



FISCAL YEARS 2017–2019

Medicare

Beneficiary

Ombudsman

REPORT TO CONGRESS

Contents

A Message from the Ombudsman.....	1
Medicare and Marketplace Transitions.....	2
Considerations for Streamlining the Enrollment Process for Individuals Transitioning to Medicare	4
Data Highlight: Enrollment, Entitlement, and Eligibility Cases, FY 2017–FY 2019	5
Customer Accessibility Resource Staff Activities in FY 2017–FY 2019.....	7
Appendix: Center for Medicare, Medicare Parts C & D Online Complaint Data, FY 2017–FY 2019.....	8
References	13

A MESSAGE FROM THE OMBUDSMAN

It is my pleasure to present this Medicare Beneficiary Ombudsman (MBO) Report to Congress and the Secretary of the U.S. Department of Health & Human Services. I am privileged to support the mission of the Centers for Medicare & Medicaid Services (CMS) to protect the health and well-being of millions of Americans by making sure the needs of the populations we represent are considered as CMS develops, implements, and evaluates its programs and policies. As the MBO, my objectives are to promote fairness, bring the Medicare beneficiary experience to the attention of policymakers, provide stakeholders with relevant information related to the appeals process, and serve as an objective source of information and referrals.

This report highlights activities undertaken in support of the MBO's objectives by staff within the CMS' Offices of Hearings and Inquiries (OHI) and in close coordination with many CMS components. Strengthening stakeholder engagement was a primary focus of mine during this period. Interaction with both internal and external stakeholders provides crucial insight into how beneficiaries experience the Medicare program. Stakeholder engagement activities included coordinating feedback forums with various external partners throughout this reporting period to gather their perspectives, visiting CMS' regional locations to engage with staff and improve my partnership with local resources, participating in CMS' Patients over Paperwork initiativesⁱ, and joining in CMS Rural Roadshow activities. I also participated in direct outreach and Medicare training to groups, including the State Health Insurance Assistance Programs, insurance agents and brokers, and internal CMS staff, to improve understanding of transitions from the Marketplace to Medicare.

Engaging with stakeholders, participating in journey mapping activities, and analyzing inquiry trends helped identify areas for potential improvements specifically related to Medicare enrollment decisions. This will continue to be a focus of mine as we strive to improve our customers' understanding of the Medicare program.

As a note, future MBO Reports to Congress will cover a reporting period based on the calendar year, rather than the fiscal year (FY). This approach aligns the reporting cycle with the annual nature of many of Medicare's policies.

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

Catherine Rippey
Medicare Beneficiary Ombudsman

About the Ombudsman

In 2003, Congress established the Medicare Beneficiary Ombudsman (MBO) to assist Medicare beneficiaries with their inquiries, complaints, grievances, appeals, and requests for information, per Section 1808(c) of the Social Security Actⁱⁱ. This position is located in the CMS' OHI.

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

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

MEDICARE AND MARKETPLACE TRANSITIONS

Issuers of individual market coverage, as well as agents and brokers, are legally prohibited by Section 1882(d)(3)(A) of the Social Security Act (known as the Medicare anti-duplication provision) from selling coverage, including Marketplace Qualified Health Plans (QHPs), to beneficiaries who are already enrolled in Medicare with the knowledge that the coverage duplicates their Medicare benefits.ⁱⁱⁱ However, the statutory prohibition applies directly to issuers, agents, and brokers, not to the Marketplace itself. Therefore, the Marketplace does not have the legal authority to prevent beneficiaries already enrolled in Medicare from also enrolling in a QHP through the Marketplace. Additionally, issuers selling QHPs through the Marketplace may have no way of knowing whether consumers are already Medicare beneficiaries.

CMS components have worked together to ease the transition of enrollees from Marketplace to Medicare coverage and have made great strides in recent years, ensuring that consumers experience smooth transitions and avoid duplicative coverage, all while helping issuers observe the prohibition on selling or issuing duplicative Marketplace coverage to known Medicare beneficiaries. However, CMS continues to receive inquiries from Medicare beneficiaries who encountered challenges when transitioning from their Marketplace coverage to Medicare coverage. Partner and advocacy organizations also continue to escalate concerns. Beneficiaries need a clear understanding of Medicare enrollment and eligibility rules to avoid potential financial liabilities and gaps in coverage such as those described below.

