be experiencing and the fact that some of the ROs did not have toll-free numbers.

Ombudsman Schreiner worked with the CMS Central Office and ROs to obtain a temporary toll-free number for each RO until the Agency's casework framework was fully implemented. The toll-free numbers gave people with Medicare improved access to the assistance and information needed to make informed health care decisions.

Case Review 1 demonstrates the Office's successful test run of its operational framework and beneficiary assistance processes as it transitioned from the Assess phase to the Build phase.

Year Three: Transform

The staffing model facilitates the OMO's ability to *listen* to those with Medicare-related issues. It enables their ability to *identify* issues whose resolution could benefit the more than 42 million people served by the Medicare program. The staffing model also supports the Office's ability to *recommend* program improvements for people with Medicare and for those involved with administering Medicare.

Working within the infrastructure described on the previous pages, the OMO is poised to identify and resolve systemic issues in order to assist individuals entitled to benefits under Title XVIII. Additionally, the Ombudsman's assessment of Medicare program and policy operations and their impact on people with Medicare will serve as the foundation for affecting positive change in the manner in which CMS provides customer service to people with Medicare.

The following section details the OMO's beneficiary assistance efforts during the Build phase of this report period.

BENEFICIARY ASSISTANCE

In section 923 of MMA, Congress detailed four core tasks for the Office of the Medicare Beneficiary Ombudsman, all related to providing assistance to people with Medicare. Three tasks centered on OMO's responsibility of assisting people with Medicare on their specific concerns. The fourth task, making recommendations for improvement in the administration of the Medicare program, indicates the need to assist people with Medicare at a program level.

With a clearly defined directive for providing assistance to people with Medicare, the OMO associated specific actions with their goals:

- ***Listen:*** Develop a process to capture the common issues and concerns of people with Medicare.
- ***Identify:*** Utilize an issues tracking mechanism to identify and address systemic issues impacting people with Medicare.
- ***Recommend:*** Make recommendations for overall program improvement based on analysis of trends.

In response to the beneficiary assistance task set out by section 923 of MMA, the OMO acted as a liaison to foster resolution of identified issues within the Medicare program. These activities occurred on two distinct levels:

- ***Individual Casework Level:*** Concerns and requests submitted to CMS from an individual Medicare beneficiary, or someone acting on the beneficiary's behalf, by telephone, letter, e-mail, or fax.
- ***Systemic Issue Level:*** Recurring or program problems affecting large segments of the Medicare beneficiary population identified through outreach, education, and issues management.

Individual Casework Level

CMS' casework load is comprised of concerns and requests from individual Medicare beneficiaries who contact the Medicare program directly or through their representative.

CMS handles inquiries from individual Medicare beneficiaries through various beneficiary service components. During 2006, CMS re-evaluated casework activities and associated procedures.

The OMO's Division of Ombudsman Casework & Trends Management

Based on conclusions drawn from 2005 research and gap analysis activities, the OMO recommended that CMS formalize and integrate existing CMS processes used to identify and monitor casework issues and trends affecting people with Medicare. In accordance with this recommendation, CMS named Ombudsman Schreiner to lead the casework efforts and the activities of the Division of Ombudsman Casework & Trends Management (DOCTM) in addressing inquiries and complaints that CMS' Central Office receives from people with Medicare. As stated in the Fulfilling the Legislation section of this report, DOCTM beneficiary assistance activities moved to the Office of the Medicare Ombudsman in 2006. This move aligns with the OMO's focus on beneficiary assistance in the areas of education, knowledge, and awareness of the rights and protections of people with Medicare.

The DOCTM Health Insurance Specialists are trained and knowledgeable in all aspects of the Medicare program. They handle each individual Medicare beneficiary contact using standard operating procedures for responding to and resolving the inquiry or complaint.

In 2006, DOCTM received numerous inquiries and complaints from people with Medicare and their representatives. The inquiries were broad in both scope and complexity. They brought everyday issues affecting people with Medicare to the forefront and involved a vast array of health care topics. The OMO noted trends or clusters of inquiries regarding specific topics and identified the trends as issues to be addressed at the higher level of program improvement. The resolution of inquiries resulting from systemic program issues directly affects not only the life of the individual Medicare beneficiary making the inquiry, but also the life of every person with Medicare who has the same needs and issues.

Not only does DOCTM respond to inquiries received from the general public, it also handles high-level, complex Medicare inquiries that are directed to the White House, the Secretary of Health & Human Services, the CMS Administrator, and other high-profile sources.

Figure 6 on page 19 shows the various sources through which the OMO received inquiries and complaints from Medicare beneficiaries in 2006.

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Division of Ombudsman Casework and Trends Management Inquiry and Complaint Sources	
2006 Sources	Percentage of Total Inquiries and Complaints
General Public	70.4%
Correspondence Forwarded to the Regional Offices for Resolution	11.2%
Part B Premium Correspondence	5.1%
Congressional Referrals	4.1%
CMS.gov E-mails	3.7%
Spanish Language	2.9%
VIP, Beneficiary Advocacy, and Ombudsman Casework	2.7%

Figure 6: In 2006, the OMO's DOCTM responded to numerous inquiries and complaints. Over 70% were received from the general public.

Regardless of the avenue the individual used to contact the Medicare program, each had an issue and requested assistance. Figure 7 below represents the top 10 inquiry and complaint issues received by the Agency and resolved by the OMO staff in 2006.

**Inquiries Addressed to CMS
Top 10 Issues**

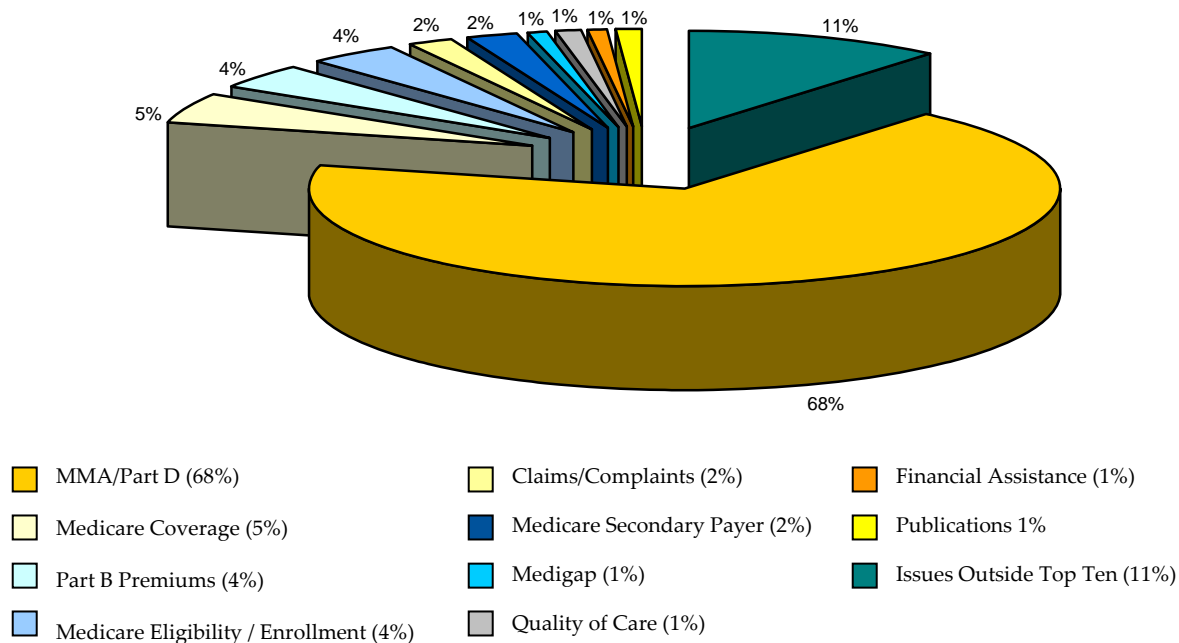


Figure 7: In 2006, the OMO's DOCTM responded to a variety of issues with the majority related to Medicare Part D. Approximately 90% of all inquiries related to one of the top 10 issues.

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One of the OMO's goals is to ensure people with Medicare receive timely, proactive, and successful resolution of their concerns. In recent years, the DOCTM team has gauged the quality of its service in providing its responses by sending a satisfaction survey with every inquiry response sent during a defined period of time that was representative of the cases throughout the calendar year. In 2005, DOCTM sent surveys to 2,872 people. Of these, 1,333, or 46 percent, responded.

The survey had four domains: timeliness, usefulness, clarity, and overall satisfaction. On a continuing scale of 1, Strongly Disagree, to 5, Strongly Agree, the respondents rated the OMO casework team at greater than 4.0 on each of the 4 domains. After removing the results from those survey responses not related to DOCTM's service, the beneficiaries' overall satisfaction with DOCTM's service was 4.1.

