OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN

IMPROVING THE MEDICARE PROGRAM FOR BENEFICIARIES

2009 REPORT TO CONGRESS

CENTERS FOR MEDICARE & MEDICAID SERVICES

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DANIEL J. SCHREINER
MEDICARE BENEFICIARY OMBUDSMAN

CONTENTS

LIST OF ACRONYMS

Acronym	
AARP	American Association of Retired Persons
BAE	Best Available Evidence
CHIP	Children's Health Insurance Program
CMIS	Contractor Management Information System
CMS	Centers for Medicare & Medicaid Services
CMS RO	Centers for Medicare & Medicaid Services Regional Office
CO	Central Office
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
CPI	Center for Program Integrity
CSR	Customer Service Representative
CTM	Complaint Tracking Module
CWF	Common Working File
DIRT	Distributed Index of Rejected Transactions
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMOA	Division of Medicare Ombudsman Assistance
DOE	Division of Ombudsman Exceptions
DORTA	Division of Ombudsman Research and Trends Analysis
EDB	Enrollment Database
EOB	Explanation of Benefits
ESRD	End-Stage Renal Disease
FBDE	Full-Benefit Dual Eligibles
FDA	Food and Drug Administration
FFS	Fee-For-Service
FPL	Federal Poverty Level
GAO	Government Accountability Office
GHP	Group Health Plan
HCBS	Home-and-Community-Based Services
HCBW	Home-and-Community-Based Waiver
HCFA	Health Care Financing Administration
HHB	Home Health Benefits

Acronym	
HHS	Department of Health & Human Services
IEQ	Initial Enrollment Questionnaire
IOM	Institute of Medicine
IPAC	Intragovernmental Payment and Collections
KFF	Kaiser Family Foundation
LEP	Limited English Proficiency
LIS	Low-Income Subsidy
LTC	Long-Term Care
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MA-PD plan	Medicare Advantage Prescription Drug Plan
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
NDW	National Data Warehouse
NPR	National Performance Report
OA	Office of the Administrator
OBIS	Office of Beneficiary Information Services
OEA	Office of External Affairs
OFM	Office of Financial Management
OIS	Office of Information Services
OMO	Office of the Medicare Ombudsman
PDP	Prescription Drug Plan
QDWI	Qualified Disabled and Working Individual
QI	Qualifying Individual
QMB	Qualified Medicare Beneficiary
SEP	Special Enrollment Period
SHIP	State Health Insurance Assistance Program
SHIP TAP	SHIP Technical Assistance Program
SLMB	Specified Low-Income Medicare Beneficiary
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
WC	Workers' Compensation

MESSAGE FROM THE MEDICARE OMBUDSMAN

I am pleased to present the 2009 Office of the Medicare Beneficiary Ombudsman's Annual Report, *Improving the Medicare Program for Beneficiaries*, to Congress and to the Secretary of Health & Human Services. This report marks the fifth year since the establishment of the Office of the Medicare Ombudsman (OMO). Over the years, the OMO has evolved to become a known and effective source for addressing individual and systemic beneficiary inquiries, complaints, and grievances. Early on, the OMO focused on implementing the necessary infrastructure for carrying out the mandates under section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Today, the OMO has established processes, activities, and relationships with other Centers for Medicare & Medicaid Services (CMS) components and external partners that allow the OMO to positively affect the day-to-day lives of Medicare beneficiaries.

The title of this report reflects the OMO's mission to serve as a voice for Medicare beneficiaries. The OMO carries out its mission by providing direct assistance to beneficiaries and by providing recommendations for addressing systemic beneficiary issues. In both respects, 2009 was a busy year. The OMO managed 16,134 direct contacts that CMS received from beneficiaries, their families, caregivers, and advocates. The OMO, in collaboration with other CMS components, handled over 35,000 entitlement and direct premium-billing issues and complaints, 43,897 third-party billing cases, and over 15,000 system exceptions from multiple data systems. Through its review of beneficiary issues, the OMO identified three systemic beneficiary problem areas: coordination of benefits, health care disparities, and Medicare prescription drug issues. As presented in this report, the OMO provides a set of recommendations for each of these areas aimed at improving beneficiaries' experience with the Medicare program.

Today, there are over 46 million Medicare beneficiaries, many of whom have complex conditions and some of whom experience challenges navigating the increasingly multifaceted Medicare program. Beneficiaries frequently require assistance with Medicare coverage of services, coordination of benefits, and a wide-range of other issues, as indicated by the over 30 million beneficiary contacts received by CMS in 2009. Given the pronounced need for beneficiary assistance, the OMO is focused now more than ever on being more accessible to Medicare beneficiaries and working closely with other CMS components to improve the Medicare program.

With the passage of the Affordable Care Act in 2010, beneficiaries may face new challenges as this law is implemented. During the coming year, the OMO will continue to collaborate with other CMS components and offer its expertise and resources to beneficiaries to ensure that their concerns are addressed within the Medicare program.

Sincerely,

Daniel J. Schreiner • *Medicare Beneficiary Ombudsman*

The Office of the Medicare Ombudsman (OMO) is a voice for beneficiaries, providing direct beneficiary assistance with inquiries, complaints, grievances, and appeals.

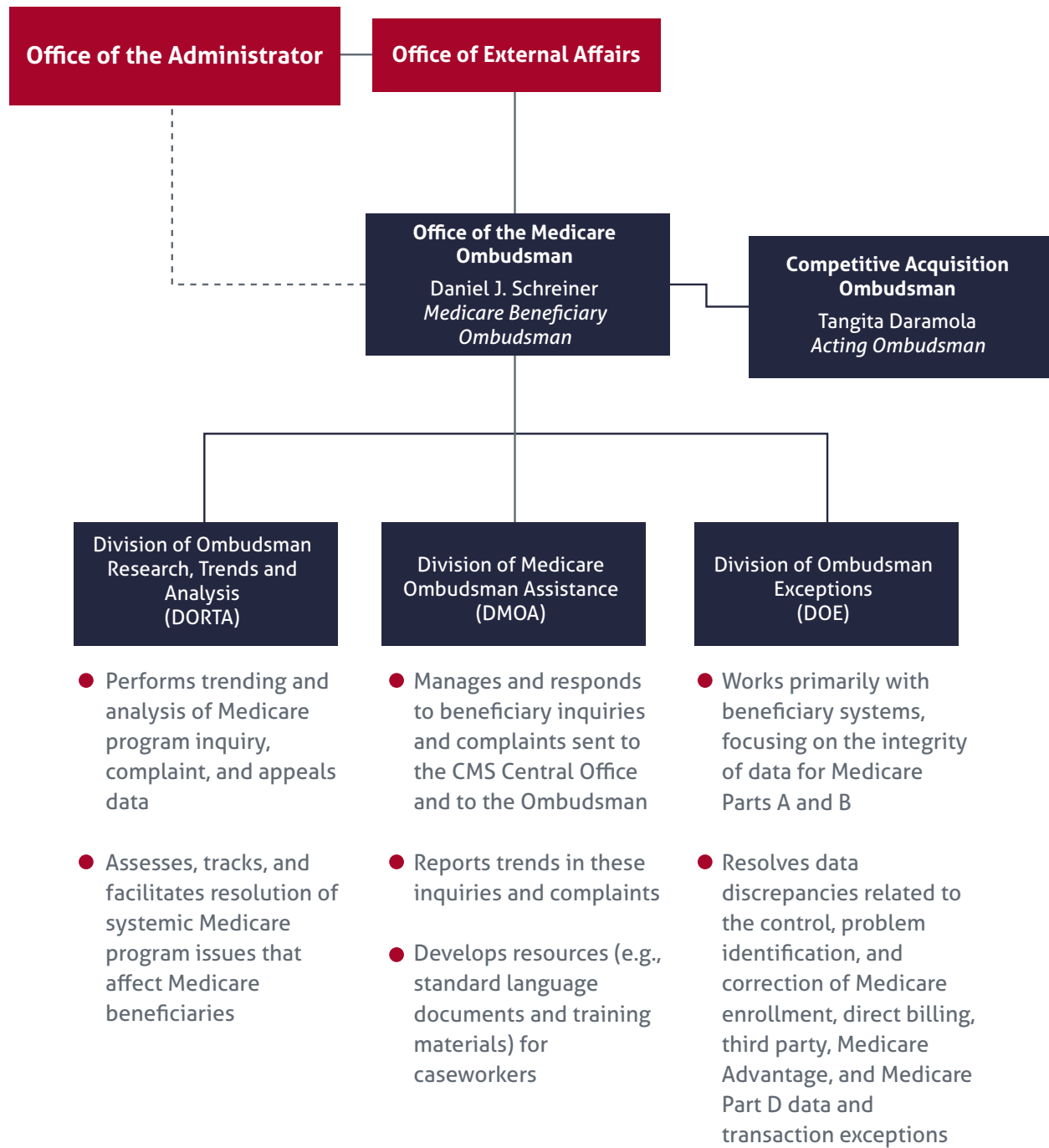# MISSION, VISION, AND ORGANIZATION

MISSION

The Office of the Medicare Ombudsman (OMO) is a voice for beneficiaries, providing direct beneficiary assistance with inquiries, complaints, grievances, and appeals. The OMO works to improve the Medicare program through analyzing data concerning inquiries, complaints, grievances, and appeals; evaluating policies and procedures with internal and external partners; and making recommendations to the Secretary of the Department of Health & Human Services (HHS) and Congress.
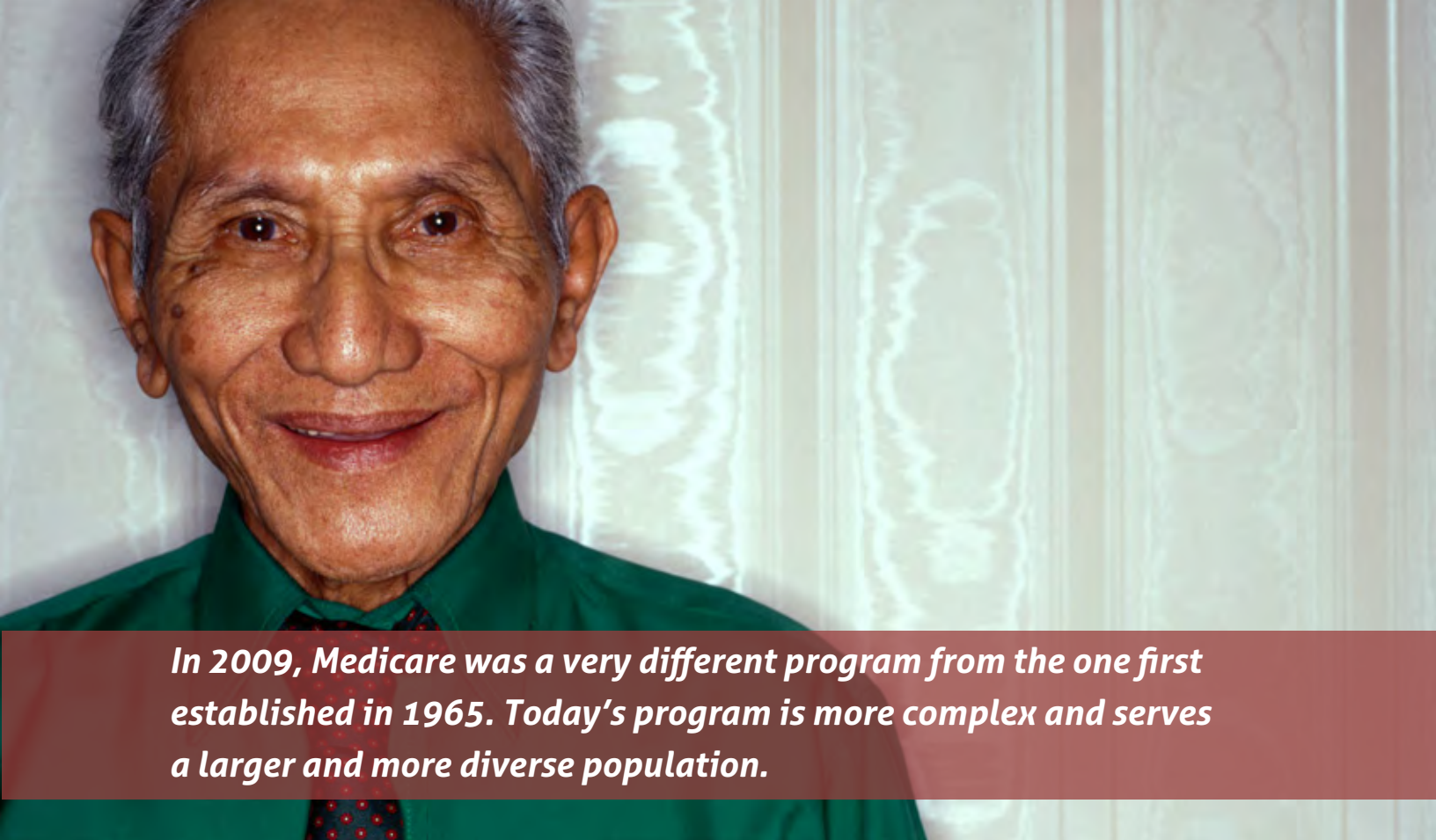
VISION

The Centers for Medicare & Medicaid Services' Office of the Medicare Ombudsman is the beneficiary's advocate.

ORGANIZATION

The OMO is located within CMS' Office of External Affairs and has direct access to the CMS Administrator to raise identified issues and concerns. To handle its range of activities, the OMO is organized into three divisions: the Division of Ombudsman Exceptions (DOE), the Division of Medicare Ombudsman Assistance (DMOA), and the Division of Ombudsman Research and Trends Analysis (DORTA). Both DOE and DMOA provide direct assistance to beneficiaries through casework. Additionally, DOE works on data transaction issues. DORTA focuses on data reporting and trending, casework collaboration, and training support, and conducts an Issues Management process, which identifies and addresses systemic problems affecting the Medicare program and its beneficiaries. The activities of each of the OMO's three divisions are discussed in more detail in this report.

Office of the Administrator

Office of External Affairs

Office of the Medicare Ombudsman

Daniel J. Schreiner
Medicare Beneficiary Ombudsman

Competitive Acquisition Ombudsman

Tangita Daramola
Acting Ombudsman

Division of Ombudsman Research, Trends and Analysis (DORTA)

- Performs trending and analysis of Medicare program inquiry, complaint, and appeals data

- Assesses, tracks, and facilitates resolution of systemic Medicare program issues that affect Medicare beneficiaries

Division of Medicare Ombudsman Assistance (DMOA)

- Manages and responds to beneficiary inquiries and complaints sent to the CMS Central Office and to the Ombudsman

- Reports trends in these inquiries and complaints

- Develops resources (e.g., standard language documents and training materials) for caseworkers

Division of Ombudsman Exceptions (DOE)

- Works primarily with beneficiary systems, focusing on the integrity of data for Medicare Parts A and B

- Resolves data discrepancies related to the control, problem identification, and correction of Medicare enrollment, direct billing, third party, Medicare Advantage, and Medicare Part D data and transaction exceptions

> *In 2009, Medicare was a very different program from the one first established in 1965. Today's program is more complex and serves a larger and more diverse population.*

EXECUTIVE SUMMARY: THE YEAR IN REVIEW

Medicare has changed substantially since it was first established in 1965; today's program is more complex and serves a larger and more diverse population. The establishment of Medicare Advantage Plans (Part C) as an option of how to receive Medicare benefits, and the later establishment of Medicare prescription drug coverage (Part D), expanded beneficiaries' enrollment options. These new enrollment choices, while enabling beneficiaries to select the coverage options that best meet their needs, created administrative complexities for some beneficiaries.