DOCTM's analysis of the surveys resulted in:

- Personalized responses,
- Improved quality control for consistency in responses, and
- Clarified responses through expanded content analysis.

In addition to answering static questions, the survey allowed participants to provide a free-form response. A sample comment from the returned surveys identifies excellent service by a Health Insurance Specialist.

*"Your service is excellent.
Thank you ..., Health Ins. Specialist.
And thank you to all employees for their
assistance. Where would we be
without you?"*

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As outlined above, the Health Insurance Specialists in the OMO's Division of Ombudsman Casework and Trends Management reply to inquiries received from the general public on an individual basis. These OMO caseworkers continually work to provide informative and timely responses through regular training and engaging in efforts to improve casework processes.

Case Review 2**Dedication to Customer Service Uncovers Significant Medicare Beneficiary Refund**

In June 2006, a female Medicare beneficiary contacted CMS to report that she had not been receiving premium billing notices and requested a bill.

Following standard operating procedures, a DOCTM Health Insurance Specialist reviewed the beneficiary's records. She had been paying the base premium rate for Part A instead of a reduced rate based on 30 quarters of coverage that began in December 2000. Although records showed that an adjustment to correct the Part A premium amount had been made in June 2006, a refund had not been generated.

DOCTM staff worked with the Office of Information Services to correct the payment overage. The DOCTM Health Insurance Specialist promptly contacted the Medicare beneficiary to answer her inquiry and notify her of a significant refund. The beneficiary expressed her gratitude and stated the refund would help alleviate some of her existing physical and mental distress.

Case Review 2 describes an individual case investigated by DOCTM that resulted in a positive outcome for a person with Medicare.

Inquiries Addressed Directly to the OMO

Since its establishment in early 2005, Ombudsman Schreiner and the OMO staff worked diligently to increase public awareness of the Office and their role. Direct contacts to the Office by people with Medicare or their representative increased, on a pro-rated basis, by more than 300 percent. During 2005, the OMO received less than 50 direct contacts from people with Medicare or their representatives; this number increased to over 200 direct contacts for calendar year 2006.

The issues identified through these direct contacts to the OMO closely aligned with those received via general beneficiary mailings to the CMS Central Office. *Figure 8* on page 22 shows the top 10 issues brought forward by people with Medicare contacting the OMO directly. Nearly half of these contacts involved issues or concerns with Part D.

Inquiries Addressed Directly to the OMO Top 10 Issues

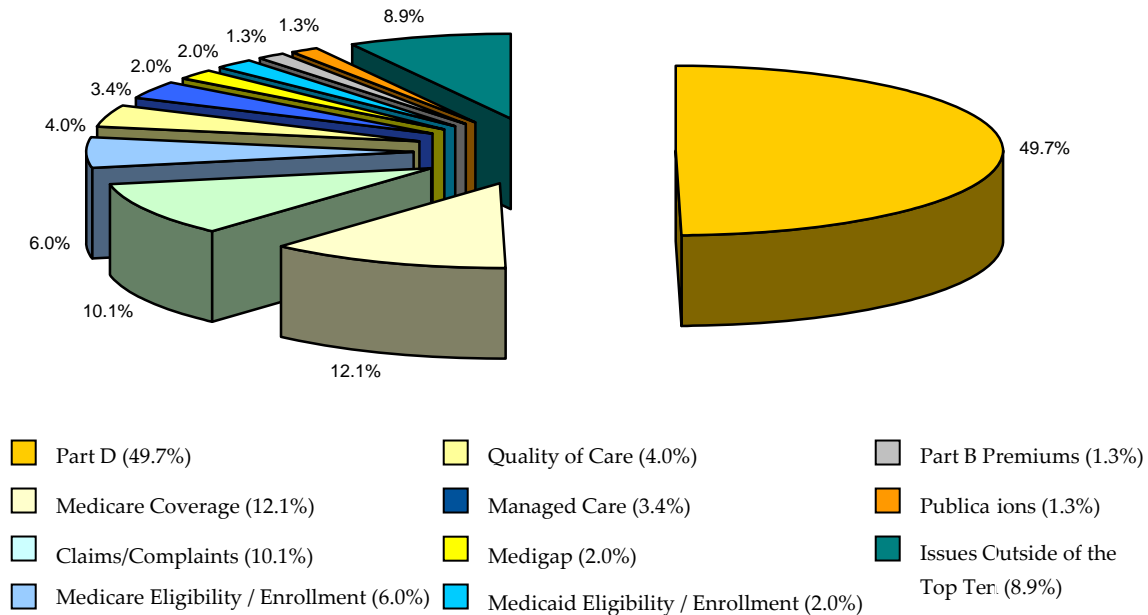


Figure 8: In 2006, the OMO responded to a variety of inquiries addressed directly to the Office with the majority related to Part D. Over 90% of all inquiries related to one of the top 10 issues.

Figure 9 below combines the ranking of those issues that appear on the top 10 list received by CMS via general beneficiary inquiries with those inquiries sent directly to the OMO in 2006. Additional primary issues addressed by the OMO in 2006 were Managed Care and Medicare Secondary Payer.

Ranking of Primary Issues Handled by the OMO	
2006 Issue	Ranking
Part D	1
Medicare Coverage	2
Medicare Eligibility / Enrollment	3
Claims / Complaints	4
Part B Premiums	5
Medigap	6
Quality of Care	7
Managed Care	8
Medicaid Eligibility / Enrollment	9
CMS Publications	10

Figure 9: The number one issue handled by the OMO's DOCTM, whether from the general public or through direct inquiries to the OMO, related to Part D.

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Many of the inquiries sent directly to the OMO closely aligned with those received by CMS through the usual Agency channels.

As previously stated, the Medicare Beneficiary Ombudsman works with other Medicare components, such as the CMS Regional Offices and other partners, to identify and facilitate resolution of system-wide issues that impact people with Medicare, and bring about changes that will prevent future problems. Unlike many traditional Ombudsmen, the Medicare Beneficiary Ombudsman is not intended to be the initial contact for issues and complaints. There are several points of contact for individual questions, complaints, grievances, and assistance such as 1-800-MEDICARE, State Health Insurance Assistance Programs (SHIPs), CMS Regional Offices and the numerous health plans that operate within the Medicare program. If issues cannot be resolved by these beneficiary services resources, individual complaints can be directed to the Ombudsman by contacting 1-800-MEDICARE, or by submitting questions or issues in the “Ask a Question” functionality located in the frequently asked questions section of www.medicare.gov.

Case Review 3**Coding Error Correction Enables Medicare Prescription Drug Plan Selection**

In March 2006, a concerned Medicare beneficiary contacted the OMO. She was unable to obtain Medicare prescription drug coverage because CMS records showed her as deceased.

She presented proof of her identity and that she was indeed not deceased. In its efforts to facilitate resolution, the OMO discovered the beneficiary’s records on the primary Medicare enrollment and eligibility system were corrected, but the update did not appear in the CMS system used by Medicare claims contractors and providers.

The OMO staff collaborated with the CMS Regional Office with oversight for the beneficiary's state of residence to resolve the coding error. The OMO then contacted the Medicare beneficiary to advise her of the correction and assist her with selection of a Medicare Prescription Drug Plan.

Case Review 3 exemplifies the type and resolution of complex cases that are received by the OMO.

National Casework Lead

During 2006, CMS appointed Ombudsman Schreiner as the Agency's National Casework Lead. In this role, the OMO worked with the CMS Regional Offices and other CMS components to develop a framework for managing CMS' individual casework and

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related activities. This framework significantly increased CMS' ability to respond to beneficiary concerns and resolve complaints - one person at a time.

The OMO standardized processes and language for responding to individual beneficiary concerns for casework that the OMO receives. The standardization is key to the work of the OMO casework staff at Central Office, and the OMO plans to make this more readily available to the casework staff at each of the 10 CMS Regional Offices.

Critical to the OMO's casework efforts is the National CMS Casework Call, an ongoing teleconference with attendees from each of the Regional Office beneficiary assistance staffs, OMO's Division of Ombudsman Casework and Trends Management, and subject matter experts from Medicare program areas as needed.

National Casework Call

The National Casework Call brings together, on a weekly basis, representatives from across the Agency who respond to individual beneficiary inquiries on a daily basis. The National Casework Call is the only venue that provides casework-specific guidance to CMS caseworkers nationwide. OMO staff participated in this call since its inception, and the OMO assumed responsibility for the call in mid-2006.

The OMO invited appropriate Medicare subject matter experts to disseminate information to all CMS staff involved in casework throughout the Agency. Attendees who participated on a regular basis represented these CMS components: Central Office, Regional Offices, Office of Beneficiary Information Services, Office of Information Services, Center for Beneficiary Choices, and Office of Financial Management.

The OMO successfully used this comprehensive, coordinated approach to proactively plan for and anticipate issues, and to adjust to and develop appropriate responses to problems as circumstances allow. The OMO relied on Medicare subject matter experts from cross-component teams to analyze, research, and resolve issues. By reviewing large numbers of individual cases, the OMO and other stakeholders could identify systemic issues, which could be resolved by modifying the process or removing the barriers to accessing information or services.

A primary focus of CMS casework efforts is to ensure that systemic issues that affect people with Medicare are resolved in order to prevent recurrence, and ultimately improve the overall satisfaction of people with Medicare and their representatives. As shown in *Figure 9 on page 25*, the number one topic for individual casework related to

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Part D. This held true as well for the issues addressed during the National Casework Call.

While working to resolve hundreds of individual complaints, the CMS Regional Offices caseworkers and OMO caseworkers identified a number of systemic issues. In 2006, the CMS Center for Beneficiary Choices (CBC) was the lead or co-lead component for resolution of over half of the resolved systemic issues originally identified during the National Casework Call. CBC is the CMS component whose responsibility includes all operations related to Medicare Prescription Drug Plans and Medicare Advantage Prescription Drug Plans. The CMS Office of Information Services and Office of Beneficiary Information Services had the lead or co-lead role in identifying and/or resolving many other systemic issues.

Individual casework as described in the previous pages, taken cumulatively, is one factor the OMO reviewed in their efforts to identify and resolve systemic issues.

Systemic Issue Level

Systemic issues are recurring or program problems that affect, or potentially affect, significant segments of the Medicare beneficiary population. The OMO identified these types of issues through:

- Analysis of individual casework, as described in the previous section;
- Outreach and education; and
- Issues management.

The OMO's ongoing assessment of broad-scope issues allows the Office to facilitate wide-ranging positive changes in how the Agency serves its constituents.

Outreach and Education

As the OMO moved from program development in 2005 to implementation in 2006, Ombudsman Schreiner developed strategies for obtaining feedback on the Medicare program. This was developed through ongoing direct interaction with people with Medicare, advocacy groups, and partners. The strategies were:

- Collaborating with existing outreach and partner relationships within the Agency;

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- Identifying new methods for obtaining feedback;
- Maximizing each opportunity to include feedback from local, regional, and national perspectives as available; and
- Informing and educating people with Medicare and their representatives about the services and resources available to them through the Medicare program and the OMO.

A critical first step in executing an outreach and education program is listening to program constituents. In 2006, utilizing the capabilities and infrastructure of OEA, the OMO conducted a series of outreach and education events to capture the voice of people with Medicare, and to raise awareness of the OMO's role and CMS' resources. Specific criteria for organizing or attending these events were to:

- Cover a broad geographic and demographic spectrum;
- Target special populations who may not be aware of the Medicare rights, responsibilities, and resources available to them; and
- Participate in existing conferences or meetings involving a targeted segment of the Medicare population.

The OMO developed both strategic and implementation frameworks to facilitate the success of outreach and education events as outlined below in *Figure 10*.

Outreach and Education Event	Outreach and Education Event
Success Model	Success Model
Strategic Level Requirements	Implementation Level Requirements
<ul style="list-style-type: none"> • Allows the OMO to obtain targeted feedback on high-level service needs 	<ul style="list-style-type: none"> • Clearly defined purpose
<ul style="list-style-type: none"> • Allows the OMO to identify specific actions to address the high-level service needs 	<ul style="list-style-type: none"> • Clearly defined partner roles and responsibilities
<ul style="list-style-type: none"> • Generates concrete examples of how high-level service issues affect individual beneficiaries 	<ul style="list-style-type: none"> • Effective issue-tracking and follow-up procedures
<ul style="list-style-type: none"> • Allows the OMO to demonstrate progress toward addressing identified needs 	<ul style="list-style-type: none"> • Replicable process
	<ul style="list-style-type: none"> • Efficient implementation process maximizing existing resources

Figure 10: The OMO developed a model to facilitate the success of outreach and education events on both strategic and implementation levels.

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Keeping in line with the models listed above, the OMO used a “drill-down” approach, creating or adapting a variety of vehicles to learn about the scope and impact of Medicare beneficiary issues. In 2006, the OMO used existing vehicles to reach a national audience and to target issues of general interest or concern. To examine the context and impact of these targeted issues at a grass-roots level, the OMO created opportunities to meet with people with Medicare and their representatives in their own communities. Listed below are some of the means through which the OMO carried out its goal to listen to the voice of the Medicare beneficiary:

- **Open Door Forums (ODF).** An existing CMS mechanism, these forums are national conference calls open to beneficiaries and their representatives to discuss national-level issues.
- **Regional and Local Advocate Meetings.** A new mechanism, these meetings are focused discussions on specific issues chosen for their relevance to the region.
- **Local Beneficiary Feedback Meetings.** A new mechanism, these meetings are roundtable discussions with small groups of people with Medicare within their own communities. Feedback meetings run concurrently with the regional and local advocate meetings to glean different perspectives on the same set of issues as the advocate meetings.
- **National Conferences.** An existing mechanism, these conferences are national in scope and/or focus on a specific segment of the Medicare population and provide the opportunity to expand the OMO’s network of outreach and education partners.

Preparatory research indicated that discussions focused on specific, addressable topics were most useful for both people with Medicare and for the OMO. The OMO launched the series of events drawing themes from surveys of targeted partners, current events and from the Ombudsman’s key focus areas of beneficiary rights and protections, beneficiary education, the appeals process, and casework. As the OMO progressed through the schedule of events, the Ombudsman also encouraged event participants to recommend topics and feedback for future forums through on-site surveys and the CMS Open Door Forum (ODF) web page, www.cms.hhs.gov/OpenDoorForums.

Open Door Forums

Conforming to the drill-down approach, the OMO began at the most expansive level, through national ODF teleconferences, bringing together 350 to 500 people at one time. Participants on these teleconferences included people with Medicare, advocacy groups,

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pharmacies, prescription drug plans, employers, and Federal and state agencies across the United States. The purpose of the ODFs was to discuss the barriers experienced by beneficiaries in accessing services.

To broaden and diversify the meetings even further, the OMO encouraged participation from people who have a high level of interaction with people with Medicare. The OMO addressed a wide range of topics on these calls that affect all, or specific segments of, the Medicare beneficiary community. The topics included:

- Prescription Drug Plans
 - Enrollment issues,
 - CMS communications regarding the extension of plans' transition plan periods,
 - Requirements for notifying beneficiaries of formulary changes, and
 - Turnaround time for follow up on cases referred through 1-800-MEDICARE.

- Navigating the appeals process
 - Original Medicare Plan,
 - Medicare Advantage Plans, and
 - Medicare Prescription Drug Plans.

- Outreach to specific populations
 - Low-income subsidy eligible individuals,
 - Minority, and
 - Homebound.

The range of experiences voiced in these forums helped the Ombudsman identify universal issues upon which the OMO could have the greatest impact. The forums were also opportunities to answer questions and disseminate current and accurate information to a national audience. The OMO enhanced the educational opportunities presented by the Open Door Forums through the participation of CMS subject matter experts, and by using this national stage to introduce the OMO and describe its role. These forums also provided the context and themes for a series of meetings at the regional and local levels.

2005-2006 Report to Congress**Local and Regional Advocate Meetings**

The OMO organized regional and local advocate meetings to learn what was happening across the nation, targeting improvements to the Medicare service experience in a particular region or within a particular segment of the Medicare population. The OMO followed a standardized format for the one- to two-hour meetings to compare the experiences of people with Medicare across regions.



Like the Open Door Forums, these were topic-driven meetings with participants who were actively engaged in Medicare outreach in their own communities. Attendance at these meetings was limited to about 15 or 20 people, to permit more detailed and in-depth discussion of the participants' perspectives on Medicare service.

Mirroring the themes of the ODFs, the 2006 regional and local advocate meetings also focused on the prescription drug plans and the appeals process. Although some of the issues raised pertained to an individual situation, many echoed experiences that people with Medicare were having across the country. Several members of the CMS Regional Office for the area attended these meetings to follow up on individual situations that required immediate assistance.