The expansion of enrollment options has resulted in an intricate matrix of interactions among beneficiaries, providers, private health and drug plans, Medicare contractors, and the Centers for Medicare & Medicaid Services (CMS). Medicare beneficiaries have to decide whether to stay in traditional Medicare or enroll in a managed care plan; which (if any) drug plan to choose; and whether to buy supplemental coverage. Additionally, a fragmented healthcare delivery system

makes it difficult to ensure that every beneficiary is able to access the most appropriate care in a timely fashion.

Within this complex environment, the Office of the Medicare Ombudsman (OMO) serves as the voice for Medicare beneficiaries, using three main approaches: casework—providing direct beneficiary assistance; partnership initiatives—working strategically with partners within and outside of CMS to analyze beneficiaries' concerns; and Issues Management—addressing systemic program issues. Through its annual report, the OMO makes recommendations to the Secretary of HHS and to Congress.

The purpose of this report is to apprise Congress of the OMO's activities and to provide the OMO's recommendations for improving the administration of the Medicare program. Through its activities, the OMO works to identify systemic issues that may negatively affect beneficiaries. Systemic issues are problems (e.g., access to care, awareness, or understanding of benefits)

that affect a large number of beneficiaries or those that have a significant detrimental effect on an individual beneficiary's well-being, and may cause the same problems for others. This report also provides a set of recommendations to the HHS Secretary and Congress to improve beneficiaries' experiences with Medicare.

KEY ACCOMPLISHMENTS

The OMO achieved success in each of the three strategies it employs to fulfill its mission: casework, partnership initiatives, and Issues Management. The following information highlights some of these accomplishments.

Casework

Casework involves providing direct assistance to beneficiaries, as well as technical assistance, and training to CMS staff for improving its national casework effort. The OMO's key accomplishments in this area were:

- **Direct Services to Beneficiaries:** In 2009, the OMO managed 16,134 direct contacts to CMS received through sources such as beneficiaries, their families, caregivers, advocates, and congressional offices.

- **The National Fee-for-Service (Parts A and B) & the Medicare Advantage and Prescription Drug Plan (Parts C and D) Casework Conference Call:** The OMO facilitated more than 40 weekly National Fee-for-Service and Casework Conference Calls. These calls serve as a forum for program analysts and caseworkers within CMS' Regional Offices (ROs) and the CMS Central Office (CO) to share ideas on how to better manage and resolve complaints in a timely manner and to identify trends and potential problems before they become complaints.

- **National Caseworker Training Program:** The OMO served a key role in facilitating and supporting training for CO and RO casework staff. In 2009, the OMO facilitated 14 such agency-wide training sessions.

- **Standard Language Letters:** Working in collaboration with other CMS components, the OMO developed or updated 134 standard language letters in 2009, bringing the total number of letters available for casework staff to 281. Standard language letters are designed to ensure consistent CO and RO caseworker responses to beneficiary inquiries.

- **Casework and Exceptions Processing Summary:** In collaboration with other CMS components, the OMO corrected records on multiple beneficiary systems at CMS; diagnosed and oversaw the correction of records on external federal, state, and financial systems that affect Medicare benefits; and handled over 35,000 entitlement and direct premium-billing issues and complaints, 43,897 third-party billing cases, and over 15,000 manual system corrections from multiple data systems.

Partnership Initiatives

The OMO places great emphasis on collaborating with partner organizations, a strategy that enables it to gather much useful information regarding the Issues Management process and to facilitate related outreach and education efforts. This strategy enables CMS partners and Medicare stakeholders, such as advocacy organizations, to communicate issues directly to the OMO. Approximately two-thirds of the large-scale issues that the OMO addressed in 2009 were raised by advocacy groups, other CMS components, and other government agencies. In 2009, the OMO's key accomplishments in this area were:

- **The Medicare Ombudsman Partner Dialogue Initiative:** In May of 2009, the OMO launched a bimonthly dialogue session with partners and advocates, such as the Medicare Rights Center and Health Assistance Partnership, to gain further insight into policy-related issues that affect Medicare beneficiaries. This initiative was launched to identify and investigate potential systemic beneficiary issues and their root causes and to develop strategies for resolution and recommendations for improvements.

The OMO handled over 35,000 entitlement data corrections and 43,897 third-party billing data exchanges in 2009.

- **National Conference Support:** In 2009, the OMO, along with the CMS staff, represented CMS at eight partner conferences, including conferences hosted by organizations such as the League of United Latin American Citizens, the National Urban League, the Organization of Chinese Americans, the National Alliance on Mental Illness, and the Annual State Health Insurance Assistance Program (SHIP) Directors' Conference. The OMO's staff also provided direct assistance to Medicare beneficiaries during the conferences and used these interactions as a platform for identifying beneficiary challenges.

Issues Management

Issues Management is the process that the OMO uses to identify and refer systemic issues to the appropriate CMS component for resolution. The OMO's casework and partner outreach activities contribute to its Issues Management process, as the OMO seeks to prevent issues from recurring and to improve the overall satisfaction of Medicare beneficiaries. In 2009, the OMO's key accomplishments in this area were:

- **Coordination of Benefits:** The OMO commissioned a comprehensive assessment to identify and detail coordination of benefits (COB) issues that affect Medicare beneficiaries, with the ultimate goal of issuing specific recommendations for improvement. The OMO is coordinating the necessary contacts and discussions with various internal and external stakeholders, and facilitating the receipt of pertinent COB data to develop actionable recommendations for addressing key issues underlying beneficiaries' concerns.

- **Therapy Services Study - "Improvement Standard/ Plateau Issue:"** In 2009, the OMO was near completion of a study on the "improvement standard" requirement for skilled rehabilitation therapy and the confusion around its application. This study was limited in its scope to a review of the skilled rehabilitation therapy under the Home Health Benefit (HHB), and the causes of beneficiaries', advocates', and caregivers' confusion regarding service coverage provided through the HHB.

ESTABLISHING THE OFFICE OF THE MEDICARE OMBUDSMAN

Section 1808(c) of the Social Security Act, which was added by section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires the Secretary of HHS to appoint a Medicare Beneficiary Ombudsman. In establishing the position and primary functions of the Medicare Beneficiary Ombudsman, Congress recognized the need for an entity that would serve as an advocate for Medicare beneficiaries within the Medicare program. In March 2005, CMS appointed Daniel J. Schreiner as the first Medicare Beneficiary Ombudsman, giving him the responsibility of establishing the OMO and fulfilling the provisions of section 1808(c).

Section 1808(c) requires the OMO to receive and provide assistance with respect to complaints, grievances, and requests for information submitted by individuals entitled to benefits under Medicare Part A or enrolled in Part B, or both, with respect to any aspect of the Medicare program, including to assist beneficiaries in collecting relevant information for appealing decisions made by a fiscal intermediary, carrier, Medicare Advantage (MA) plan, or the HHS Secretary; assist with problems arising from disenrollment from an MA plan under Part C; and assist in presenting information concerning income-related premium adjustment. The OMO is also tasked with working with health insurance counseling programs to help provide information to such individuals regarding MA plans and changes to those plans.

The OMO is also required to submit annual reports to Congress and to the HHS Secretary that describe its activities and include recommendations for improving the administration of Medicare.

CREATION OF THE COMPETITIVE ACQUISTION OMBUDSMAN (CAO) WITHIN THE OMO

Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), established CMS' Competitive Acquisition Ombudsman (CAO) to respond to complaints and inquiries made by suppliers and individuals relating to the application of the Competitive Acquisition Program. The CAO must submit an annual report to Congress that is coordinated with the report of the Medicare Beneficiary Ombudsman.

To fulfill this mandate, CMS appointed a Competitive Acquisition Ombudsman within the OMO. The CAO indirectly serves as an agent of change within CMS by working with external partners and other CMS components to facilitate competitive bidding policy clarifications and changes and to identify and address regulatory issues that affect the Competitive Bidding Program. However, the CAO does not address supplier complaints during the contracting process; it only addresses issues after the award of a contract.

In fulfilling the first year's mission of implementing the CAO program, Tangita Daramola—the Acting CAO—has plans to collaborate with other CMS components and external organizations to facilitate the establishment of processes and services for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers and individuals. This collaboration will involve the development of an outreach communication plan, the assessment of the DMEPOS Competitive Bidding complaint handling processes, the establishment of an Issues Management and trending framework, and strategies to enhance CMS' outreach efforts.

- **CTM Report:** The OMO continued to develop and distribute a weekly summary report pertaining to Medicare Parts C and D complaints. The report informs CMS leadership, caseworkers, and other stakeholders of trends and/or systemic issues that are detected by analyzing Complaint Tracking Module (CTM) data or identified by other means.

- **MAISTRO Report:** Beginning in mid-2009, the OMO developed a summary report pertaining to Medicare Parts A and B complaints. The report informs CMS leadership, caseworkers, and other stakeholders of trends and/or systemic issues that are detected by analyzing data from the Medicare Administrative Issue Tracker and Reporting of Operations (MAISTRO) system or other sources.

- **Issues Outreach:** In 2009, the OMO produced a detailed synopsis that examined coverage issues resulting from provider determinations and beneficiaries' understanding of whether hospital services are inpatient or outpatient. The OMO also contributed to the development of CMS educational materials that provide information to beneficiaries on specific topics such as domestic partner coverage, caregiver-physician interactions during treatment of Medicare beneficiaries with cognitive impairment, and Qualified Medicare Beneficiary (QMB) assistance programs.

AREAS FOR FURTHER CONSIDERATION BY CMS

The OMO's review of issues in 2009 identified three issue areas that warranted more comprehensive assessment: coordination of benefits, disparities in health care, and Medicare prescription drug issues. Each of these issues, and the OMO's recommendations for addressing them, are discussed in more detail in the Issues and Recommendations section of this report.

Coordination of Benefits

For Medicare beneficiaries who are also covered by another public or private insurance plan, Medicare must coordinate its provider payments with the payments supplied by other health plans through the COB process. Approximately 87 percent of the 46.5 million Medicare beneficiaries had some form of supplemental

insurance in 2009. Most beneficiaries had supplemental private coverage either through Medigap (12.2 million) or through group health plans (11.6 million). An additional 7.8 million beneficiaries had coverage through Medicaid, and 1.8 million had coverage through TRICARE. Approximately 6.4 million beneficiaries had some other form of public or private coverage.

Issues involving COB cause concerns and frustration for both beneficiaries and providers for a number of reasons. First, COB is complex. Beneficiaries often do not understand their other sources of coverage and how they coordinate with Medicare and thus are not able to provide accurate information to providers. Providers, who often interact with beneficiaries, need additional educational resources to assist beneficiaries with COB. Thus, beneficiaries and providers both need education on the COB rules governing primacy of coverage and who pays first. One factor causing COB problems is the inability to maintain accurate CMS records on primacy of coverage as beneficiaries' status changes. For example, group health plans may lack accurate information on changes to a beneficiary's current employment status, and submit inaccurate information to CMS.

Other complexities occur as a result of multiple entities providing information on sources of coverage, which can cause data system overwrites of new coverage information. Event-based changes in coverage related to workers' compensation and liability and no-fault insurance are especially challenging issues for COB; the primacy of coverage rules are particularly complex in such cases, as they are tied to specific conditions and injuries.

Health Care Disparities

Medicare is the largest health insurer in the United States, providing coverage for elderly, disabled, and socioeconomically disadvantaged populations. Ensuring that each of these diverse populations has equitable access to quality health care is vital to the success of the Medicare program. The Institute of Medicine (IOM) defines access to care as "the timely use of affordable personal health services to achieve the best possible health outcomes."[1]

Scholarly research indicates that factors such as cultural and physical environments, individual beneficiaries'

personal management of health, and health care financing and delivery systems all contribute to disparities of access and quality of care. The OMO's own investigations into health care disparities in Medicare revealed that disparities in outcomes can occur due to many factors, including language, culture, and financial barriers, among others.

The OMO reviewed three health care disparity issues:

- **Limited English Proficiency (LEP):** Language barriers can create challenges in communications between patients and providers and can lead to situations where LEP beneficiaries face a greater risk of receiving suboptimal care.

- **Qualified Medicare Beneficiary (QMB) Balance Billing:** Providers may receive only partial payment for services provided to QMBs because of low Medicaid reimbursement rates in some states and statutory prohibitions on balance billing, which may potentially deter providers from accepting QMBs.

- **Minority Utilization of Long-Term Care (LTC) Facilities:** Cultural factors influence how some ethnic and racial groups access Long-Term Care services, increasing the need for information about alternatives to institutional LTC.

Medicare Prescription Drug Issues

This topic included a wide variety of issues, such as the lack of uniformity in grace periods offered by plans for late premiums, disenrollment due to nonpayment of premiums, noncovered services (e.g., flu, pneumonia, and hepatitis B vaccines which are covered under Part B but not Part D), and off-label drug use for rare diseases.

The OMO assessed two main issues in 2009 that related to Part D: involuntary disenrollment from Part D plans due to nonpayment of premiums by low-income subsidy (LIS) beneficiaries; and lack of uniformity among the 3,600 Part D plans in applying grace periods for nonpayment of premiums. The OMO's findings on these issues are:

- **Low-Income Subsidy (LIS) Grace Period:** The OMO's investigations revealed that in 2009 1.5 million Medicare beneficiaries with limited income and

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1 Michael Millman. (1993). *Access to Care in America.* Washington, D.C.: National Academy Press.

resources, or 12 percent of all LIS eligible recipients, did not automatically qualify for the LIS subsidy and had to apply and have their eligibility determined by either the Social Security Administration or their state Medicaid agency. These LIS recipients are eligible for the subsidy throughout the calendar year in which they qualify and must undergo redetermination of LIS status on an annual basis. Problems arise after the redetermination period if the beneficiary is subsequently found not to be eligible for the subsidy. This ineligibility can result in the untimely payment or nonpayment of beneficiary premiums. Consequently, the beneficiary may be disenrolled and have difficulties accessing necessary medications.

- **Part D Disenrollment Due to Nonpayment of Premiums:** Sponsors of Medicare Part D plans may disenroll beneficiaries who fail to pay premiums in a timely fashion after a grace period and after providing proper notice at any time during the year. Problems arise when plans delay disenrollments and conduct mass disenrollments outside of annual enrollment periods. The health consequences of disenrollment from a Medicare Part D plan due to nonpayment of premiums could be significant, if a disenrolled beneficiary cannot obtain his or her medically necessary medications.

The OMO is committed to continuously improving its process for identifying and resolving beneficiary issues.

CONCLUSION

Although the activities and issues that the OMO managed in 2009 addressed a wide range of challenges for beneficiaries, new challenges will arise as changes are made to Medicare and Medicaid with the implementation of The Affordable Care Act (P.L. 111-148). The OMO is committed to continuously improving its process for identifying and resolving beneficiary issues. The OMO has established partnerships and the means to identify and address beneficiary issues, and it continued to improve upon them in 2009, enhancing the OMO's ability to provide proactive solutions and recommendations for resolving beneficiary challenges in the future.

Medicare has changed from focusing solely on paying claims to becoming dedicated to improving customer service.

THE MEDICARE PROGRAM AND BENEFICIARY COMPLAINTS AND INQUIRIES

INTRODUCTION

Through the Medicare program, CMS currently provides health insurance to nearly 46 million elderly and disabled individuals in the United States. Since its inception, the Medicare program's focus has evolved from solely paying claims to an increased emphasis on customer service. Despite its size and complexity, Medicare aims to respond in a timely and efficient manner to beneficiaries' concerns and questions about their benefits. In 1999, CMS (then called the Health Care Financing Administration) introduced the 1-800-MEDICARE helpline as a nationwide resource for responding to beneficiary concerns about the program.

This chapter describes key characteristics of Medicare and provides a closer look at the intricacies of the program. The chapter also identifies common beneficiary complaints and establishes the context for the activities of the OMO.

MEDICARE: CHANGES ADD COMPLEXITY

Medicare is the largest health insurance program in the United States, serving individuals who are 65 years and older, as well as individuals who are under the age of 65 and disabled. As figure 1 shows, this population has steadily increased over the years. Beneficiaries have a wide range of options for obtaining Medicare coverage and receiving care. The increasing complexity of Medicare and the burgeoning demand for services present challenges to Medicare's mission of ensuring appropriate access to care for all eligible beneficiaries.

Many Coverage and Care Options

Medicare is administered by the Federal government and its contractors. Qualifying beneficiaries receive Part A (hospital insurance) and may choose to enroll in Part B (medical insurance) under the original Medicare program, or elect for Part C coverage (Medicare

Advantage) for both hospital and medical insurance. Enrollees in Medicare may choose to supplement their coverage with a Medigap policy.

Medicare beneficiaries who choose to enroll in a Medicare Advantage (MA) plan receive coverage from private insurance companies that contract with Medicare. MA plans provide Part A and Part B coverage as one benefit, and may also offer prescription drug plans and other additional coverage. MA plan co-insurance payments may differ from those of Medicare fee-for-service. In 2009, 10.2 million—or 23 percent of total Medicare beneficiaries—were enrolled in an MA plan, almost double the enrollment levels in 2003.[2]

An individual Medicare beneficiary may receive care from multiple physicians—including primary care physicians, specialists, and other health care providers—and in multiple settings, such as inpatient hospitals, hospital-based outpatient departments, ambulatory surgery centers, skilled nursing facilities, and rehabilitation facilities. Beneficiaries enrolled

in original Medicare (Parts A and B) may choose any doctor or treatment setting that accepts Medicare on a fee-for-service basis. MA plans may restrict where a beneficiary receives care and may require different copayment amounts to create incentives for using providers within the MA plans' respective service and provider networks.
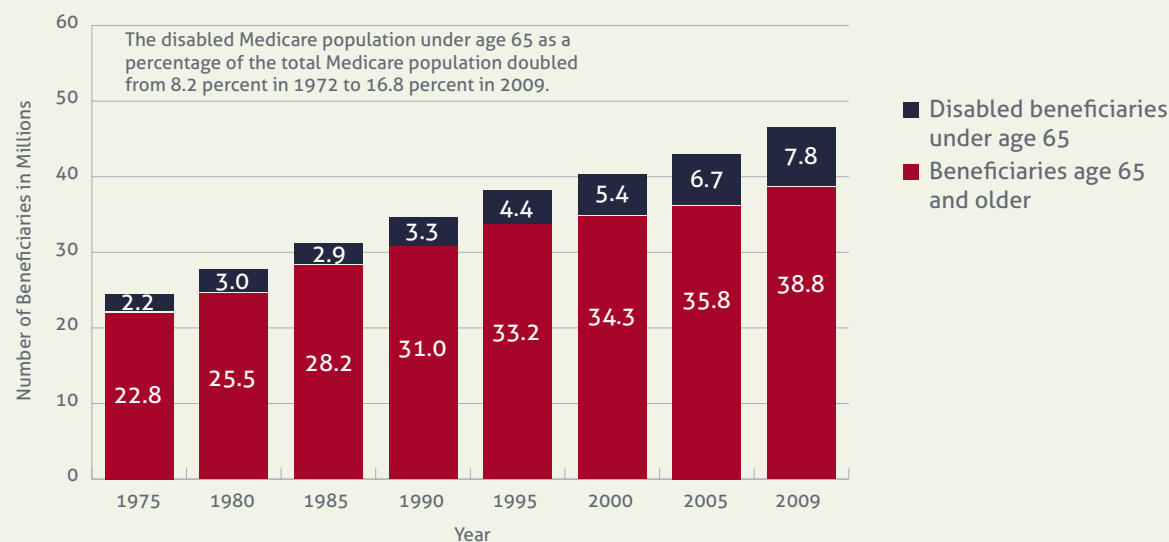
The Medicare Modernization Act of 2003 (MMA) expanded Medicare coverage to include optional prescription drug coverage (Part D). Beginning in January 2006, Medicare enrollees could opt to enroll in this new prescription drug benefit. As with Part C, private insurance companies contract with Medicare to offer prescription drug coverage.

In 2009, there were 1,689 stand-alone prescription drug plans, with at least 45 plans in each of the Prescription Drug Plan (PDP)-designated regions.[3]

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2 Kaiser Family Foundation. (2009). *Medicare Factsheet: Medicare Advantage.* Retrieved June 8, 2010, from http://www.kff.org/medicare/upload/2052-13.pdf

3 Kaiser Family Foundation. (2009). *Medicare Factsheet: The Medicare Prescription Drug Benefit.* Retrieved June 8, 2010, http://www.kff.org/medicare/upload/7044-09.pdf3

Figure 1. Historical growth in the Medicare disabled population under age 65, 1975-2009

The disabled Medicare population under age 65 as a percentage of the total Medicare population doubled from 8.2 percent in 1972 to 16.8 percent in 2009.

Disabled beneficiaries under age 65 / Beneficiaries age 65 and older

Year	Beneficiaries age 65 and older	Disabled beneficiaries under age 65
1975	22.8	2.2
1980	25.5	3.0
1985	28.2	2.9
1990	31.0	3.3
1995	33.2	4.4
2000	34.3	5.4
2005	35.8	6.7
2009	38.8	7.8

SOURCE: Data Compendium: 2009 Edition, Chapter IV.
https://www.cms.gov/DataCompendium/15_2009_Data_Compendium.asp#TopOfPage/

Over the years, Medicare has increased its efforts to communicate more efficiently with beneficiaries.

Prior to Part D, Medicare beneficiaries who also qualified for Medicaid (dual eligibles) could receive prescription drug coverage through their respective state Medicaid programs. With the advent of Part D, Medicare became the primary insurer for prescription drugs for Medicaid enrollees. The addition of Part D made Medicare larger and more complex.

An Expanding, More Complex Medicare Population

The number of Medicare enrollees has nearly doubled since 1975, reaching approximately 46.5 million in 2009. The profile of a Medicare beneficiary has also changed with the growth of the program. Today, Medicare enrollees are older and their circumstances are often more complex. Data from the 2006 Medical Expenditure Panel Survey and older have at least one or more chronic conditions.[4] The percentage of beneficiaries above the age of 84 has doubled since 1975, from 8 percent to 14 percent. Beneficiaries qualifying for Medicare because of a disability have also doubled, from 8 percent (2 million) to 16 percent (7.5 million) over the same period (see figure 1). Dual-eligible beneficiaries (i.e., Medicare beneficiaries who also qualify for Medicaid) now represent about 15 percent of all Medicare enrollees.[5]

Older Medicare enrollees and those who qualify as a result of a disability tend to have more than two chronic conditions and require frequent medical services. These characteristics translate into increased interactions with providers and Medicare contractors. Similarly, dual eligibles' level of use of health care services is higher and disproportionate to their share

of enrollment, and they may experience the most difficulty in accessing care. This population also presents unique challenges for coordination of medical services and benefits.

Medicare beneficiaries now have more choice of benefit options than ever. The freedom to choose how and where to receive benefits adds complexity and the potential for problems in accessing care. For example, Medicare Administrative Contractors (MACs) and health and prescription drug plans all process claims, which results in multiple entities interacting with beneficiaries and providers.

Over the years, Medicare has increased its efforts to communicate more efficiently with beneficiaries by offering dedicated websites and a national telephone helpline, and by concentrating on providing customer service. The name change in 2001 from the Health Care Financing Administration (HCFA) to the more "customer-oriented" Centers for Medicare & Medicaid Services (CMS) reflects this fundamentally different perspective. The establishment of the OMO has sharpened CMS' focus on improving beneficiary services and communications.

Medicare beneficiaries have a variety of information sources, including the Medicare.gov and MyMedicare.gov websites, the 1-800-MEDICARE national telephone helpline, numerous Medicare health and prescription drug plans, various Medicare contractors, multiple components within CMS (including the CMS Central Office [CO] and 10 Regional Offices [ROs]), the State Health Insurance Assistance Programs (SHIPs), numerous CMS partner organizations, advocacy organizations, and other entities. However, because beneficiaries lack a single point of initial contact beyond the 1-800-MEDICARE helpline, which provides information and limited services to address issues and complaints, the process for dealing with issues can be convoluted and may result in missed opportunities for advocacy or resolution of beneficiary concerns.

Multiple programs within CMS must coordinate to address beneficiary concerns successfully. CMS' Regional Offices (ROs) use a number of correspondence management tools to document and track information, allowing them to resolve inquiries and complaints from Medicare

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4 Robert Wood Johnson Foundation (2010). *Chronic Care: Making the Case for Ongoing Care.* Retrieved, June 8, 2010, from
http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf

5 Centers for Medicare & Medicaid Services (2010). *Overview Data Compendium.* Retrieved, June 8, 2010, from https://www.cms.gov/DataCompendium/

IMPROVING BENEFICIARY SERVICES: CMS MILESTONES

Since the Medicare and Medicaid programs were signed into law in 1965, CMS has evolved from an agency solely focused on paying claims to an organization that puts increased emphasis on improving beneficiary services. Several milestones reflect this transformation.

The Health Care Financing Administration (HCFA) was originally established in 1977 to administer Medicare and Medicaid. Two decades later, Medicare.gov was launched to provide updated information and education materials about Medicare. The following year, another key resource became available nationwide to beneficiaries: 1-800-MEDICARE. Beneficiaries can call the toll-free number to receive help with their Medicare questions, to request information on Medicare health plans, and to order Medicare publications.

In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS) with the goal of emphasizing the vital mission of the agency: ensuring effective, up-to-date health care coverage and promoting quality care for beneficiaries.

The MMA, which was passed in 2003, required the HHS Secretary to appoint a Medicare Beneficiary Ombudsman. Two years later, Daniel J. Schreiner was appointed as the first Medicare Beneficiary Ombudsman.

1965 – Medicare and Medicaid enacted
1977 – HCFA established
1998 – Medicare.gov launched
1999 – 1-800-MEDICARE made available
2001 – Name changed from HCFA to CMS
2003 – MMA requires appointment of a Medicare Beneficiary Ombudsman
2005 – Daniel J. Schreiner appointed as first Medicare Beneficiary Ombudsman

beneficiaries. Sometimes, one RO or the CMS CO may not have direct access to another RO's correspondence management system to gather information. Using a single management tool for customer service and correspondence issues could reduce response time, hasten resolution of beneficiary problems, and reduce duplication of effort in such instances.

CMS must continue its work to improve customer support and strengthen its efforts to educate beneficiaries and providers about new policies and regulations.

NUMBER AND SOURCES OF CONTACTS

This section presents data on the number and types of beneficiary contacts and complaints that CMS has received through its CO and ROs, the 1-800-MEDICARE helpline, state partners, and other sources. The OMO tracks these data as one way of identifying potential systemic issues. Because of the aggregate nature of these data, however, the information cannot always be readily used to identify the exact root causes of issues or to assess the effectiveness of interventions.

Figure 2 displays the total number of contacts to 1-800-MEDICARE from 2004 through 2009 as well as contacts to all other CMS data sources since 2007.[6] It is important to note that the total number of contacts is not equivalent to the total number of unique beneficiary contacts. For example, 1-800-MEDICARE receives both beneficiary inquiries and complaints, and the National Data Warehouse forwards the complaints to the CTM; therefore, some of the 1-800-MEDICARE contacts are also reflected in CTM. CMS reports that 34.6 million beneficiary contacts were made in 2007, declining by 15 percent to approximately 30.0 million in 2008, and then rising slightly to 30.2 million in 2009. The decline in total contacts by 4.6 million from 2007 to 2008 was largely attributed to a continuing decline in Medicare Part D-related inquiries and issues.

Figure 3 presents the volume of calls that 1-800-MEDICARE received, per quarter, during 2007-2009. Calendar year 2007 had the highest volume of calls throughout all four quarters. In 2009,

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6 Data from the SHIP NPR and all other sources are not available prior to 2007.

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Medicare must continue its work to improve customer support and its efforts to educate beneficiaries and providers.
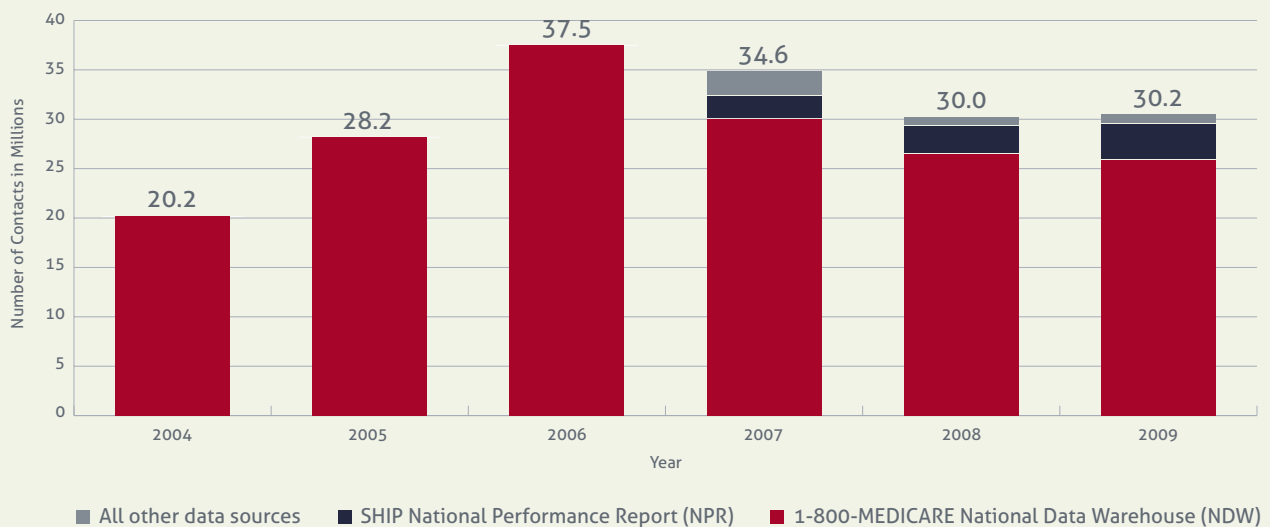
1-800-MEDICARE received the fewest number of calls over all four quarters. As Figure 3 shows, the pattern of calls changed in similar fashion during all three years, with higher volumes in the first and last quarters of the year. This trend is a result of open enrollment occurring during the fourth quarter and issues arising during the first quarter for beneficiaries who changed plans.

When 1-800-MEDICARE customer service representatives (CSRs) assist callers, they respond by using information scripts. The CSRs may log multiple reasons for each call; therefore, the concerns captured are not unique for each call. Figure 4 provides the top ten scripts accessed by

CSRs in 2009 as well as the number of hits for the same category of scripts in 2008.