Local and Regional Beneficiary Meetings

Drilling down further from the level of the regional and local advocate meetings, the Ombudsman made the most of his visits to communities such as Atlanta and Boston by conducting supplementary roundtable discussions with small groups of no more than 12 people with Medicare residing in the same area. Meeting with small, focused groups of people with Medicare brought unique perspectives to the meetings as they offered a broad view of Medicare, a close understanding of their own communities, and personal experience with Medicare service delivery. These concurrent events paralleled the topics discussed at the Regional and Local Advocate meetings. Speaking with local beneficiaries provided a better understanding of high-level issues in the context of an individual beneficiary's experience and helped clarify the actions necessary to resolve them.



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Ombudsman Schreiner also took time in each of these local meetings with beneficiaries and advocates to introduce the OMO and describe the services the Ombudsman's Office provides to people with Medicare and the resources it makes available to those who serve them.

National Conferences

The OMO chose to attend specific conferences based on their national scope and/or focus on a specific segment of the Medicare beneficiary population, such as enrollees in managed care plans, particular ethnic groups, or those with rare disorders.

Attendance at national conferences gave the Ombudsman and his staff a venue for expanding public awareness of the Office and the occasion to:

- Hear firsthand about the issues and concerns of people with Medicare.
- Provide direct service by resolving individual beneficiary issues.
- Introduce OMO staff members to others offering consumer assistance to people with Medicare.
- Form new partnerships.
- Further develop the Office staff and infrastructure.

On occasion, the OMO identified a conference with a broad-enough scope or large-enough segment of the Medicare population and participated as a conference presenter. A formal presentation by the Ombudsman or a member of the OMO staff facilitated and expanded their reach to a wide range of conference attendees.

One example is the national conference of End-Stage Renal Disease (ESRD) networks at which the OMO gave a presentation highlighting the information resources available to the approximately 300,000 people nationwide who suffer from ESRD. The OMO facilitated a discussion about how to make these resources more widely known and accessible to people with Medicare who may be too ill and isolated to initiate a comprehensive search.

The OMO's attendance at these national conferences also provided an opportunity to identify common issues and provide broad-based assistance to the Medicare beneficiary community through raising these issues to the appropriate CMS components for action.

The OMO's outreach and education activities allowed for a reciprocal flow of information. This two-way communication afforded the OMO the opportunity to

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identify, prioritize, and address systemic issues resulting in improved access to Medicare services and resources by large numbers of people. As the Medicare program and the OMO evolve, the vehicles for outreach and education will also change to continue providing effective and appropriate forums for discussion.

As discussed in other sections of this report, the OMO has and will continue to put great effort into expanding its reach to the beneficiary population by partnering with other groups.

Partnerships

The OMO understands that partnership efforts enabled the Office to assist people with Medicare from a program perspective and have far-reaching impacts among the people served by the program.

As mentioned in the Local Beneficiary Feedback Meeting subsection, the OMO participated in partner meetings scheduled in the same city as Local Beneficiary Feedback and Regional and Local Beneficiary Advocate meetings. Some of the participants in the partner meetings were Regional Office staff and representatives from the Quality Improvement Organization and the Long-Term Care Ombudsman.

These meetings afforded the OMO the opportunity to introduce local and regional resources to the people with Medicare that were present, and solidified the two-way relationship. The Ombudsman heard firsthand about the service delivery issues beneficiaries experienced while he shared information about the OMO and the Office's activities.

A partnership with wide-reaching implications the OMO formed during this report period was with the SHIPs. The following section details the OMO's support of SHIP activities in serving those members of the beneficiary population who are often underserved.

Technical Assistance Program

During its assessment and evaluation activities, the OMO found that SHIPs, staffed mostly by volunteers, do not always have the resources for conducting outreach and education activities to vulnerable populations. The OMO developed a Technical Assistance Program (TAP) that provided training and expertise to assist beneficiary service agencies in better serving vulnerable populations. The OMO established four guiding principles; the TAP must:

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- Be a sustainable model applicable to diverse vulnerable populations,
- Complement, not duplicate, existing programs,
- Be developed in collaboration with the beneficiary assistance agency and designated partners, and
- Be implemented incrementally.

The basis for the development of the TAP is a three-pronged approach:

- Guidance on conducting outreach to the targeted Medicare beneficiary population segment,
- Network expansion between the Medicare entity and appropriate partners at the state and/or local level, and
- Sensitivity and awareness training about the targeted Medicare beneficiary population segment presented to those who provide information to people with Medicare about their benefits.

SHIP TAP Mental Illness Pilot

In 2006, the OMO tested the SHIP TAP concept with a pilot program that reached out to people with mental illness. The OMO sought direction from internal partners, the Division of Partnership Development and the Division of Community Based Education, in activating existing networks. The OMO's collaborative efforts in the development and implementation of a TAP focused on mentally ill Medicare beneficiaries, and included the following entities:

- SHIPs,
- National Alliance on Mental Illness (NAMI),
- National Council for Community Behavioral Healthcare (NCCB), and
- Mental Health America (MHA).

This SHIP TAP Mental Illness Pilot was one method the OMO utilized to address the MMA 923 mandate to work with SHIPs to facilitate communication to people with Medicare.

Through this initiative, the OMO expanded the technical assistance capacity of the North Carolina Seniors Health Insurance Information Program and the Texas Health

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Information Counseling Assistance Program to provide benefits counseling to mentally ill Medicare beneficiaries.

Pilot Planning

During the planning stage, the OMO assembled a coalition of experts. They engaged CMS subject matter experts on the SHIP grant program from the Partner Relations and the Strategic Research & Campaign Management Groups. Working with these internal CMS partners, the OMO extended the coalition to include SHIP professionals and mental health professionals.



The coalition performed a needs assessment to evaluate the technical capacity of the SHIP community for providing benefits counseling to Medicare beneficiaries with a mental illness. The coalition noted several opportunities for SHIP improvement:

- Increase sensitivity to Medicare beneficiaries with a mental illness and increase understanding of symptoms or behaviors associated with prevalent mental illnesses.
- Address potential stigma associated with mental illness.
- Provide tools for working with Medicare beneficiaries with specific mental illnesses.
- Conduct outreach to Medicare beneficiaries with a mental illness, particularly those under age 65.
- Offer guidelines and tools for making professional referrals.
- Provide support for network expansion activities between mental health and SHIP organizations.

Pilot Development

The SHIP TAP Mental Illness Pilot objectives were to:

- Enhance the experience of people with mental illness in accessing information associated with their Medicare benefits,
- Provide information on the types of support that people with mental illness may need to make informed Medicare benefit decisions,
- Solidify relationships between SHIPs and local mental health partners, and

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- Facilitate targeted outreach by SHIPs to people with mental illness who have Medicare benefits.

"Thanks for leading the effort on this. It will be helpful for me." "Continue! Great start!"

The OMO presented a workshop at the 12th Annual SHIP Directors Conference in Denver, Colorado in June 2006. Approximately 10 SHIP Directors and other interested individuals attended the workshop. The purpose of the workshop was to:

- Introduce the SHIP TAP Mental Illness Pilot,
- Provide SHIP Directors with tools to increase capacity, and
- Gather feedback from key stakeholders.

The OMO solicited feedback by means of a survey and through verbal discussion facilitated by the OMO. One hundred percent of the stakeholder respondents thought the network expansion between mental health partners and local SHIP offices would be useful or very useful.

In addition to the feedback outlined above, attendees offered positive comments.

Pilot Implementation

Two state SHIP Directors, Roger Adams of Texas and Carla Obiol of North Carolina, volunteered to participate in the SHIP TAP Mental Illness Pilot. The OMO conducted the Pilot in three locations between August 17, 2006 and October 20, 2006:



- Heart of Texas Area Agency on Aging, Waco, Texas.
- Bexar County Area Agency on Aging, San Antonio, Texas.
- Seniors Health Insurance Information Program, Raleigh, North Carolina.

The OMO implemented the Pilot in two stages. The OMO first communicated the approach with SHIP Directors before sharing a full set of SHIP TAP Mental Illness Pilot materials with participants in the three pilot locations. *Figure 11* on page 35 depicts the pilot implementation model.