In 2009, there were nearly 17.4 million scripts accessed by the CSRs for calls to 1-800-MEDICARE, an increase of approximately 4.6 million compared with 2008. Issues related to Part B coverage of services were the primary reason for beneficiary contacts in both years. This is a broad category that includes all Part B-related coverage concerns. The top three reasons to contact 1-800-MEDICARE in 2009 were the same as in 2008: Part B-covered/non-covered services, Medicare Secondary Payer (MSP) issues, and enrollment/disenrollment periods (for drug coverage and Medicare Advantage). The script hits for the topic of MSP exhibited a dramatic increase from 750,000 in 2008 to 1.1 million in 2009. Three of the top ten reasons to contact 1-800-MEDICARE in 2009 were not among the top ten reasons in 2008: drug coverage overview, authorizations for someone to speak on behalf of the beneficiary (i.e., representative payees or designated family members), and replacement of Medicare cards and entitlement letters.
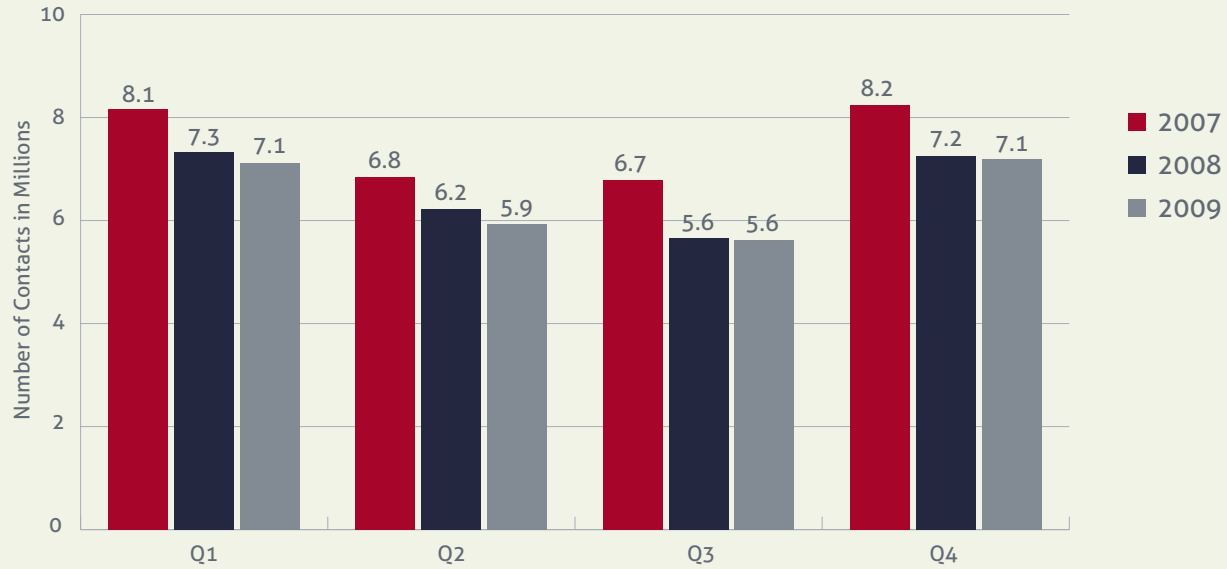
Figure 2. Total contacts received from 2004-2009, by CMS data sources

SOURCE: 1-800-MEDICARE National Data Warehouse (NDW), SHIP National Performance Report (NPR), DMOA Reports, Complaint Tracking Module (CTM), Contractor Management Information System (CMIS), and Medicare Appeals System (MAS)
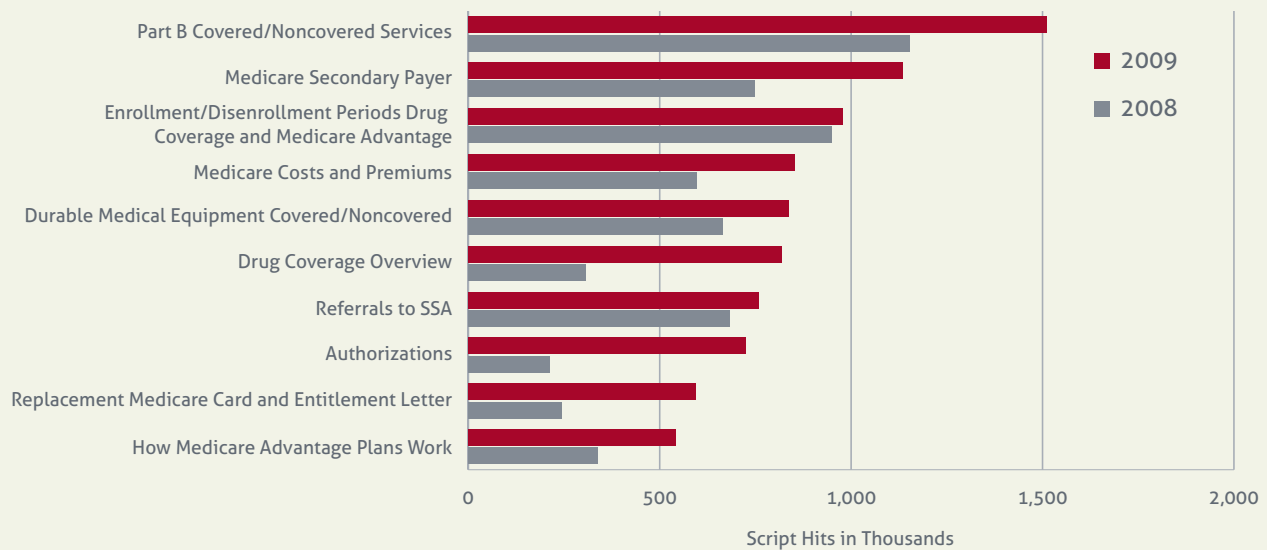
NOTE: All other data sources comprise contacts received from the Contractor Management Information System, the Complaint Tracking Module, the Medicare Appeals System, and DMOA Reports. Data from the SHIP NPR and all other sources are not available prior to 2007.

Figure 3. Quarterly beneficiary contacts to 1-800-MEDICARE, 2007-2009

Legend: 2007, 2008, 2009

Number of Contacts in Millions

Q1: 8.1, 7.3, 7.1
Q2: 6.8, 6.2, 5.9
Q3: 6.7, 5.6, 5.6
Q4: 8.2, 7.2, 7.1

SOURCE: 1-800-MEDICARE National Data Warehouse

Figure 4. Comparison of 1-800-MEDICARE script hits for 2008 and 2009 based on top 10 script hits in 2009

Legend: 2009, 2008

- Part B Covered/Noncovered Services
- Medicare Secondary Payer
- Enrollment/Disenrollment Periods Drug Coverage and Medicare Advantage
- Medicare Costs and Premiums
- Durable Medical Equipment Covered/Noncovered
- Drug Coverage Overview
- Referrals to SSA
- Authorizations
- Replacement Medicare Card and Entitlement Letter
- How Medicare Advantage Plans Work

Script Hits in Thousands

SOURCE: 1-800-MEDICARE National Data Warehouse

In 2008, the State Health Insurance Assistance Programs' (SHIPs') staff and volunteers recorded approximately 2.2 million beneficiary-related contacts. Topics related to Part D accounted for nearly 40 percent of all topics discussed with the SHIPs. The most frequent Part D questions involved plan eligibility and benefit comparisons (18 percent), enrollment and application assistance (8 percent), federal assistance for low-income beneficiaries (7 percent), and State Pharmacy Assistance Programs (SPAPs) (6 percent).

In 2009, there was a significant increase—by 1.3 million—in the total number of contacts to the SHIPs. This increase can be attributed to improved reporting accountability, as a result of enhanced training and education of SHIP staff and volunteers about the importance of and need for reporting. Other reasons include the incorporation of reporting as part of the SHIP performance measures; more funding and grants for enhanced Part D and low-income subsidy (LIS) counseling as a result of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). As in 2008, Medicare Part D accounted for the highest percentage (50 percent) of contacts during 2009. Additionally, topics related to Medicaid represented about 11 percent of all contacts during 2008 and 2009.

In 2009, the Complaint Tracking Module (CTM), which registers and categorizes complaints related to Parts C and D, recorded 226,858 complaints. The top two categories of complaints were enrollment/disenrollment and pricing/co-insurance. These two complaint topics represented 79 percent of all CTM contacts in 2008 and 74 percent of all CTM contacts in 2009. There were 18 percent fewer CTM complaints in 2009 compared with 2008.

The most frequently accessed source of beneficiary contact during the 2007-2009 period was the 1-800-MEDICARE helpline.

Beneficiary contacts to CMS for 2007-2009 were collected from six different sources in the Beneficiary Contact Trend Report: the 1-800-MEDICARE National Data Warehouse (NDW), the SHIP National Performance Report (NPR), the Contractor Management Information System (CMIS), the Medicare Appeals System (MAS), Division of Medicare Ombudsman Assistance (DMOA) reports, and the Complaint Tracking Module (CTM).

The most frequently accessed source of beneficiary contact during the 2007-2009 period was the 1-800-MEDICARE helpline, which reported over 27 million annual contacts. However, calls to 1-800-MEDICARE declined during 2007-2009, while contacts to the SHIPs increased. The SHIP NPR was second to 1-800-MEDICARE in number of beneficiary contacts, averaging almost 2.8 million annual contacts from 2007-2009.

FULFILLING ITS MISSION: HOW THE OMO MANAGES BENEFICIARY ISSUES

INTRODUCTION

Section 1808(c) of the Social Security Act, added by section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), required the HHS Secretary to appoint a Medicare Beneficiary Ombudsman to assist Medicare beneficiaries and to address the problems they may face with understanding and accessing their Medicare benefits and services. The Office of the Medicare Beneficiary Ombudsman (OMO) strives to be an independent reviewer of the Medicare program, while also collaborating with the other components of the Centers for Medicare & Medicaid Services (CMS). To increase its efficacy in identifying and resolving beneficiary issues, the OMO fosters cooperative relationships with the other CMS components, government agencies, and advocacy organizations.

The OMO facilitates the resolution of beneficiary issues that require the coordination of multiple CMS components and, sometimes, complex interactions between those components. Often, the OMO is the contact of last resort for those beneficiaries who feel that other organizations and entities have been unable to satisfactorily resolve their inquiries and complaints. Unlike other Medicare complaint resolution entities, the OMO is charged with addressing systemic program and policy issues and presenting Congress and CMS leadership with recommendations for policy and system changes. The OMO employs three primary approaches to accomplish its mission:

- **Casework** involves providing direct assistance to beneficiaries and supporting CMS' national casework efforts. The primary means by which the OMO resolves individual beneficiary complaints is through working directly with beneficiaries. The OMO often functions as a liaison between beneficiaries and the Medicare system, expediting the resolution of complex and urgent-need cases. The OMO also supports casework efforts by providing technical assistance to its internal and external partners.

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- **Partnership Initiatives** contribute to the OMO's identification of systemic issues and facilitation of outreach and education efforts to beneficiaries. These collaborative relationships incorporate meaningful stakeholder input into the Medicare system.
- **Issues Management** is the process that the OMO uses to identify systemic programmatic issues that affect large segments of the Medicare population, or that could otherwise have a profound impact on beneficiaries' well-being. The Issues Management process also allows the OMO to conduct root cause analyses of problems, and to make recommendations for improvement.
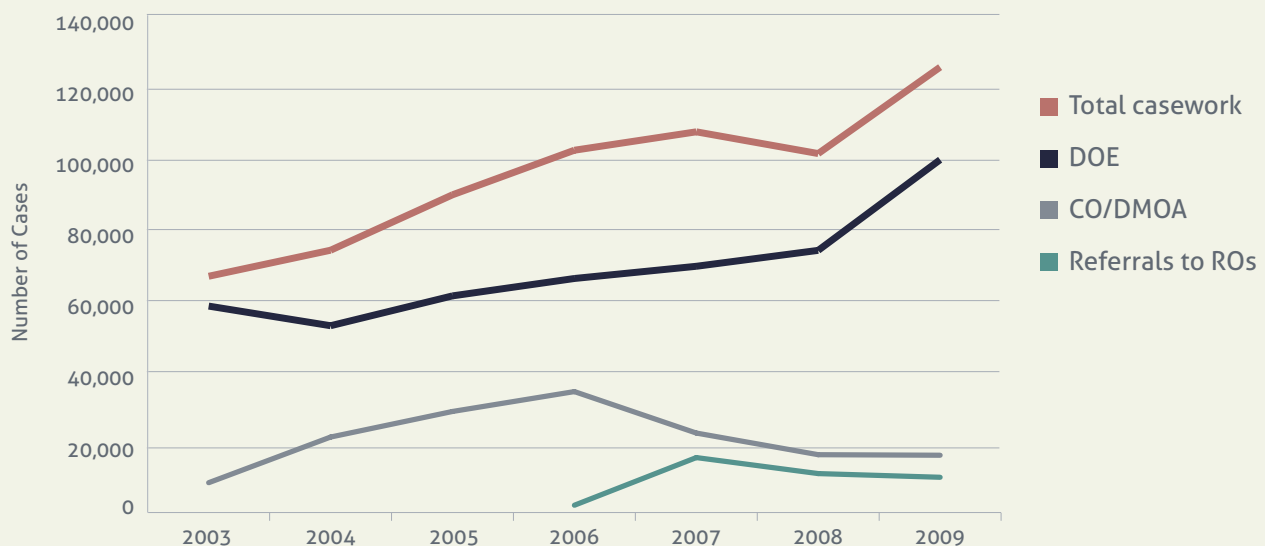
CASEWORK

Volume of Direct Services to Beneficiaries

Casework is the OMO's fundamental and most direct approach to resolving beneficiary issues. In addition to handling numerous routine inquiries and complaints, the OMO regularly addresses complex and urgent-need cases that other entities have been unable to resolve to

the beneficiary's satisfaction. Whereas other Medicare complaint resolution components are largely focused on resolving individual cases, the OMO also analyzes the caseload for trends that may indicate systemic issues.

In 2009, the OMO addressed beneficiary inquiries and complaints submitted in English, Spanish, and a variety of other languages. Beneficiaries contact the OMO by postal mail, e-mail, fax, telephone, or via referral sources, including state Medicaid offices, the Social Security Administration (SSA), congressional offices, the Office of the HHS Secretary, CMS' Press Office, CMS' Office of Legislation, the Office of the CMS Administrator, and, on occasion, the Executive Office of the President.

The OMO's casework responsibilities are shared between two divisions: the Division of Medicare Ombudsman Assistance (DMOA) and the Division of Exceptions (DOE). Figure 5 provides the casework volume that the OMO handled between 2003 and 2009.

As Figure 5 shows, the total OMO casework volume exhibited a steady increase for most years, except for a small decline in 2008. The overall upward trend

Figure 5. Office of the Medicare Ombudsman casework volume 2003-2009

NOTE: Routine referrals to CMS' Regional Offices and corresponding tracking began in 2006.

reflects growth in the DMOA's capacity to conduct casework since 2003 and the addition of referrals to the Regional Offices (ROs) starting in 2006. DOE's casework, which focuses on issues related to Medicare data systems, increased nearly 35 percent between 2008 and 2009, which resulted in a significant increase in overall OMO casework. In 2009, DOE's work included resolving 36,347 direct billing and 43,897 third-party billing issues (figure 5 shows routine referrals only, not cases resolved).

National Casework Calls

In 2009, the OMO hosted more than 40 national conference calls for program analysts and caseworkers concerning Medicare Parts A, B, C, and D. The ongoing weekly National Casework Call for CMS employees who are engaged in beneficiary casework services and related policy and operations, includes representatives from CMS' ROs and Central Office (CO), the Office of Beneficiary Information Services (OBIS), the Office of Information Services (OIS), the Center for Drug and Health Plan Choice, and the Office of Financial Management (OFM). The OMO also coordinates the participation of subject-matter experts from Medicare program areas, as needed. The primary functions of the National Casework Conference Call are as follows:

- Support RO efforts to provide oversight to ensure that complaints are resolved quickly and appropriately.
- Identify systemic obstacles that impede resolution of beneficiary inquiries and complaints.
- Disseminate information pertinent to caseworkers handling inquiries and complaints.
- Standardize casework processes across CMS' components and ROs.
- Identify policies and processes that negatively affect beneficiary casework.
- Coordinate strategies to resolve issues affecting the resolution of beneficiary complaints.

In 2009, the OMO addressed topics such as low-income subsidy (LIS) plan transitions, e-prescribing initiatives, Medicare's Caregiver Program, coordination of benefits (COB), and secondary payer issues.

ORGANIZATION: OMO DIVISIONS AND FUNCTIONS

The OMO serves as an advocate for Medicare beneficiaries to improve their experience with the program. To fulfill its mission, the OMO directly assists beneficiaries, works closely with its internal and external partners, and monitors trends in inquiries, complaints, grievances, and appeals. The OMO has three distinct divisions to carry out its mission:

The Division of Medicare Ombudsman Assistance (DMOA) responds to, manages, and works to resolve beneficiary inquiries and complaints. DMOA's casework staff triages urgent-need beneficiary issues and facilitates the resolution of complex cases. DMOA collects and reports significant trends in beneficiary contacts and casework.

The Division of Ombudsman Research & Trend Analysis (DORTA) performs trending and analysis of Medicare inquiry, complaint, and appeals data. DORTA also leads the Ombudsman's Issue Management process, which identifies and resolves systemic program and policy issues that affect Medicare beneficiaries. It also develops resources and facilitates trainings for Medicare caseworkers.

The Division of Ombudsman Exceptions (DOE) resolves beneficiary data system anomalies and errors in data exchanges that would otherwise cause eligible Medicare beneficiaries to lose coverage. This division interacts directly with beneficiaries and data systems to identify system errors and make necessary corrections or to submit change requests for Medicare Part A and B systems.

The OMO places great emphasis on collaborating with CMS components and partner organizations.

Highlighted Accomplishments

Standard Language Letters: In 2009, the OMO prepared or updated 134 standard language letters that may be used for the development of personalized responses to beneficiary inquiries. The standard language letters, which result from issues that the OMO most frequently receives from beneficiaries, assist in providing more consistent responses to beneficiary inquiries. The casework staff of CMS' ROs can access these standard-language letters through the HHS (intranet) portal when responding to beneficiary inquiries on topics such as condition-specific coverage policies, telemarketing fraud, identity theft, medical records requests, and low-income subsidy (LIS) standard benefits.

Distributed Index of Rejected Transactions (DIRT) Analysis/Enhancements: The OMO led a cross-functional team that included staff from the Office of External Affairs (OEA), OIS, and OFM, the Center for Drug and Health Plan Choices, and SSA to implement enhancements to the DIRT system. When an incoming transaction attempts to update Medicare Part A and Part B entitlement or premium billing data but fails to process to completion, a record of the failed transaction is categorized and maintained in the DIRT system. As chair of CMS' DIRT workgroup and co-chair of the collaborative SSA/CMS DIRT workgroup, the OMO has overseen the implementation of extensive DIRT system enhancements. The resulting changes eliminated over 500,000 alerts and exceptions from the system in 2009. The decrease in alerts and exceptions created a more user-friendly system and enabled proactive administrative changes to address issues before they developed into alerts. Both Medicare and SSA records are more accurate because of the enhancements, and exceptions are processed in less time. The OMO will continue to collaborate with the SSA to implement the DIRT workgroup recommendations to update the entitlement and premium-billing data exchanges.

PARTNERSHIP INITIATIVES

The OMO places great emphasis on collaborating with CMS components and partner organizations as a means of increasing its efficiency in addressing systemic beneficiary issues. This strategy enables advocacy organizations to communicate issues directly to the OMO. Approximately 66 percent of the large-scale issues that the OMO assessed in 2009 were raised by advocacy groups, other CMS components, and other government agencies. The OMO primarily solicits beneficiary-related concerns—and suggestions from its external partners for addressing those concerns—by meeting regularly with representatives from beneficiary advocacy organizations. The OMO also participates in the National Medicare Education Program forums, Medicare Advantage conferences, and various CMS partners and stakeholder-sponsored conferences.

Internal Partnerships

The OMO's coordination with other CMS components enhances its ability to identify and resolve beneficiary issues. The OMO often serves as an intermediary or facilitator when issues involve input, actions, and/or agreement from multiple CMS components. In these instances, the OMO uses various methods, such as quarterly reports, caseworker calls, and temporary work groups, to communicate with its internal partners. Figure 6 provides examples of OMO partners within CMS.

External Partnerships

In addition to its internal partnerships within CMS, the OMO develops and maintains relationships with external organizations and advocacy groups. In May 2009, the OMO launched a bimonthly dialogue session to solicit the insight of partners and advocates on Medicare program-related issues. The regular meetings facilitate the OMO's identification and resolution of systemic beneficiary issues by leveraging the expertise of external partners.

In conjunction with CMS' Partner Relations Group, the OMO represented CMS at eight partner conferences in 2009, hosted by organizations such as the League of United Latin American Citizens, the National Urban League, the Organization of Chinese Americans, the National Alliance on Mental Illness, and the Annual

SHIP Directors' Conference. In addition, the OMO provided direct assistance to Medicare beneficiaries during the conferences and reviewed concerns that indicated possible systems or policy issues.

The State Health Insurance Assistance Programs (SHIPs) are also important OMO partners. SHIPs are part of a national program that funds free, one-on-one counseling for Medicare beneficiaries. The SHIPs and the OMO identify issues requiring national education campaigns, for which the OMO then provides technical assistance. The goal of the SHIP technical assistance program (SHIP TAP) is to provide guidance to the SHIP staff in conducting culturally sensitive outreach services to targeted beneficiary populations while

facilitating the relationship between Medicare and its State and local partners. The SHIP TAP is governed by three key principles:

- Initiatives must complement—not duplicate—existing efforts.
- Programs must be relevant to diverse populations.
- Projects must be developed in collaboration with partner agencies.

The OMO also attended the 2009 SHIP Directors' Conference and discussed issues raised by the partners, including disabilities, illiteracy rates, training,

Figure 6. Examples of how the OMO works with other CMS components

Organization	Purpose
Office of the Administrator (OA)	The OMO elevates primary systemic issues to CMS leadership and obtains leadership support for addressing those issues.
CMS Regional Offices (ROs)	The OMO collaborates with CMS ROs to identify and facilitate the resolution of systemic issues regarding the Medicare program and CMS processes, resolve individual complaints, fulfill requests for information from Medicare beneficiaries, and develop standard procedures for assisting Medicare beneficiaries.
Center for Drug and Health Plan Choice (CPC)	CPC provides assistance with issues regarding Medicare health and prescription drug plan operations, policies, and communications.
Office of Beneficiary Information Services (OBIS)	The OMO works with the OBIS to identify systemic issues that impact Medicare beneficiaries, and to resolve a small percentage of highly complex beneficiary issues.
Office of Information Services (OIS)	The OMO engages components within the OIS proactively to identify CMS data system changes and updates that may impact Medicare beneficiaries.
Office of Legislation (OL)	The OMO collaborates with the OL, as needed, for assistance with issues involving Medicare beneficiary correspondence to lawmakers and identifying or addressing issues that impact their constituents.
Office of External Affairs (OEA)	The OMO collaborates with other components in the OEA to identify systemic issues that impact Medicare beneficiaries and communicate information regarding those issues optimally. Particularly, the OEA's Partner Relations Group supports the OMO in engaging external partners to identify and/or validate issues that impact people with Medicare, and to provide outreach and education regarding such issues when necessary.
Center for Medicare Management	The OMO collaborates with the Center for Medicare Management to assess and address issues regarding the traditional fee-for-service Medicare program, including existing payment policy and concerns or problems involving the Medicare fee-for-service contractors.

regulation compliance, access to the CMS Complaint Tracking Module, preventive care, and the *Medicare & You* handbook. In 2009, the OMO assisted the SHIPs by composing reference sheets on mental health conditions and by conducting the SHIP TAP survey. Moving forward, the OMO will focus on assessing the needs of the SHIP office with regard to serving Medicare beneficiaries and developing the most effective strategies for OMO collaboration.

ISSUES MANAGEMENT

Issues Management is the process through which the OMO seeks to proactively identify and resolve systemic problems affecting the Medicare program and its beneficiaries. The OMO's casework and partner outreach activities contribute to its Issues Management process as the OMO seeks to prevent issues from recurring and to improve the overall satisfaction of Medicare beneficiaries.

The Issues Management process has four activities: collating summary reports of inquiry, complaint, and appeals data; hosting issue review meetings; performing issue tracking; and producing quarterly reports. The OMO Beneficiary Contact Trend (BCT) report tracks the reasons for and volume of complaints and inquiries across several Medicare complaint and inquiry data sources. Issues Management review meetings provide OMO leadership and analysts with an opportunity to prioritize issues and to develop effective strategies for addressing complex cases. Issues selected from the Issues Management process are tracked in the Medicare Ombudsman Issues System database, which provides a centralized overview of the Issues Management efforts, and detailed information about each issue. The OMO uses its issues-tracking data to compose quarterly reports that document its progress toward addressing beneficiary and system-related concerns.

Figure 7. CMS data sources, 2009

CMS Source	CMS System	Information collected
1-800-MEDICARE	National Data Warehouse (NDW)	• Total call volume for 1-800-MEDICARE • Top 10 reasons and associated volumes for contact (i.e., script hits)
State Health Insurance Assistance Programs (SHIPs)	National Performance Report (NPR) System	• SHIP contact volume • Reasons for contact (i.e., topics discussed)
Division of Medicare Ombudsman Assistance (DMOA)	• Strategic Work Information Folder Transfer (SWIFT) • DMOA Workload Reports	• Volume of contacts handled by the OMO • Reasons for contacting the OMO or the Agency's Central Office
Components that log CTM complaints: • 1-800-MEDICARE • CMS' CO & ROs	Complaints Tracking Module (CTM) – Parts C and D	• Volume of complaints • Reasons for complaints
Medicare Administrative Contractors (MACs)	Contractor Management Information System (CMIS) – Part A and Part B	• Volume of Level 1 appeals • Volume of inquiries
Qualified Independent Contractors (QICs)	Medicare Appeals System (MAS) – Parts A, B, C, and D	• Total volume of Level 2 appeals • Volume by type of appeals

Issues Management is the process through which the OMO seeks to proactively identify and resolve systemic problems affecting the Medicare program and its beneficiaries.

Issues are identified through both quantitative and qualitative methods, enabling the OMO to assess a greater variety of issues than would be possible if it relied solely on one methodology. The OMO takes advantage of the complaint-tracking data available through CMS by analyzing the data to identify outliers that may indicate systemic problems. The OMO investigates significant increases in complaints for a particular topic by analyzing data trends from several data sources (see figure 7).

The OMO also relies on qualitative sources to identify issues. OMO caseworkers who notice patterns in their casework present salient issues to the Issues Management team, whose work complements that of advocacy groups and other sources working to flag noteworthy issues.

After an issue has been identified, it must be validated prior to being assigned to the Issues Management process. During issues review meetings, the OMO analysts discuss the validation, the impact of specific issues, and whether or not they warrant further assessment, tracking, and resolution via the Issues Management process. An issue that enters the Issues Management process is assigned to an analyst for root cause analysis. When necessary, analysts solicit feedback and assistance from other members on the Issues Management team, CMS subject-matter experts, and other sources as they work toward resolving an issue.

The outcome of the root cause analysis assists the Issues Management process to categorize beneficiaries' challenges. The challenges facing beneficiaries are typically assigned to three categories: insufficient beneficiary education, systemic issues, and policy issues. The OMO addresses the first two categories by providing solutions and the latter category by providing recommendations.

After the OMO's root cause analysis of an issue, its Issues Management process often leads to developing educational and outreach materials. For those issues that do not require extensive policy analysis, tip sheets are an effective tool for providing additional guidance to beneficiaries. The OMO assisted in producing several publications in 2009, including handbook updates and several tip sheets regarding topics such as domestic partner coverage, Qualified Medicare Beneficiaries (QMBs), and caregiver-physician interactions during treatment of Medicare beneficiaries with cognitive impairment. In coordination with other CMS components, the OMO also participated in updating the *Medicare & You* handbook and in developing the *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* publication. The OMO uses its Annual Report to Congress to present CMS leadership and Congress with recommendations for those issues attributable to Medicare policies and operations.

The review of the 2009 issues indicated three areas that require more investigation: coordination of benefits, health care disparities, and Medicare Part D issues.

ISSUES AND RECOMMENDATIONS

INTRODUCTION

Through a broad range of activities, the OMO identifies and works to resolve beneficiary issues. The OMO engages partners within and outside of CMS, follows an Issues Management process, and tracks complaint data. This multifaceted approach is necessary because of the many types and sources of beneficiary issues.

This chapter describes the types of issues the OMO evaluated and attempted to resolve in 2009. The following section provides an overview of the beneficiary issues the OMO received, analyzed, and managed in 2009, from which the OMO identified 19 specific issues that were presented to CMS leadership through the OMO's 2009 quarterly reports. The "Detailed Review and Case Studies of Select Issues" section then details issues that the OMO identified as complex or systemic concerns, or which offered opportunities to improve beneficiaries' experience with Medicare through the adoption of actionable OMO recommendations.

OVERVIEW OF ISSUES RECEIVED BY THE OFFICE OF THE MEDICARE OMBUDSMAN

In 2009, the OMO received 26,063 inquiries and complaints from beneficiaries, their families, caregivers and advocates, CMS' Central and Regional Offices, legislators, and others. This number represents a decline from 2007 (37,853) and 2008 (27,253), although the change from 2008 to 2009 is relatively small. Reductions in the number of contacts relative to 2007 are largely a result of the maturation of the Medicare Part D program, which began in 2006. In 2009, the OMO directly managed approximately 16,000 contacts.

In 2009, the OMO received 7,408 contacts pertaining to Medicare premiums issues; this issue topic accounted for 28 percent of all contacts, more than any other issue topic. Medicare premiums and eligibility and enrollment issues were two of the top

In 2009, the OMO directly managed approximately 16,000 contacts.

three reasons for contacting the OMO in 2008 as well. Other top reasons for contacts received by the OMO in 2009 included coordination of benefits issues (see figure 8). It is difficult to compare the number of COB contacts between 2008 and 2009, because of the differences in the way incoming correspondence was screened and categorized.