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SHIP TAP Mental Illness Pilot Implementation Process			
Element	Method	Audience	Rationale
Initial Outreach	Brief verbal overview of the content	State SHIP Directors	SHIP Organizations routinely create marketing materials and have expertise in this area. The OMO provided the information as a written resource for SHIP Directors for repurposing SHIP marketing materials and/or creating new materials focusing on the unique audience of people with a mental illness. The verbal overview ensured that SHIP Directors were aware of the content.
Element	Method	Audience	Rationale
Network Expansion Partner Meetings	A series of three facilitated working meetings consisting of two on-ramp conference calls and a face-to-face meeting	State SHIP Directors Local SHIP Staff Mental Health Partners	Successful networks require planning and strong relationships grounded in trust and shared vision. Optimal productivity for the face-to-face meetings depended on engaging potential network partners in advance dialogue. In addition, multiple contacts and shared planning enhanced the likelihood of continued network expansion.
Element	Method	Audience	Rationale
Sensitivity & Awareness Training Sessions	Roundtable Training	State SHIP Directors SHIP Counselors SHIP Volunteer Coordinators	Roundtable training sessions led by a skilled facilitator optimized knowledge transfer. Participants were engaged in dynamic training activities such as role-play and group discussion. New training information built on the Medicare benefits counseling skills and knowledge participants already possessed. Participants benefited from knowledge shared. The facilitator effectively assessed participant understanding and clarified questions.

Figure 11: The OMO's pilot implementation process supported TAP success.

2005-2006 Report to CongressPilot Results

The OMO utilized three methods to measure success:

- Dialogue with SHIP Directors,
- Qualitative observation of the Network Expansion Partner Meeting and the Sensitivity and Awareness Training, and
- Evaluation feedback forms for the Network Expansion Partner Meeting and the Sensitivity and Awareness Training.

The Directors of the SHIPs participating in the Pilot indicated the materials were a helpful resource. North Carolina SHIP Director, Carla Obiol, said:

“North Carolina recognized the need to reach out to underserved populations some time ago. We had been working on a solution and when we heard about the SHIP TAP initiative. We saw it as a good opportunity to enhance our early work with mental health partners and create new opportunities to educate people with a mental illness about their Medicare benefits.

The tip and fact sheets provide good information that will be useful to our SHIP Counselors, just as most SHIP counselors could benefit from a better understanding of the facts and impact of mental illness.

Even though North Carolina has worked very hard to reach out to people with a disability, there is still much to do. SHIP TAP helps bridge the gap between where we are and where we need to go... Everyone benefits when we work together to achieve a common goal.”

Texas SHIP Director, Roger Adams, said:

“SHIP TAP was successful in Texas because of the strong support for the project at the federal, state and local level partners.

The major impact of SHIP TAP in Texas is it enhanced SHIP communication with organizations serving Medicare Beneficiaries with mental illness and provided essential tools our program can use to assist Benefits Counselors with identifying symptoms of mental illness as well as facilitating improved communication with this particular beneficiary population.

In the future, the SHIPs would benefit from additional efforts by the OMO on issues related to health disparities.”

Respondents' feedback about their experience with both the Network Expansion Partner Meeting and the Sensitivity and Awareness aspect of Pilot implementation was positive. The results of the feedback are located in *Appendices 4 and 5*.

Technical Assistance Program Model

The TAP model will allow the OMO to continue assisting SHIPs and other partners who serve Medicare beneficiaries, particularly vulnerable populations. Based on analysis of SHIP TAP Mental Illness Pilot results, Ombudsman Schreiner identified the Mental Illness Pilot implementation process as a model for reaching out to any segment of the Medicare beneficiary population. *Figure 12* below outlines this TAP model framework.

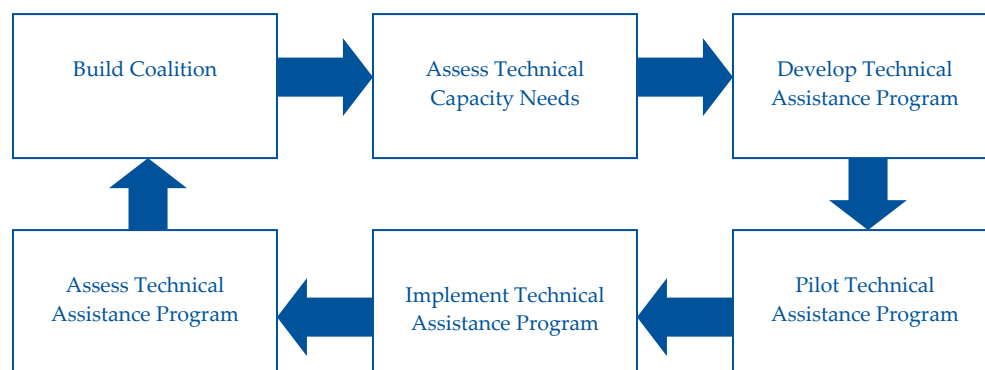


Figure 12: Framework for sustainable Technical Assistance Program success

The OMO's placement within OEA better enables the Office to make the TAP execution model publicly available through the Partnership Relations Group for use by any group that serves diverse and/or vulnerable Medicare populations. Avenues for making the TAP execution model public include the following web pages found at www.cms.hhs.gov:

- Office of the Medicare Beneficiary Ombudsman, and
- Partnering with CMS.

While the foregoing activities gave the OMO qualitative feedback on services provided to people with Medicare, the OMO also understood the need for quantitative data to identify and prioritize issues.

Issues Management

As previously discussed, the OMO used a number of channels to gather information and feedback from people with Medicare and to identify systemic problems which may prevent beneficiaries from accessing the information, benefits, rights, and protections to which they are entitled. To address these issues the Office developed and implemented an end-to-end Issues Management model. In the past year, the issues management process was utilized primarily to address beneficiary issues regarding the primary Medicare program area of focus for 2006: Part D.

The OMO's Issues Management process ensured beneficiary service issues were *identified* at the source, *validated*, *escalated*, and *tracked* to the appropriate resolution, and *communicated* in attempts to ensure the issues do not recur.

Identifying Issues

The OMO utilized a variety of data sources to identify high-impact issues. These data sources included:

- The Customer Inquiry System and OMO internal casework reporting,
- Part D Complaint Tracking Module, and
- Various CMS inquiry and complaint data sources.

The OMO also engaged key stakeholders who provided a qualitative perspective through their daily work in resolving beneficiary issues. These stakeholders were:

- National Casework Call participants,
- SHIP MMA forum,
- 1-800-MEDICARE leadership,
- OIS leadership and subject matter experts,
- Senior leadership and CMS component meetings, and
- OEA component collaboration: Media Relations Group, Partner Relations Group, and Intergovernmental Relations Group.

Validating Issues

The validation step included a correlation of the qualitative and quantitative data on the issues the OMO identified. Using the primary Part D data sources, the OMO substantiated the impact of the issue on the beneficiary population. Next, the OMO

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conducted a root cause analysis of patterns and trends to determine the scope of the issue, the number of beneficiaries or population segment of beneficiaries affected, long-term or short-term effect, etc.

The validation step helped focus the OMO's efforts on issues of such scope and impact where resolution would involve a broad cross-section of the Medicare beneficiary population.

Escalating Issues

Once validated, the OMO participated in a cross-functional forum at which the representatives identified the CMS component responsible for resolving the issue. The OMO then forwarded the identified issue to the appropriate CMS entities for resolution through one of the following courses of action:

- ***Awareness***: a well-known issue within the Agency in active resolution process.
 - The OMO communicated the issue to the responsible CMS component to make sure the issue was known, and monitored the Agency's progress to resolution.
- ***Action***: a new issue to the Agency and/or no active resolution work underway.
 - The OMO forwarded the issue to the appropriate CMS component for action or status, and reviewed regular updates from that entity until resolution.
- ***Champion***: a significant issue requiring facilitation by the OMO staff.
 - The Ombudsman assigned the issue to his staff for managing and/or facilitating resolution.

Every issue was unique in both its scope and the Medicare beneficiary population affected, and required an individual approach to address the issue. Regardless of the method of resolution, the OMO's primary goal was to ensure that people with Medicare have full access to their benefits, rights, and protections.

Tracking Issues

Following escalation to the appropriate entity, the OMO documented those issues, ensuring no personal health information was included, in the OMO's issues tracking tool. The point-of-contact within the responsible CMS component provided status updates and actions taken during the resolution process.

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This method allowed the OMO to track identified issues, the number of Medicare beneficiaries affected, the appropriate CMS resolving entity, and the actual resolution or closure of the issue.

Communicating Issues

As the OMO worked with others to facilitate the resolution via the identification, validation, escalation, and tracking of beneficiary issues, the Agency utilized existing means to communicate the resolution to CMS entities and Medicare beneficiaries. The following vehicles ensured standard communication across the organization:

- Letters to people with Medicare,
- Guidance/memos to Medicare Advantage Plans and Medicare Drug Plans,
- Partner tip sheets,
- Fact sheets,
- The Ombudsman website,
- Standard Operating Procedures for Central Office and Regional Office caseworkers, and
- Regularly scheduled meetings with CMS Leadership including the Administrator.

The OMO's leadership roles, in national casework management and oversight and existing casework and issues management, combined with its reporting structure within OEA, make it the CMS component best suited to identify and track Medicare beneficiary issues.

Case Review 4**File Sharing Solution to Correct Data System Problems for Many Low-Income Subsidy Beneficiaries**

In late 2006, detailed analyses of premium withhold cases and additional data sources led to the identification of a significant number of Low-Income Subsidy (LIS) beneficiary complaints. The OMO found that many LIS beneficiaries had been charged higher copay amounts, which would have impacted the beneficiary's ability to obtain their prescription medications.

The OMO supports Social Security Administration and CMS Leadership to efforts to achieve a more consistent and timely process for sharing beneficiary files and information, to solve a program issue that is affecting a large segment of the Medicare beneficiary population.

The OMO Issues Management Process Direction and Coordination of Activities

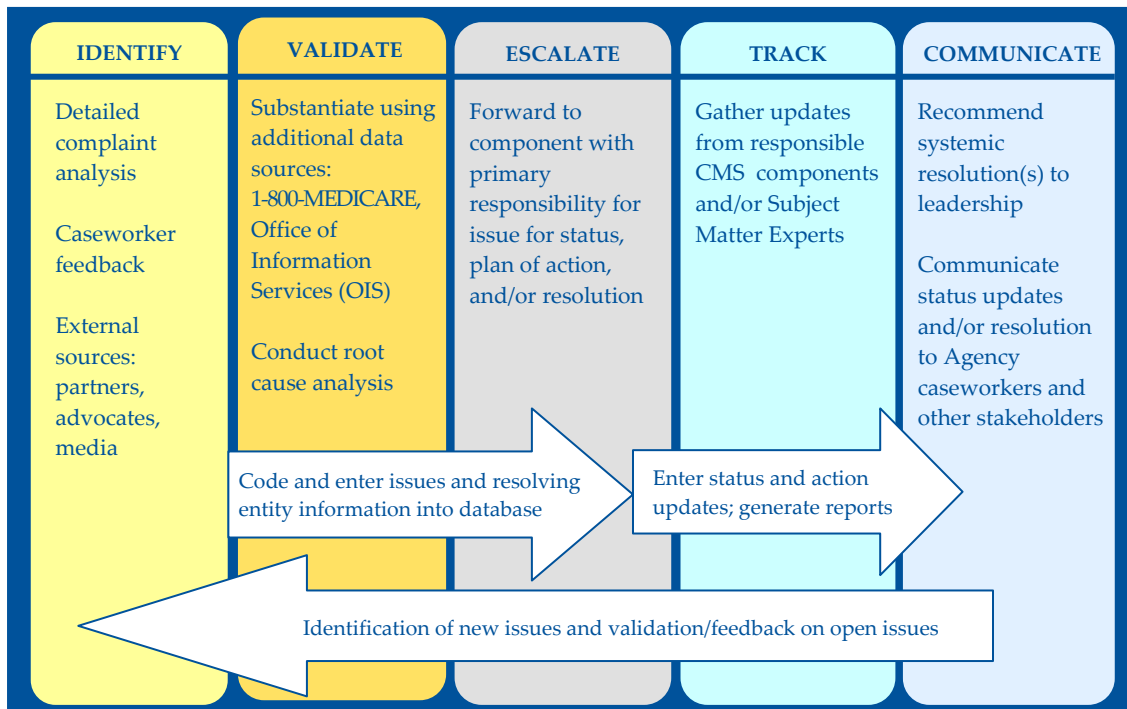
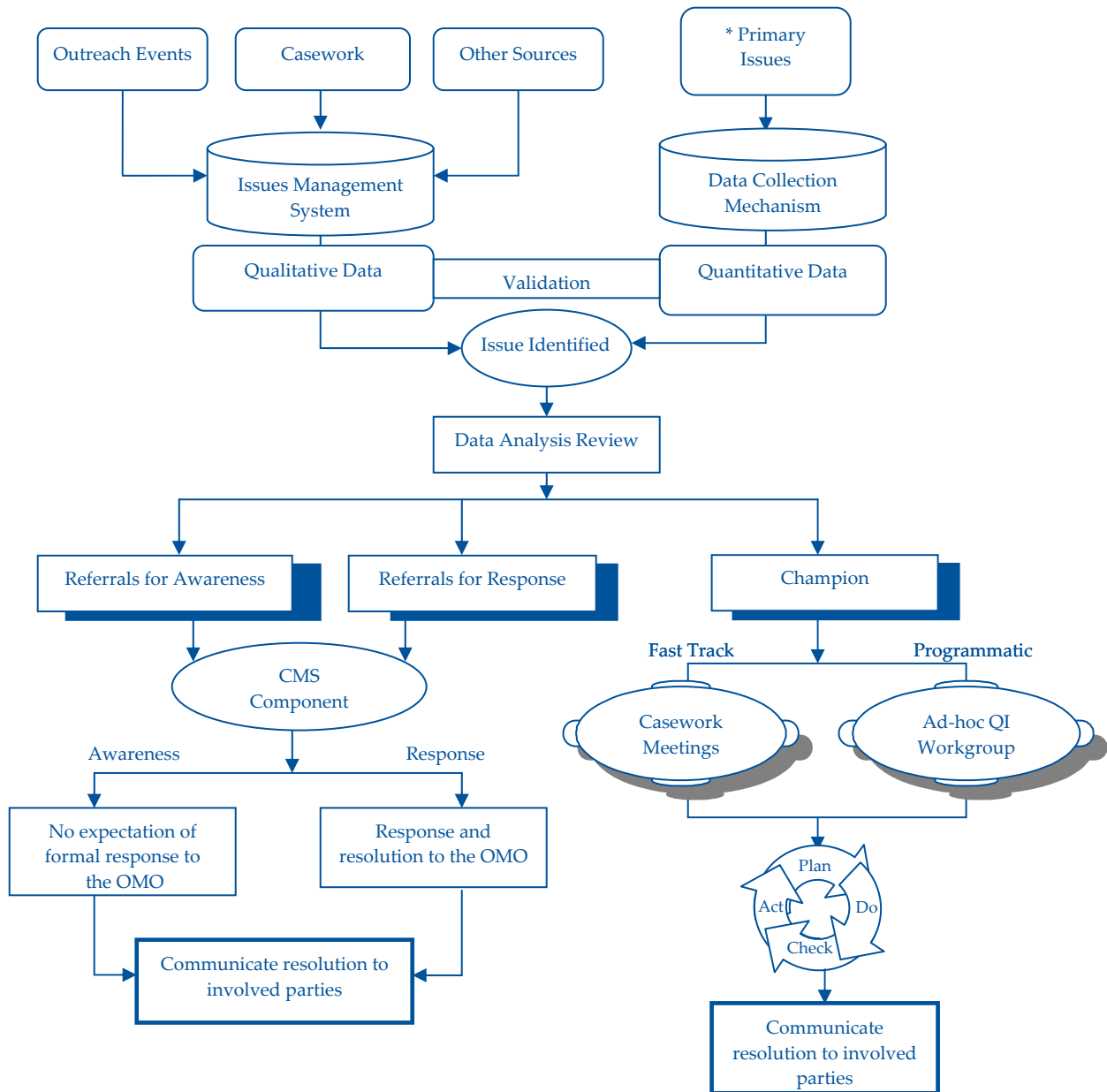


Figure 13: The OMO's Issues Management Process with direction and coordination of activities

During the 2006 calendar year, the OMO assisted individual people with Medicare with their specific issues and identified those issues affecting people with Medicare as a whole. The Issues Management Process helped the OMO promote collaboration across CMS components that resulted in timely and efficient resolution of issues affecting people with Medicare, and helped prevent recurrence. *Figure 14* on page 42 details the OMO's Issues Management Process outlining the data sources and courses of action for resolution.

The OMO Issues Management Process Data Sources and Courses of Action for Resolution



Legend
* Includes data from 1-800-MEDICARE National Data Warehouse and Complaint Tracking Module

Figure 14: The OMO's issues management process with data sources and courses of action for resolution

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Another goal of the Office is to affect positive change in the administration of the Medicare program. Ultimately, the goal should not be limited to collecting data reporting trends, and tracking the status of issues. The data and information must be utilized to foster appropriate and timely changes to policy and processes, overall improving the services and access to those services for people with Medicare. To meet these goals, the OMO employed the data resource management practices detailed in the following section.

Data-Driven Transformation

The OMO's goal is to make the Medicare beneficiary the central component in transforming the way Medicare services are delivered. Therefore, the OMO gathers both the qualitative data from individual casework and the quantitative data from reported issues to assess where improvements can be made. The OMO collects information from the following sources for a comprehensive picture of how the Medicare program meets the needs of beneficiaries:

- Data from a number of program sources, and
- Feedback from external entities.