Through its Issues Management process, the OMO identified 19 specific issues that required consideration by other components and CMS leadership. Criteria that the OMO uses to highlight or prioritize an issue include:

- The number of beneficiaries potentially affected by an issue
- The significance of an unresolved issue on beneficiaries' access to care
- The complexity of the issue
- The potential financial hardship for beneficiaries

The review of the 2009 issues indicated three areas that require more investigation as they constitute complex and systemic beneficiary concerns: coordination of benefits, health care disparities, and Medicare Part D issues. A detailed analysis, and case studies, follow the general introduction of these issues.

Issue: Coordination of Benefits

Coordination of benefits (COB) refers to provisions that regulate payments to providers when a beneficiary is covered by more than one insurance plan. With respect to Medicare, this situation would occur if a beneficiary is covered by Medicare and either a private plan or another public plan. Some of the challenges that beneficiaries face with respect to COB have been identified in scholarly literature and reports commissioned by entities such as the Commonwealth Fund and the Kaiser Family Foundation (KFF). The timely payment of claims is a common challenge for beneficiaries and providers alike. The OMO has initiated its own work to examine the ongoing issue of COB in the Medicare population. A final report with recommendations is expected to be developed in 2010.

Issue: Health Care Disparities

The Institute of Medicine (IOM) defines access to care as "the timely use of affordable personal

Figure 8. OMO beneficiary contacts data, 2009

Reason for contact	Contacts	Percentage of all contacts
Premiums	7,403	28%
Medicare eligibility/enrollment	2,141	8%
Coordination of benefits	1,471	6%
Inquiries not Medicare/Medicaid specific	1,022	4%
Medicare coverage	906	3%
Medicare Advantage	830	3%
Low-income subsidy	770	3%
Disenrollment/termination/withdrawal	656	3%
Claims inquiries/complaints	612	2%
Creditable coverage	443	2%
All other categories (combined)	9,809	38%
Total	26,063	100%

health services to achieve the best possible health outcomes."[7] Access to care is necessary to eliminate disparities in outcomes for minority, elderly, disabled, and socioeconomically disadvantaged populations in the United States.

Medicare is the largest health insurer in the United States, providing coverage for elderly, disabled, and socioeconomically disadvantaged populations. Scholarly research indicates that factors such as cultural and physical environments, individual beneficiaries' personal management of health, and health care financing and delivery systems all contribute to disparities in access to and quality of care. The OMO's own investigations into health care disparities in Medicare revealed that disparities in outcome could occur due to many factors, including language, cultural, and financial barriers, among others.

Issue: Medicare Part D Issues

In 2009, approximately 59 percent or 26.7 million Medicare beneficiaries were enrolled in Part D, generally through a Medicare Advantage plan that offers Part D coverage (MA-PD plan) or a stand-alone prescription drug plan (PDP). During the same period, 36 percent of the Part D enrollees qualified for extra help, also called low-income subsidy (LIS).[8] LIS beneficiaries receive reduced premiums and cost-sharing requirements and are not subject to a coverage gap or a late enrollment penalty.

Through its Issues Management process, the OMO identified two issues related to the Medicare prescription drug benefit that warranted additional assessment. First, Part D plans can provide up to a 3-month grace period for the collection of premiums and cost-sharing to those formerly LIS-eligible beneficiaries who lose their deemed status and are able to demonstrate that they have applied for the LIS, although plans are not required to do so. Second, in 2009 Part D plans were required to provide at least a 1-month grace period for non-payment of premiums, but could disenroll beneficiaries for non-payment of premiums at any point during the year, after applying the grace period and providing proper notice.

7 Millman (1993).

8 Centers for Medicare & Medicaid Services (2010). *Prescription Drug Coverage - General Information- 2010 Enrollment information.* Retrieved June 8, 2010, from http://www.cms.gov/PrescriptionDrugCovGenIn/

In 2010, approximately 59 percent of Medicare beneficiaries were enrolled in Part D, either through a Medicare Advantage plan (MA-PD), a stand-alone Part D plan, or some other source.

DETAILED REVIEW AND CASE STUDIES OF SELECT ISSUES

This section provides a more detailed review of the coordination of benefits, disparities in health care, and Medicare Part D issue areas, focusing on:

- **Coordination of Benefits:** premium billing, data overwrites, and lack of beneficiary and provider information
- **Health Care Disparities:** limited English proficiency (LEP), Qualified Medicare Beneficiary and balance billing, and use of long-term care by Asian Medicare beneficiaries
- **Medicare Prescription Drug (Part D) Issues:** low-income subsidy grace period and plan disenrollment due to nonpayment of premiums

The OMO identified these issues as important to highlight because they represent systemic challenges and offer opportunities to improve beneficiaries' experience with Medicare through adoption of actionable recommendations.

Coordination of Benefits

Issues concerning COB can be complex because they may involve multiple internal entities, such as CMS' Office of Financial Management, and external entities, such as employer group health plans. Within the OMO, for example, COB issues for Medicare Parts A and B (traditional Medicare) may be handled by both the Division of Medicare Ombudsman Assistance and the Division of Ombudsman Exceptions, if comprehensive analysis and manual correction of data records are

required. Additionally, the Division of Medicare Ombudsman Assistance caseworkers' involvement may be needed if an issue involves benefit coverage concerns.

COB-related issues have the potential to affect most Medicare enrollees. Roughly 87 percent of Medicare enrollees had some type of supplemental coverage in 2009. An estimated 12.2 million (26.6 percent of all Medicare beneficiaries) had a Medigap plan; and 11.6 million (25 percent) had supplemental coverage through private group health plans (see Figure 9). Together, these two insurance plan types accounted for over half of the supplemental coverage received by Medicare beneficiaries.
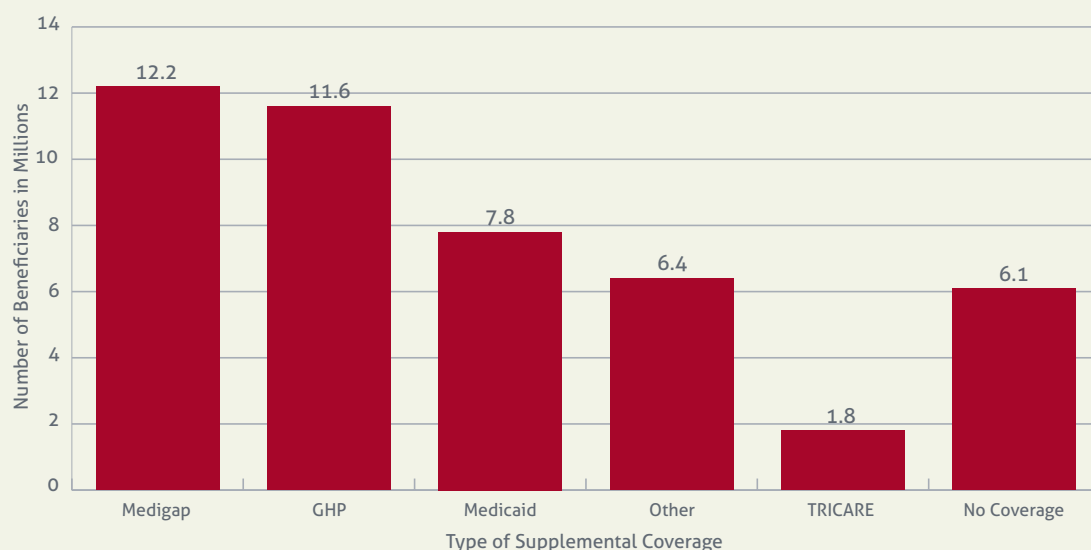
Coordination of benefit activities can adversely affect beneficiaries and their family members who become involved in a beneficiary's health care. The rules governing COB are complex and may not be readily apparent to beneficiaries and their families. Beneficiaries do not always have or understand the information they need to present to providers and payers, including Medicare, so that claims requiring COB can be appropriately adjudicated. Resolving COB issues can be time consuming, involve multiple phone calls, create beneficiary financial concerns, and cause stress for individuals already managing health issues.

Medicare COB also adversely affects providers. Beneficiaries often turn first to providers for information and help with understanding and resolving COB issues. In addition, providers frequently must deal with COB when they seek payment for services: the complexity of COB often results in delayed payment to providers.

Coordination of benefits issues arise for many reasons, including:

- Beneficiaries have a poor understanding of their other coverage and how it coordinates with Medicare.
- Providers lack sufficient knowledge of COB issues to assist beneficiaries.
- It is difficult to maintain current records on beneficiaries' supplemental forms of coverage due to the timing of updates and conflicting information from different sources, which can result in the overwriting of records.
- The complexity related to primacy rules for beneficiaries with end-stage renal disease (ESRD) and workers' compensation claims.

Figure 9. Number of Medicare beneficiaries, by type of supplemental coverage, 2009

SOURCE: Coordination of Benefits Contractor, 2009

While coordination of benefits situations arise with all of the sources of supplemental coverage, issues are reportedly most common, challenging, and have a more serious impact for beneficiaries and providers where Medicare is the secondary payer. In these situations, conflicts among payers and confusion about payment rules may lead to the denial of payments, the over-or underpayment of claims, and beneficiary confusion. Coordination of benefit issues arising from workers' compensation and liability and no-fault insurance can be particularly complex and difficult to resolve because the primacy of coverage is related to a subset of specific conditions and injuries. In these cases, delays in corrections or updates of settlement information and the complexity of claims adjudication can result in denied payment of claims.

As a first response to nonsystemic COB challenges, the OMO contributed to the revision of a CMS publication titled *Medicare and Other Health Benefits: Your Guide to Who Pays First.*

Other actions CMS can undertake to rectify nonsystemic COB challenges include:

- Improve accessibility of COB-related information by using a single point of access for information on CMS' website.

- Provide a more visible placement for the *Who Pays First* guide on Medicare.gov.

- Distribute appropriate information tools (such as fact sheets and quick reference guides) to providers so they can assist beneficiaries to make informed decisions.

- Replace English links and language on the Spanish version Medicare.gov site.

- Develop educational materials for beneficiaries and providers on the first payers for disability-related services and how ESRD rules affect reimbursement.

CASE STUDY

Beneficiary Overpayment: Systems Duplication Errors

Issues in COB can result in beneficiaries being liable for provider bills that should be paid by Medicare. The OMO works with individuals to resolve such issues and to ensure that beneficiaries receive appropriate refunds.

A female beneficiary contacted the OMO because she was unable to obtain a refund for overpayment of a premium payment to a Medicare contractor. According to the beneficiary, the Social Security Administration (SSA) erroneously used two Social Security numbers (SSNs) to withhold her premium payments from her Social Security check. A caseworker from the Division of Medicare Ombudsman Assistance (DMOA) reviewed the beneficiary's record and confirmed that both of the SSNs had been transferred to the Common Working File (CWF). The DMOA caseworker alerted the appropriate Medicare component of the error. To rectify the problem, the Division of Ombudsman Exceptions (DOE) corrected the CWF to reflect only one SSN. Once this change occurred, the beneficiary could receive her refund for the overpayment. The OMO caseworker and the Medicare contractor collaborated to ensure that the beneficiary's records reflected one SSN in her plan record, and the plan resubmitted the denied claims for processing. Within 2 days of contacting the OMO, the caseworker called the beneficiary to inform her that the Medicare contractor would be issuing a refund check.

As a first response to nonsystemic COB challenges, the OMO contributed to the revision of a CMS publication titled Medicare and Other Benefits: Your Guide to Who Pays First.

The OMO's 2009 COB study identified other systemic challenges—namely, data integrity issues, provider-related factors affecting timely reimbursement, and the lack of industry-wide standards for explaining benefits. Data integrity issues pertain to preventing data inaccuracies from occurring within the Common Working File. These inaccuracies can arise for several reasons, such as data system overwrites of new beneficiary coverage information and multiple data entries for single beneficiaries.

In order to improve standardization of data collection and data integrity, the OMO recommends that CMS do the following:

- Accelerate the OFM workgroup's development of "hierarchy rules" for updating CWF records to prevent beneficiary data overwrites.

- Assist the Coordination of Benefits Contractor (COBC) with flagging beneficiary data when beneficiary data change requests are inconsistent with previous requests, so as to prevent duplication errors within the CWF.

- Coordinate the standardization of industry-wide explanation of benefits (EOB) codes and messaging.

The OMO will forward recommendations in 2010 to its agency partners to solicit feedback.

CASE STUDY

Medicare Secondary Payer: Manual Data System Override

The OMO works closely with various beneficiary assistance entities to resolve issues, which sometimes requires performing the manual deletion of erroneous records.

In one case, a male beneficiary contacted the OMO via e-mail on behalf of his spouse, indicating that Medicare was erroneously designated as a secondary payer and that this designation was impeding Medicare's processing of his wife's claim. The OMO caseworker reviewed the spouse's records in the Common Working File and confirmed that there were two open Medicare Secondary Payer (MSP) files. To prevent Medicare claim denials, the open MSP files needed to be deleted from the spousal beneficiary's record. The caseworker contacted CMS' Coordination of Benefits Contractor (COBC) for assistance. Two days after contacting the beneficiary, the OMO and COBC staff manually deleted the MSP files. The OMO caseworker contacted the Medicare Administrative Contractor (MAC) with this information, requesting that the MAC flag the beneficiary's record to expedite his wife's claims. The OMO caseworker followed up daily with the MAC to ensure that the data system override was in effect. Within 4 days of the beneficiary's first contacting the OMO, the issue was resolved and the beneficiary's wife was able to obtain preapproval for an upcoming mammogram. The OMO caseworker informed the beneficiary by phone that the issue was resolved, and that his wife could resubmit any denied claims and submit upcoming claims.

Health Care Disparities

In the first quarter of 2009, the OMO established the OMO Health Disparities Workgroup, the purpose of which was to collaborate with internal CMS partners to develop programs that would help to reduce health disparities for Medicare beneficiaries. Health disparities frequently occur as a result of barriers in access to care due to financial limitations, provider availability, and language proficiency. Consistent with the Department of Health & Human Services' Strategic Plan, the workgroup identified three matters that require CMS' immediate attention:

- The need for effective methods of disseminating information to beneficiaries

- Language access issues

- Disease prevention initiatives

Limited English Proficiency

On the basis of the workgroup's recommendations, the OMO drafted a white paper on the effect of limited English proficiency (LEP) on Medicare beneficiaries. This draft white paper identifies LEP beneficiaries' challenges in accessing health care and recommends ways CMS can better provide information to these beneficiaries.

In drafting the white paper, the OMO worked with several entities within and outside CMS. The nature and scope of the LEP issue for Medicare beneficiaries is highlighted in a Census Bureau report on language use in the Unites States.[9] The Census Bureau's report, *Language Use in the United States*, analyzed 2007 data on American communities and found the following:

- Of the 281.1 million people aged 5 and older, 55.4 million (20 percent) spoke a language other than English at home.

- Of the 55.4 million mentioned above, 62 percent spoke Spanish, 19 percent spoke another Indo-European language, 15 percent spoke an Asian/Pacific Island language, and 4 percent spoke "other" languages.

- Fourteen percent of non-English speakers overall were aged 65 or older.

- Seven and a half percent (4.1 million) of those aged 65 or older reported they speak English "less than well."

- Sixty-five percent of Spanish speakers aged 65 or older reported they speak English "less than well."

Furthermore, according to the OMO white paper, approximately 12 percent (or 5 million Medicare beneficiaries) belong to a non-English-speaking ethnic group.[10] Many of these beneficiaries are LEP, meaning they cannot speak, read, write, and/or understand English at a level that permits them to interact effectively with medical personnel and to make sound decisions.[11]

In 2007, a Government Accountability Office (GAO) report estimated that of the more than 30 million calls to the 1-800-MEDICARE helpline, 1 million callers were assisted in a language other than English.[12] A total of 98 percent of those calls were from Spanish-speaking individuals. The GAO report identified 134 Medicare documents (e.g., general educational materials, forms, and notices specific to individual beneficiaries' coverage), and found that 117 documents were translated into Spanish and seven documents were available in Chinese, Korean, and Vietnamese (note: as of the 2009 GAO report, nine publications on the Medicare.gov website are available in Chinese, Korean, and Vietnamese).[13]

Although CMS has translated most Medicare documents into Spanish, the GAO noted the paucity of documents available in other languages mentioned in comments by many external stakeholders. Specific complaints addressed the lack of documents translated into Native American languages. Providers have taken it upon themselves to assist in overcoming

9 Census. (2010). *Language Use in the United States 2007: American Community Survey Reports.* Retrieved June 8, 2010, from http://www.census.gov/prod/2010pubs/acs-12.pdf

10 Kaiser Family Foundation (2008). *State Health Facts: Distribution of Medicare Enrollees by Race/Ethnicity, States (2007 2008), U.S. (2008).* Retrieved June 8, 2010, from http://www.statehealthfacts.org/comparebar.jsp?typ=1&ind=297&cat=6&sub=75

11 OMO. (2010) *CMS Limited English Proficiency White Paper.* Personal Communication. March 10, 2010.

12 Government Accountability Office (2008). *Medicare Report: Callers Can Access 1-800-MEDICARE Services, but Responsibility within CMS for Limited English Proficiency Plan Unclear.* Retrieved June 8, 2010, from http://www.gao.gov/new.items/d09104.pdf

13 Government Accountability Office. (2009). *CMS Language Access Policy Report.* Retrieved June 8, 2010, from http://www.gao.gov/new.items/d09752r.pdf

these language challenges by obtaining language-appropriate information for many beneficiaries.

A brief developed by the AARP, which summarizes survey findings and other research about the ease of access to care among Spanish, Asian, and English language speakers, indicates that language barriers can create challenges between patients and providers. The brief also notes that language barriers can lead to situations where LEP beneficiaries are at higher risk of receiving suboptimal care. Other findings noted in the brief include:[14]

- LEP Medicare beneficiaries have limited access to the usual sources of health care, receiving fewer cancer screenings than those individuals who were not LEP.

- Spanish-speaking beneficiaries are less likely than those more proficient in English to understand fully their diagnoses or to follow providers' instructions.
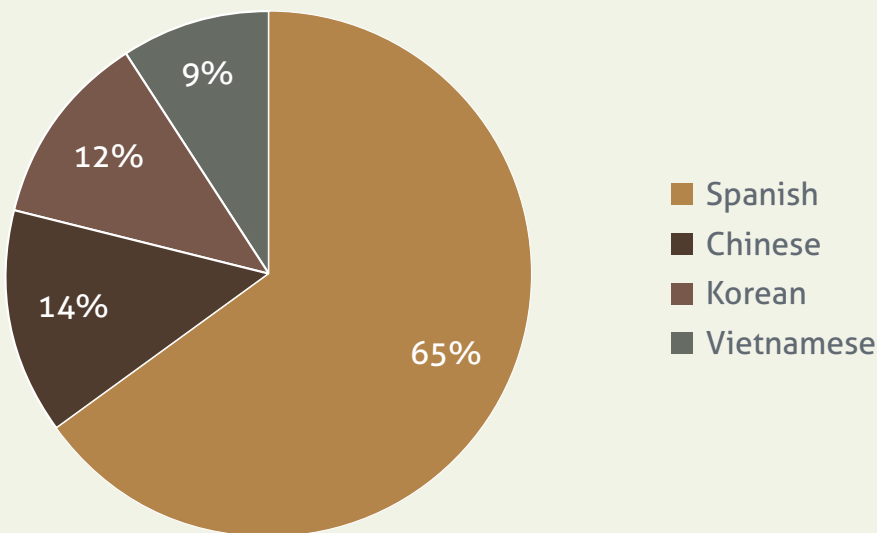
- LEP beneficiaries whose providers do not speak the patient's language report more medication-related problems.

- LEP Asian beneficiaries whose providers do not speak the patient's language are less likely to receive primary prevention education, compared with beneficiaries having same-language providers.

- Fifty-six percent of Hispanic and 44 percent of Asian Medicare beneficiaries reported difficulties with following instructions on prescription bottle labels.

To comply with Title VI of the Civil Rights Amendment provisions and a 2000 presidential executive order,[15] CMS published a Medicare Part A policy manual articulating meaningful language access to care. The manual encourages hospitals to make multilingual services available to all who need them. In addition, CMS requires MA and prescription drug plans to provide oral and written language access services.

14 AARP. (2006). *Improving Access to Care Among Medicare Beneficiaries With Limited English Proficiency.* Retrieved June 8, 2010, from http://assets.aarp.org/rgcenter/health/i6_medicare.pdf

15 US Department of Justice. (2000). *EXECUTIVE ORDER 13166. Improving Access to Services for Persons With Limited English Proficiency.* Retrieved June 8, 2010, from http://www.justice.gov/crt/cor/Pubs/eolep.php

Figure 10. Percentage of website downloads for documents in languages other than English, 2009

- Spanish
- Chinese
- Korean
- Vietnamese

65% Spanish, 14% Chinese, 12% Korean, 9% Vietnamese

SOURCE: Office of Beneficiary Information Services, Website Project Management Group, 2009

CMS publishes informational documents in Spanish, Chinese, Vietnamese, and Korean.

CMS has established a Spanish language website and publishes the *Medicare & You* handbook in Spanish. In 2009, there were over 289,000 hits on the Spanish Medicare.gov website. CMS also publishes informational documents in Chinese, Vietnamese, and Korean.

Overall, there were 62,411 multilanguage downloads in 2009. The two most popular multilanguage documents were *Medicare Coverage of Diabetes and Supplies* and *What is Medicare? What is Medicaid?* These documents accounted for 58 percent of total downloads. The multilanguage documents are available in Spanish, Chinese, Korean, and Vietnamese. Most of these downloads were for documents in Spanish (see figure 10).

The LEP white paper that the OMO produced also recommends that information be provided through new social media formats (e.g., YouTube, Twitter, and Facebook). The use of social media formats is growing among Medicare beneficiary caregivers and increasingly among beneficiaries themselves. These new social media provide more immediate access to current information and can alert users in a more timely fashion when new information becomes available.

The OMO remains keenly aware that only 38 percent of all Medicare beneficiaries and/or their caregivers or advocates access the Internet,[16] and among low-income beneficiaries, more than 68 percent do not have access to the Internet. The OMO will continue to work on improving information access through its partners in 2010.

Qualified Medicare Beneficiaries (QMBs) and Balance Billing

Low-income individuals who receive Medicare may also qualify for Medicaid benefits. The Medicare Catastrophic Coverage Act of 1988 requires

Medicaid to provide cost-sharing subsidies to certain dually eligible individuals. Low-income Medicare beneficiaries may be eligible to receive Medicare premium and cost-sharing subsidies through the Qualified Medicare Beneficiary (QMB) program. Under the QMB program, eligible beneficiaries are entitled to Medicare Part A and are eligible for Medicare Part B (an optional program). Medicaid pays the Medicare premiums, deductibles, co-insurance, and copays for Parts A and B.

According to the Medicare physician fee schedule, when a provider files a claim, Medicare typically pays 80 percent of the amount allowed by Medicare and Medicaid pays the 20 percent coinsurance amount (for those services covered by both Medicaid and Medicare). As amended by the Balanced Budget Act of 1997, however, the Social Security Act makes clear that Medicaid pays no more for a service received by a Qualified Medicare Beneficiary (QMB) than it would normally pay for other Medicaid-eligible beneficiaries. As a result, providers may receive only partial payment for services provided to QMBs because of low Medicaid reimbursement rates in some states. State Medicaid reimbursement rates to providers are frequently set below Medicare rates. Providers, however, are prohibited by statute from billing beneficiaries for the difference between Medicaid rates and either their charges or Medicare payment rates to make up the shortfall, a practice called "balance billing."

The practice of balance billing could increase the financial stress experienced by QMBs, who may be unaware that they do not have to pay the balance billed. Some QMBs may feel the need to pay the balance to maintain a relationship with the provider and ensure continuity of care. As a result, the practice of balance billing could impose real or perceived financial barriers for QMBs to access care.

QMBs' access to care could also be affected if providers are deterred from seeing QMBs because of the low Medicaid reimbursements and prohibitions on balance billings. Moreover, providers are concerned that the act of billing Medicaid for care provided to a QMB may automatically designate them as a Medicaid provider.

16 Pew Charitable Trust. (2010). *Demographics of Internet users.* Retrieved June 8 2010, from http://www.pewinternet.org/Trend-Data/Whos-Online.aspx

Although there is no federal statute dictating how states must enroll providers into Medicaid, Section 3490.14 of the State Medicaid Manual instructs that states may enroll providers for the services furnished to the individual QMB through the submission of a claim. An OMO study found that no states allowed QMB providers to enroll simply by billing the Medicaid agency.

The OMO was alerted to the balance billing challenge that low-income beneficiaries face, contrary to the statutory prohibition on such practice, during one of the bimonthly Medicare Ombudsman Partner and Beneficiary Meetings. As a result, the OMO initiated a study to provide an overview of the federal guidelines governing the QMB issue and the state of Medicaid practices for enrolling QMB providers. On the basis of the findings of its review of this issue, the OMO presents the following long-term recommendations for CMS' deliberation to overcome the systemic challenges posed to both providers and QMBs:

- Ensure the development of additional scripts for 1-800-MEDICARE that address specific questions posed by both beneficiaries and providers.
- Establish a joint working group among Medicare and Medicaid officials and program managers to define and clarify statutes and regulations for provider enrollment.
- Develop effective and appropriate processes and materials for assisting Medicaid officials to disseminate information to providers on the registration process.
- Encourage states to include in their provider education materials the QMB balance billing prohibitions that were mandated by the Balanced Budget Act of 1997.

Minority Populations' Underutilization of Long-Term Care Facilities

Cultural factors influence access to long-term care (LTC) in institutional settings for Asian American, Pacific

CASE STUDY

Qualified Medicare Beneficiaries (QMBs) and Balance Billing

Low-income Medicare beneficiaries may qualify for state Medicaid benefits under the provisions of the Medicare Catastrophic Coverage Act of 1988. The challenge facing beneficiaries arises when the state Medicaid reimbursement to providers is insufficient to cover the provider's costs for giving care. In this circumstance, some beneficiaries are directly billed by providers for the difference between the Medicare reimbursement and the provider's costs, although this practice is not allowable.

The OMO received a complaint from a female beneficiary about a bill from her physician. She indicated that this bill reflected a payment for the total annual Medicare deductible. An OMO caseworker contacted the physician's office and was informed that the office did not accept Medicaid patients; therefore, service claims were submitted to Medicare. When the claim was denied, the physician's office billed the beneficiary. Suspecting that the beneficiary was a QMB, the caseworkers contacted the Medicare Administrative Contractor (MAC) to confirm. The MAC data system confirmed that the beneficiary was indeed a QMB. The MAC system also indicated that the beneficiary's state Medicaid office had been notified to pay the beneficiary's portion of the deductible. The caseworker called the beneficiary and explained to her that because she was categorized as a QMB, she would need to contact her state Medicaid office to ascertain her share of the deductible. Within 26 days of the initial contact with the OMO, the case was resolved to the satisfaction of all parties.

Islanders, and other cultural groups. On the basis of the Census data of 1990, it is estimated that about 1.4 percent of Chinese Americans aged 65 or older lived in nursing homes, compared with the overall rate of 5 percent for all Americans in that age group.[17]

The degree of utilization of institutional LTC depends on acceptance of this type of service by patients and their families, and on barriers such as mistrust, lack of resources, family responsibilities, and a perceived loss of community respect for placing an elder in an institution. Impediments to accessing LTC and other health care include geographic and economic barriers, lack of English language proficiency, and a paucity of culturally competent services.

Regardless of cultural factors, many beneficiaries and their families prefer to receive LTC services at home and in their communities. As a result, Medicaid spending on home-and-community-based services (HCBS) has grown significantly as a share of total LTC expenditures. Despite the overall growth, Medicaid spending on HCBS as a share of total LTC expenditures varies widely among states, ranging from 13 percent in Mississippi to 73 percent in New Mexico.[18] In addition, overall demand for HCBS exceeds availability as 38 states had waiting lists for Medicaid HCBS in 2008.

During the course of its investigation into use of LTC services by minorities, the OMO learned the following:

- States have different home-and-community-based waiver (HCBW) requirements.

- Depending on the waiver type, states have the discretion to allow payment for care supplied by family members.

- Most states operate multiple waiver systems, and not all waiver systems allow payment to family members, creating a lack of uniformity in waiver systems.

17 Tom, Linda. (1998). *Health and Health Care for CHINESE-AMERICAN ELDERS.* Retrieved on June 8, 2010, from http://www.stanford.edu/group/ethnoger/chinese.html

18 Kaiser Family Foundation (2010). *Medicaid and Long-Term Care Services & Support. Kaiser Commission on Medicaid and the Uninsured.* Retrieved February 1, 2011 at http://www.kff.org/medicaid/upload/2186-07.pdf

To better inform beneficiaries of available resources to obtain HCBS, the OMO recommends providing state-based information on Medicare.gov, with direct links to the state assistance websites and related information. This recommendation was timely, given the expansion of access to Medicaid programs by the Affordable Care Act. The OMO also facilitated the development of language to be included in the 2011 *Medicare & You* handbook. This language will provide information to all Medicare beneficiaries, including Asian and Pacific Islander beneficiaries, about the state-level options for community-based care.

Medicare Prescription Drug and Health Plan Issues

Introduction

In January 2006, Medicare added a voluntary outpatient prescription drug benefit (Part D). The benefit is available through private plans that compete for Medicare enrollees. Beneficiaries generally can obtain Medicare drug coverage through a stand-alone prescription drug plan (PDP) or a Medicare Advantage plan that provides coverage for both medical care (through Parts A and B) and prescription drugs (through Part D).

Medicare subsidizes beneficiaries' Part D premiums and drug costs, although premiums and cost-sharing requirements may differ depending on the plan chosen and an individual beneficiary's resources. Qualifying beneficiaries can receive extra help to cover the cost of prescription drugs through a low-income subsidy (LIS). Approximately one quarter of Medicare Part D beneficiaries are eligible to participate in the LIS program.

Low-Income Subsidy Grace Period

Beneficiaries qualifying for LIS receive full or partial subsidies for premiums and reduced cost sharing based on income and resources. There are two ways in which a beneficiary may qualify for LIS. First, certain groups of Medicare beneficiaries automatically qualify and are deemed LIS-eligible. These beneficiaries, who are automatically enrolled into an eligible plan by CMS, include full-benefit dually eligible individuals, partial dually eligible individuals (QMBs-only), specified low-income Medicare beneficiaries (SLMBs-only), qualifying individuals (QIs), and people who

receive supplemental security income (SSI) benefits but not Medicaid. Secondly, low-income beneficiaries who do not automatically qualify may apply to determine their LIS eligibility.