During the time of this report, more than 1,100 entities provided information, resources, and assistance to people with Medicare. Each entity type utilized unique systems for managing its Medicare performance and issues data. To improve the Medicare program, the OMO created and executed a process model applying the same three-phased approach used in building the Office's infrastructure: assess, build, transform. The result was a data collection, analysis, and trending process that facilitated program-wide issue identification leading to resolution of systemic issues.

When this process was deployed, and areas for attention were identified, the OMO forwarded enhancements to service by:

- Sharing ideas and successes with service-providing entities,
- Reporting problems,
- Facilitating resolutions, and
- Recommending improvements.

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Data Collection

The first step in monitoring beneficiary service activities is data collection. *Figure 15* below identifies the primary resources for obtaining Medicare beneficiary service and issues data to improve the program.

Primary Data Collection Resources Available to the OMO	
Primary Resource	Data
Casework Report	Assistance on an individual Medicare beneficiary basis
Complaint Tracking Module	Database for tracking complaints involving Medicare Drug Plans
Issues Management Report	Issues identified across all sources prioritized by impact and volume
Regional Offices	Assistance to individual beneficiaries
	Outreach and education
	Oversight of Medicare Drug Plans located in region
1-800-MEDICARE Data Warehouse	Volume of calls to beneficiary helpline at 1-800-MEDICARE
	Topics of calls to beneficiary helpline at 1-800-MEDICARE
	Service delivery data of calls to beneficiary helpline at 1-800-MEDICARE
Weekly OMO Direct Contacts Log	Tracking document for individual beneficiary contacts to the Ombudsman

Figure 15: Primary resources for data collection, the first step to monitoring service and improving the program

As needed, the OMO makes use of other data sources. *Figure 16* below lists these resources.

Additional Data Collection Resources Available to the OMO	
Entity	Data
Quality Improvement Organizations	Complaints about quality of health care received
Fee-for-Service and Medicare Administrative Contractors	Volumes of beneficiary contacts and volumes and types of first level appeals
Medicare Advantage Plans	Enrollment, disenrollment, premium payments
State Health Insurance Assistance Programs	Assistance with healthcare choices and decisions
	Outreach and education

Figure 16: Additional resources for data collection, the first step to monitoring service and improving the program

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The OMO staff reviewed customer service and issues reports as the reports become available. These reviews resulted in a compilation of data for weekly evaluation, assignment, and determination of root causes.

The CMS Strategic Plan 2006-2009 identifies an integrated data repository as an objective. Until the Agency meets this strategic objective, the OMO will continue to utilize the Agency's current data systems to avoid duplication of efforts. The OMO's ongoing use of existing data systems also allows Ombudsman Schreiner to provide CMS input to ensure that emerging data management resources meet the OMO's requirements.

Data Analysis

Data analysis is the act of transforming data to extract meaningful and actionable information to facilitate solutions. During the timeframe for this report, the OMO's analysis efforts focused on the number one issue: Part D. Weekly, the OMO staff looked at a significant sampling of cases on an individual level to determine patterns by region or plan. They then reviewed the comprehensive Part D complaint data report to validate the review of the individual cases. Once validated, the OMO examined the underlying causes of the top issues. This review allowed the OMO to escalate the issue to the appropriate CMS component for research and resolution.

Data Trending

The OMO used data trending to determine repeated patterns or normal trend variances of issues over time. Tracking increases or decreases in the volume of the issues reported provided substantiation of successful issue resolution.

Data-Driven Recommendations

As demonstrated throughout this report, much of the beneficiary assistance provided by the OMO in 2006 centered on Part D. The OMO's primary conduits for learning about beneficiaries' experiences with Part D organizations were the National Casework Call and direct beneficiary contact. At times, beneficiaries' experiences, in the areas listed below and in other areas, resulted in official complaints against the plan:

- Delay in receiving plan materials,
- Difficulty in obtaining prescription medications,
- Enrollment issues,
- Issues with premium payments, and

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- Difficulties with opting out of a Medicare-chosen plan.

The Agency tracked all Part D complaints including those that involved Medicare Prescription Drug Plans in the Complaint Tracking Module (CTM). While the Center for Beneficiary Choices is primarily responsible for operations related to all Part D organizations, each of the CMS Regional Offices received and worked to resolve hundreds of PDP complaints because the plans did not have easy access to CTM. Eventually, CMS transitioned the ownership for the initial resolution of the majority of PDP complaints to the individual plans.

This transition occurred over time and resulted from the collaborative efforts of all parties involved in the weekly National Casework Call. *Figure 17* below lists highlights of the transition process that enabled timely and efficient issue resolution by the PDPs.

Complaint Tracking Module Transition for Improvement Process			
Date Identified	Issue	Resolution	Date Resolved
February 2006	Manual entry of complaints into CTM	Complaints entered by 1-800-MEDICARE representatives directly uploaded to CTM	April 2006
		Plans access CTM directly via Health Plan Management System (HPMS)	May 2006
July 2006	Complainant cannot correctly identify prescription drug plan	1-800-MEDICARE representatives assign complaint to parent organization who contacts ROs to reassign to appropriate plan	July 2006
August 2006	Duplicate complaints for the same beneficiary	Plans use CTM extract linked to beneficiary identifiers to flag duplicates	August 2006
August 2006	Difficulty reassigning complaint to correct Part D organization or a subsidiary; Part D organization needs RO assistance	Enhancements to CTM allow updates to complaint record as appropriate	September 2006

Figure 17: Collaboration on the National Casework Call facilitated timely resolution of beneficiary complaints and enhanced the Agency's CTM.

During this report period, members of the OMO staff completed the data collection, analysis, and trending functions in addition to their everyday job responsibilities. Recognizing the integral role of data in meeting the OMO's obligations, Ombudsman Schreiner plans to acquire an additional staff resource in 2007 whose primary responsibility will be to review, compile, analyze, and trend beneficiary service data.

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The additional staff resource will:

- Rank issues by volume,
- Identify the segment of beneficiary population impacted by issues,
- Determine the root cause of issues,
- Collaborate with the entity that has primary responsibility for the issue to facilitate resolution, and
- Communicate trends and root causes to the Ombudsman, OMO staff, and appropriate CMS components.

These activities will support the OMO's efforts to monitor the Agency's Medicare beneficiary concerns, evaluate the Medicare program's beneficiary service operations, and make recommendations to Congress for resolving deficiencies across all program areas: Part A, Part B, Part C, and Part D.

SUMMARY OF ACCOMPLISHMENTS

During this reporting period, Ombudsman Schreiner and his team made crucial strides toward establishing the OMO and reaching out to the more than 42 million people with Medicare. The OMO developed strategies, methods, and the framework which:

- Assist Medicare beneficiaries with their inquiries, complaints, grievances, and appeals;
- Provide information that facilitates informed health care decisions; and
- Approach program issues identification related to beneficiary services systematically.

The OMO's accomplishments, by major operational areas, are outlined below.

Casework Management

- Integrated existing CMS processes, in collaboration with CMS Regional Offices and other CMS components, to develop a fully operational framework for management of CMS casework.
- Led development of standard operating procedures and standard language for CMS Central Office and Regional Office caseworkers to improve responses to inquiries and complaints.
- Assumed responsibility and led the weekly CMS National Casework Call to facilitate communication and information sharing for CMS Central Office and Regional Office caseworkers.
- Improved upon the CMS Intranet Casework site devoted to Part D casework, to supplement existing resources for CMS caseworkers.
- Responded to more than 36,000 Medicare beneficiary inquiries.

Outreach

- Conducted several beneficiary-focused outreach and education events:
 - Ombudsman Open Door Forums targeted to beneficiaries, those who act on their behalf, and those who provide direct assistance to beneficiaries.
 - Beneficiary advocate and beneficiary service partner meetings, in several regional locations, to open the lines of communication regarding issues impacting beneficiaries and associated needs at the local level.

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- Developed facilitation framework for OMO events.
- Implemented the Ombudsman Center web page, at www.cms.hhs.gov, to empower Medicare beneficiaries and educate them on their rights and protections.
- Developed a Technical Assistance Program model for SHIPs to assist targeted groups of beneficiaries who require specialized assistance.

Continuous Quality Improvement

- Developed and implemented an issues management process that involves issue identification and tracking, and actions to facilitate the resolution of systemic beneficiary service issues that impact Medicare beneficiaries when necessary.
- Developed requirements for a consolidated data collection and reporting mechanism.
- Conducted extensive assessment and evaluation of the Agency's data and systems capabilities with regard to tracking beneficiary inquiries, complaints, grievances, and appeals.
- Received approval from the Office of Management and Budget to conduct a second round of surveys to assess beneficiary satisfaction with the individual inquiry responses provided by the OMO.