Each year, CMS re-evaluates, through a redeeming process, the LIS eligibility of those beneficiaries deemed LIS eligible (i.e., those beneficiaries who automatically qualified because of Medicaid status, SSI, or low income). In addition, each year, SSA sends a letter to a group of LIS-eligible beneficiaries whose status needs to be re-determined for the following year. By late September, beneficiaries who must apply for the low-income subsidy or have their status re-determined receive a notice along with instructions on how to complete the process.

Beneficiaries who lose their LIS eligibility because they are not redeemed or who are selected by SSA for redetermination must take action to maintain their LIS status. For varying reasons, some beneficiaries do not complete the application process for the low-income subsidy prior to the start of the new coverage year. In these cases, the beneficiary may be charged the full cost of the premium and cost sharing, although the beneficiary may eventually regain LIS status. Higher premium and cost-sharing requirements could result in beneficiaries losing access to medically necessary medications.

Relatively few Part D plans offered a low-income subsidy grace period to beneficiaries who lost their LIS-deemed status in 2009. Plans have little incentive to offer an optional grace period, as it imposes an administrative burden, and places plans at some financial risk. If a plan does offer a grace period, the grace period must be available to all of the plan's beneficiaries that meet the requirements. If the grace period expires and a beneficiary does not appear to be LIS-eligible or has not submitted best available evidence (BAE) documentation, the plan is allowed to pursue payment recoupment from the beneficiary for premiums and other cost sharing. It can take time and effort to recover underpayment for premiums and cost sharing and a plan may not be able to recover payments at all. On the other hand, plans that offer a grace period may be viewed as more desirable by LIS-eligible beneficiaries, which may increase plan enrollment.

Relatively few Part D plans offered a grace period to LIS-eligible beneficiaries in 2009.

The main challenges for LIS beneficiaries (within the redetermination period) are twofold: their ability to comprehend the written or verbal information provided by CMS and SSA, and their ability to act on that information.

Therefore CMS should consider the following recommendations:

- Require that PDPs offer an LIS grace period as a condition for receiving automatic assignment of LIS-eligible beneficiaries.
- Enhance its outreach directly to beneficiaries at pharmacies and other key areas to urge current LIS-eligible beneficiaries to make sure they pay attention to notices they receive from Social Security and Medicare beginning in September, and to call the SSA or CMS if they are not sure what their LIS status may be for the upcoming year.

CASE STUDY

Disenrollment due to Nonpayment of Premiums

A male beneficiary with mental health challenges who was receiving Social Security Disability Insurance (SSDI) was disenrolled due to failure to pay one of his Medicare Advantage plan premiums. The nature of the beneficiary's disability requires constant access to medication. The beneficiary contacted the OMO regarding his disenrollment. The OMO identified that the rules articulated in chapter 2 of the Medicare Prescription Drug Benefit policy manual prohibited the beneficiary from reenrolling into the same plan until his past due premiums were paid. Within 8 days of first contact, the OMO advised the beneficiary of the Medicare rules but also indicated that he would be enrolled into a traditional Medicare plan. While this resolution did not provide direct access to prescription drugs for the beneficiary, it presented a short-term resolution for obtaining needed medication through emergency visits.

Part D: Disenrollment Due to Nonpayment of Premiums

Sponsors of Medicare Part D plans may disenroll beneficiaries who fail to pay premiums in a timely fashion after a grace period and after providing proper notice. In 2009, MA-PD plans were required to provide at least a one-month grace period and proper notice before disenrolling a beneficiary (at the time of the release of this report a mandatory two-month grace period was required). Additionally, MA-PD plans may downgrade coverage if the beneficiary pays the premium for basic and mandatory supplemental benefits but fails to pay the premium for optional supplemental plan benefits. During the same time period, PDPs had discretion on whether or not to provide a grace period and on the length of the grace period, if one was offered. Regardless of how sponsors choose to handle nonpayment of premiums, a sponsor must apply its policy equally to all plan enrollees except that, as discussed above, the plan may offer an optional grace period of up to 3 months to LIS beneficiaries who lose their deemed status and are applying for an LIS determination.

If a plan sponsor chooses to disenroll a member, it first must make a reasonable effort to collect payment and to provide a notice to the affected member. In addition, sponsors are not permitted to disenroll a beneficiary for nonpayment of premiums in special circumstances, such as cases where beneficiaries have requested that premiums be withheld from their Social Security checks.

Medicare beneficiaries may have limited opportunities to obtain drug coverage, aside from enrollment in a Part D plan. The open enrollment period each year is from November 15th through December 31st,[19] although LIS-eligible beneficiaries have a special enrollment period that is continuous throughout the duration of their LIS eligibility. In contrast, a beneficiary who is involuntarily disenrolled from a Medicare Advantage plan is placed in traditional Medicare (Part A and Part B) and still receives medical coverage.

The health consequences of disenrollment from a Medicare Part D plan due to nonpayment of premiums could be significant if the disenrolled beneficiary cannot obtain his or her medically necessary medications. One of the notable issues related to plan disenrollments is that some plans have delayed disenrollments of beneficiaries throughout a given year, and have disenrolled beneficiaries en masse outside of the annual enrollment period, preventing these beneficiaries from obtaining drug coverage until they reached an enrollment period sometime later. This also creates spikes for the need for customer service to address the questions and concerns of the affected beneficiaries, and to assist them with their drug coverage.

19 Beginning in 2011 for plan year 2012, the open enrollment period will be from October 15 to December 7.

CASE STUDY

Part D: Insufficient Notice Provision on Pending Disenrollment

The OMO received an e-mail from a couple regarding an erroneous disenrollment from a Part D plan. According to the beneficiaries, their employer had cancelled their retiree drug coverage and had failed to notify them of the change. They discovered the disenrollment only after checking the MyMedicare.gov website. The couple also found that they had been automatically reassigned to a prescription drug plan (PDP). The beneficiaries indicated that they had made numerous calls to the PDP but were informed that there was no record of enrollment. They had also called various divisions within CMS but were unable to correct the problem. An OMO caseworker reviewed the Common Working File (CWF) and found that the retiree's drug plan was still active as the first payer on the beneficiaries' records. Within 2 days of first contact, the OMO caseworker deactivated the retiree drug plan and retroactively reenrolled the couple into a PDP of their choice. In addition, the caseworker—working with the SSA—modified the method of premium withholding and contacted the new PDP and the retiree drug plan about the changes to the beneficiaries' records in the CWF and SSA data systems. Four days after the first contact, the caseworker called the beneficiaries to inform them that their issue was resolved within the system and that they could begin resubmitting their claims to the PDP for processing.

The OMO's recommendations for CMS to address the problem of Part D disenrollment due to nonpayment of premiums include the following:

- CMS should discourage plans from conducting mass disenrollments, especially during periods when beneficiaries do not have an option to enroll in a new Part D plan.

- CMS should encourage all plans to offer one-time flexible repayment plans for beneficiaries who have fallen behind on their premium payments.

OTHER ISSUES REVIEWED BY THE OMO

The OMO addressed topics other than those described in the detailed analysis section, including nonreimbursement, excessive provider billing, and domestic partner coverage. Three examples are described below.

Nonreimbursement for Off-Label Uses of Drugs Prescribed for Rare Diseases

In July 2009, the National Organization for Rare Disorders informed the OMO that beneficiaries were having difficulty obtaining Medicare coverage for off-label uses of drugs that are prescribed to treat symptoms of rare conditions for which there are currently no specific therapies. The OMO's external partners indicated they believed that the root cause of the problem could involve inconsistencies in the application of Medicare Part B and Part D coverage rules.

The OMO noted that Medicare would not pay for drugs that did not have a primary or secondary treatment indication. As required under statute, Medicare excludes payment under Medicare Part D for drugs that are prescribed for uses other than those approved by the Food and Drug Administration (FDA) or supported by one or more citations included or approved for inclusion in specific medical compendia. The investigation confirmed the inconsistencies between Part B and Part D regulations. From discussions with advocacy groups and others, the OMO learned the following:

- The current standards for coverage of off-label drugs under Medicare Part D are sometimes inconsistent with evidence of effectiveness found in peer-reviewed literature.

CASE STUDY

Part D: Disenrollment due to Nonpayment of Premiums

The OMO received an e-mail from a female beneficiary regarding erroneous disenrollment for nonpayment of premiums. The beneficiary was disenrolled from a PDP without proper notification, despite having paid all past premiums. Within 6 days of receiving the inquiry, the OMO caseworker, in collaboration with the PDP account manager, ensured that the beneficiary was retroactively reenrolled through the provisions of a special enrollment period. The PDP updated its records to allow the beneficiary to resubmit claims for the four medically necessary prescription drugs she was taking and mailed reimbursement forms to the beneficiary to enable her to claim any out-of-pocket expenses incurred. The OMO caseworker also contacted the pharmacy, advising it to reprocess all of the beneficiary's denied claims and to process any pending claims.

- Part D regulations are also sometimes inconsistent with Medicare Part B regulations, many Medicaid programs, and private insurance rules.

As a result of its investigation, the OMO noted that statutory changes would be required to address this issue.

Excessive Expenses Incurred by Beneficiaries and Medicare for Oxygen Supply

In the second quarter of 2009, the OMO learned from beneficiaries and their advocacy groups about the excessive costs incurred for renting oxygen equipment versus the cost to purchase the same equipment. Medicare pays durable medical equipment (DME) suppliers for the rental of oxygen equipment for a period of continuous use of up to 36 months, provided medical necessity for the oxygen equipment continues during this time. Following the end of the 36-month rental period, a supplier who provides oxygen equipment during a beneficiary's 36th rental month must continue to provide oxygen and the equipment, maintenance, repairs, and accessories at no additional cost to either Medicare or the beneficiary for the remainder of the useful life of the equipment, or at least 5 years from the date that the equipment was first delivered to the beneficiary. Medicare pays 80 percent of the cost of the rental, and the beneficiary is responsible for the remaining 20 percent. The amount beneficiaries pay, however, can be higher if they are

enrolled in a Medicare Advantage (MA) plan. The OMO investigation confirmed that long-term rental of oxygen costs beneficiaries and Medicare more in the end than simply purchasing the equipment outright. A change in this provision would require congressional action.[20] The competitive bidding program for Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) may address this issue.

Domestic Partner Coverage

At the beginning of the third quarter of 2009, the AARP informed the OMO that no information was available on the Medicare.gov website about benefits for Medicare beneficiaries' domestic partners. In addition, if a beneficiary receives health coverage through a domestic partner, Medicare does not equate the relationship to a marital one. In a marriage, the working spouse's insurance pays first, and Medicare pays second; but in a domestic partner relationship, it is the opposite: Medicare pays first, and the employer-sponsored insurance pays second.

The OMO reached out to the Office of Financial Management (OFM) and the Financial Services Group-Division of Medicare Benefit Coordination to obtain clarification on CMS' policy. The OMO learned that no covered individual described and reported as a

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20 Social Security Administration. (1987). P.L. 100-203, Approved December 22, 1987 (101 Stat. 1330). *Omnibus Budget Reconciliation Act of 1987 Section 4062*. Retrieved June 8, 2010, from http://www.ssa.gov/OP_Home/comp2/F100-203.html

is the opposite: Medicare pays first, and the employer-sponsored insurance pays second.

The OMO reached out to the Office of Financial Management (OFM) and the Financial Services Group-Division of Medicare Benefit Coordination to obtain clarification on CMS' policy. The OMO learned that no covered individual described and reported as a "domestic partner," who is eligible for Medicare due to age, is considered a family member by Medicare. As a general rule, CMS does not recognize domestic partner relationships, except under the following two circumstances:

- An employer-sponsored group health plan (GHP) reports coverage of an individual using "domestic partner" as a qualifying relationship.
- The covered individual is a Medicare beneficiary who has eligibility due to disability or ESRD.

Under these circumstances, Medicare regulations have been interpreted to permit CMS to extend "family member" coverage to a domestic partner.

In response to the complications in interpretation created by the different statutory provisions, the OMO developed a fact sheet to inform beneficiaries and their partners about this issue. Some of the information is contained in the fact sheet entitled *Medicare and Other Health Benefits: Your Guide to Who Pays First.*

Figure 11 provides a brief issue description along with a status update as of December 31, 2009 about the remaining issues the OMO evaluated and attempted to resolve in 2009.

Figure 11. Status of other issues

Issue	Issue description	Status as of December 31, 2009
Beneficiary confusion with premium billing	During an internal issue review meeting, analysts noted that a small number of beneficiaries were remitting premium payments to the OMO instead of to their respective plans.	The OMO found that the low-income subsidy (LIS) plan enrollment letters and the Medicare.gov website provided inconsistent information about remitting premium payments. CMS updated the beneficiary letters, the Medicare.gov website, and the *Medicare & You* handbook.
Beneficiary access to drugs removed from a plan's formulary	The OMO identified a potential issue for beneficiaries whose medications are removed from a plan's formulary.	The OMO's investigation found that beneficiary protections are adequate and appropriate, requiring no further action.
Infusion therapy	At a 2009 National Medicare Education Program Alliance meeting, advocates raised concerns that beneficiaries were not receiving timely access to home infusion therapy.	The OMO is monitoring complaint volume related to this issue.
Zostavax® shingles vaccine	The New York RO alerted the OMO that providers were not aware that the Zostavax® shingles vaccine was not covered under Medicare Part B but was instead covered under Medicare Part D. Thus, beneficiaries would have to enroll in a Part D plan in order to receive coverage of the vaccine.	The OMO found a lack of adequate information available to beneficiaries and providers. CMS updated the *Medicare & You* handbook, developed a caregiver tip sheet, and increased RO outreach and education efforts.
Nonmatched National Drug Code list	The Center for Drug and Health Plan Choice informed the OMO that Part D plans would be encouraged to no longer cover medications with nonmatched National Drug Codes (NDCs) that were not listed in the National Food and Drug Administration (FDA) Drug Registration and Listing System as well as the FDA NDC Directory.	CMS facilitated the development of a 1-800-MEDICARE call script; the issue was also addressed during the National Casework Medicare Part D Call.
Beneficiaries issues in hospital outpatient settings	At the American Health Lawyers' Conference, the OMO was notified of issues including hospitals changing inpatient/outpatient statuses without notifying beneficiaries, skilled nursing facility coverage, self-administered drug coverage, and issuing advanced beneficiary notices.	The OMO presented its white paper, *Beneficiary Issues in Hospital Outpatient Settings*, to CMS leadership. Based on the OMO's findings, CMS updated the fact sheet entitled *Are You an Inpatient or Outpatient?- If You Are on Medicare–Ask!*

Issue	Issue description	Status as of December 31, 2009
Cognitive impairment/ dementia	At the 2009 State Health Insurance Assistance Program Conference, advocates relayed caregiver concerns that they believe Medicare requires beneficiaries who suffer from cognitive impairment and/or dementia to be present while their caregivers and doctors discuss their treatment plan. Advocates explained that candid discussion of treatment plans may agitate dementia patients.	The OMO worked closely with other CMS components to facilitate the development and publication of a fact sheet for beneficiaries and providers. The OMO raised awareness of this resource to the partner community.
State Health Insurance Assistance Program (SHIP) access to the Complaint Tracking Module (CTM)	During the first quarter of 2008, SHIPs expressed concern regarding the wait times when they contact 1-800-MEDICARE to log beneficiary complaints in the CTM.	The pilot project to extend CTM access to eight SHIPs began in March 2008. In 2009, 13 additional SHIPs were granted access to the CTM. The OMO offers ongoing support to provide CTM access and training to the SHIPs.