Tracking and Reporting

- Analyzed data systems and elements.
- Developed a weekly report from the Part D Complaint Tracking Module data, the summary CTM report, which provides weekly trends on Part D casework and a summary of key Part D issues that impact casework.
- Continued development of the CMS Intranet Casework site devoted to Part D as a primary resource for CMS caseworkers.

Office Operations

- Formed the OMO, which includes the Division of Ombudsman Casework & Trends Management.
- Worked closely with CMS Regional Office casework staff to develop CMS caseworker standard operating procedures for specific types of casework.

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- Developed the OMO's Report to the Secretary of Health & Human Services and Congress as outlined in MMA 923.

RECOMMENDATIONS

Based on evaluations performed during this reporting period, Ombudsman Schreiner makes the following recommendations for the Agency:

- Bring together a cross-functional team at the outset of any new program, process, or benefit to determine its effects on people with Medicare and develop risk mitigation plans as needed.
- Create a consistent and standard method for all Medicare entities to report beneficiary inquiries, complaints, and issues. The current lack of standardization makes it difficult to track trends and problems across the Medicare program.
- Strengthen the communication within CMS to be proactive in detailing beneficiary impacts and enhance resolution of issues impacting beneficiaries.
- Prepare for significant program change by educating Medicare beneficiaries and their advocates about where to obtain assistance. Ensure the entities assigned to provide assistance have appropriate and adequate information and resources to provide quality service to people with Medicare.

LOOKING TO THE FUTURE

2007 Goals

MMA Task: receive complaints, grievances, and requests for information from Medicare beneficiaries

- Continue to refine casework procedures for the Agency.
- Further develop OMO staff to enhance understanding of the program, policies, internal and external entities providing services.

MMA Task: provide assistance regarding complaints, grievances, and requests for information

- Assist individuals with issues they are having with the Medicare program, for example:
 - Disenrollment from Medicare Advantage Plans,
 - Income-related premiums, and
 - Appeals.
- Augment the Medicare Beneficiary Ombudsman web page.
- Develop OMO staff to enhance their understanding of the program, policies, internal, and external entities providing services.
- Identify and develop working relationships with liaisons at each Medicare Administrative Contractor.
- Work to develop an enhanced Fee-for-Service (Part A and Part B) complaint tracking and issues management process.
- Continue to work with Medicare beneficiary advocacy groups.
- Promote agency-wide use of Technical Assistance Program model for target segments of the Medicare beneficiary community.
- Develop a Fee-for-Service issues management process.

MMA Task: submit an annual report of OMO activities to Congress and the Secretary of Health & Human Services (HHS), which will include the

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Ombudsman's recommendations for improvement in the administration of the Medicare Program

- Hire resources dedicated to data analysis and trending.
- Implement a mechanism to capture inquiry, grievance, and complaint data regarding all Medicare program areas to comprehensively quantify and assess the need for appropriate changes to policy and processes, and to promote the necessary changes.

MMA Task: work with insurance counseling programs whenever possible to help provide Medicare beneficiaries with the information they need to make decisions

- Make mental illness Technical Assistance Program (TAP) available to all SHIPs.
- Work with SHIPs on outreach to Medicare beneficiaries in vulnerable populations.

CONCLUSION

In his 500-Day Plan, Health & Human Services Secretary, Michael Leavitt, wrote that “energizing broad participation” would be critical to the successful implementation of the MMA. Exemplifying this directive, the OMO has created an ongoing dialogue with Medicare beneficiaries, their representatives, and their advocates to find effective ways to communicate information, deliver services, and empower their health care and prescription drug coverage decisions. In addition, the Office has worked with all areas within CMS and external entities to improve the customer service process.

Identifying beneficiary concerns is central to Ombudsman Schreiner’s role as *a voice for Medicare beneficiaries*. As the Ombudsman listens to and assists people with Medicare on an individual or program level, the OMO team interrelates these experiences with additional data to make proactive recommendations for further improvement of related Medicare program services.

The OMO’s ongoing cycle of identification, analysis, and action will lead to the realization of their mission to provide direct beneficiary assistance and continuously improve the Medicare program. Continually analyzing data on complaints, inquiries, grievances, and appeals, evaluating policies and procedures with multiple internal and external partners, and making annual recommendations to the Secretary of Health & Human Services and Congress through the Medicare Beneficiary Ombudsman Report will ensure *a voice for Medicare beneficiaries*. Additionally, it will serve to make the beneficiary the central and most critical component to the improvement of the entire program.

APPENDICES

Appendix 1: Table of Acronyms

Table of Acronyms	
Acronym	
CBC	Center for Beneficiary Choices
CMS	Centers for Medicare & Medicaid Services
CO	Central Office
COBC	Coordination of Benefits Contractor
CTM	Complaint Tracking Module
DBICS	Division of Beneficiary Inquiry Customer Service
DBITA	Division of Beneficiary Inquiry Trends Analysis
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMERC	Durable Medical Equipment Regional Carrier
DOCTM	Division of Ombudsman Casework and Trends Management
ESRD	End-Stage Renal Disease
FI	Fiscal Intermediary
GAO	Government Accountability Office
HHS	Health & Human Services
HPMS	Health Plan Management System
IRE	Independent Review Entity
LIS	Low-Income Subsidy
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAP	Medicare Advantage Plan
MHA	Mental Health America
MMA	Medicare Prescription Drug, Improvement and Modernization Act
NAMI	National Alliance on Mental Illness
NCCB	National Council for Community Behavioral Healthcare
OA	Office of Administrator

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Table of Acronyms	
Acronym	
OBIS	Office of Beneficiary Information Services
ODF	Open Door Forum
OEA	Office of External Affairs
OIG	Office of Inspector General
OIS	Office of Information Services
OMB	Office of Management and Budget
OMO	Office of the Medicare Beneficiary Ombudsman
PDP	Prescription Drug Plan
PSC	Program Safeguard Contractor
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
RHHI	Regional Home Health Intermediary
RO	Regional Office
SHIP	State Health Insurance Assistance Program
SOP	Standard Operating Procedure
SSA	Social Security Administration
TAP	Technical Assistance Program

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Appendix 4: Feedback Results, Network Expansion Partner Meetings

SHIP TAP Mental Illness Pilot Implementation Network Expansion Partner Meetings					
Evaluation	Scale of 1 to 5: 1 = Strongly Disagree, 5 = Strongly Agree				
Meeting Facilitation	5	4	3	2	1
The purpose of the meeting was clear.	19	6			
The learning objectives were met.	21	4			
The meeting ran smoothly.	24		1		
There was sufficient interaction to hold my interest.	23	1	1		
Questions were responded to appropriately.	20	4	1		
Content	5	4	3	2	1
This meeting was a good use of my time.	22	3			
I have access to new ideas on expanding networks.	20	4	1		
I understand the tools available to me for network expansion.	16	7	2		
I am better prepared to complete tasks associated with my work because of today's meeting.	17	7	1		
I have a clear understanding of the next steps I need to undertake related to network expansion.	16	7	2		

The majority of 25 respondents provided positive feedback regarding Network Expansion Partner Meeting activities.

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Appendix 5: Feedback Results, Sensitivity & Awareness Training

SHIP TAP Mental Illness Pilot Implementation Sensitivity & Awareness Training					
Evaluation	Scale of 1 to 5: 1 = Strongly Disagree, 5 = Strongly Agree				
Training	5	4	3	2	1
The purpose of the training was clear.	25	2	1		
The learning objectives of the training were met.	20	7	1		
The trainer was knowledgeable about the topic.	23	5			
There was sufficient interaction to hold my interest.	24	4			
Questions were responded to appropriately.	24	3	1		
I am better prepared to complete tasks associated with my work because of today's training.	18	6	1		
The role-plays added to my understanding of the material.	17	3	5	1	
Materials	5	4	3	2	1
The slides helped me understand how to use the tip/fact sheets.	17	6	4		
The information on the slides supported the trainer's words.	19	5	1		
These tip/fact sheets are useful tools for SHIP Counselors	5	4	3	2	1
Mental Illness Myths	23	4	1		
Counseling People with a Mental Illness	21	4	2		
What Should You Do in a Difficult Conversation?	20	5	2		
Counseling People Who Take an Antipsychotic, Anticonvulsant, or Antidepressant	18	3	3	1	
Depression	24	3	1		
Anxiety	23	4		1	

The majority of 28 respondents had positive feedback regarding Sensitivity & Awareness training methods and materials.