MEDICARE DATA MATCHING FOR NEW ENROLLEES

Under current law, individuals generally may remain enrolled in their Marketplace QHP when they later become eligible for or enroll in Medicare Part A, but those individuals are not eligible to receive Marketplace premium and cost-sharing subsidies, called advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs),

respectively. Since its inception, the Marketplace has denied financial assistance to applicants who attested to being Medicare beneficiaries and ended financial assistance for new applicants whom CMS determined to be enrolled in Medicare who were unable to prove otherwise. The Marketplace application for applicants on Marketplaces using the federal eligibility and enrollment platform has helpful text for those at or approaching Medicare eligibility age directing them to Medicare. Some beneficiaries may not be aware that there are programs to help with Medicare out-of-pocket costs, such as the Medicare Savings Programs and the Part D Extra Help program. Further promotion of these programs could help improve the financial security for eligible beneficiaries when they transition from the Marketplace to Medicare.

Medicare Periodic Data Matching for Enrollees Who Age Into Medicare

In 2017–2018, the Marketplaces using the federal eligibility and enrollment platform focused on identifying Marketplace enrollees receiving financial assistance who later aged into Medicare and advising them that they should consider either ending their Marketplace financial assistance or ending their Marketplace coverage. However, during this period the Marketplace lacked automatic functionality to end financial assistance for enrollees found to be dually enrolled. Under this periodic data matching (PDM) effort, the Marketplaces using the federal eligibility and enrollment platform identified and notified Marketplace enrollees in Medicare Part A twice per year.

In 2019, the Marketplaces using the federal eligibility and enrollment platform added automated functionality to find and end financial assistance for Marketplace enrollees who were initially eligible for and receiving APTC but subsequently enrolled in Medicare without notifying the Marketplace. This automated Marketplace PDM activity finds and notifies dual enrollees and ends APTC or CSRs for enrollees who fail to respond. For enrollees who indicated on their initial Marketplace applications that they want their Marketplace coverage to end if the Marketplace finds them to be enrolled in Medicare, PDM also culminates in the termination of Marketplace coverage. In 2019, the Marketplace using the federal eligibility and enrollment platform identified, notified, and adjusted eligibility for

Medicare/Marketplace dual enrollees at four different times, due to these IT improvements.

Some beneficiaries may become dually enrolled because they assume that their Marketplace plans will end once they become Medicare eligible or enrolled. However, due to both operational and statutory reasons, the eligibility and enrollment information between the Marketplace and Medicare is not integrated across CMS. In other words, Marketplace and Medicare eligibility systems are not interoperable.

While the Marketplace asks every applicant seeking financial assistance about Medicare status, and actively searches for, notifies, and ends financial assistance for dual enrollees, some Medicare beneficiaries may mistakenly remain dually enrolled for a period of months. Individuals receiving APTC may be required to pay back all or some of the APTC they received while dually enrolled in Medicare Part A when they file their federal income taxes. This dual enrollment may also result in the individual's unnecessary duplicative premium payments to both the Marketplace QHP and Medicare. Some Marketplace-only enrollees aged 65 or older report experiencing coordination-of-benefit issues and claim denials that appear related to issuers treating enrollees as entitled to Part B coverage even if they have not enrolled in Part B. These claim denials pose challenges for beneficiaries accessing health care services.

Marketplace Non-Renewal for Dual Marketplace/Medicare Enrollees

In 2017, CMS was able to reduce periods of dual coverage by clarifying that guaranteed renewability of individual health insurance coverage did not ensure that coverage would be renewed for dual Medicare enrollees in some scenarios. The HHS Notice of Benefit and Payment Parameters for 2018 proposed and finalized a regulatory interpretation of the Medicare anti-duplication provision and the Public Health Service Act's individual market guaranteed renewability provisions. The interpretation of these provisions prohibits issuers that have knowledge that an enrollee in individual health insurance coverage is entitled to Medicare Part A or enrolled in Medicare Part B from renewing the individual health insurance coverage if it would duplicate Medicare or Medicaid benefits to which the enrollee is entitled unless the

renewal is effectuated under the same policy or contract of insurance.

State insurance rules determine when a change in policy or contract of insurance has occurred. QHP issuers that have knowledge that an enrollment covers a QHP enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B must non-renew the policy if the QHP reenrollment plan is a change of policy or contract into coverage that duplicates Medicare. This has had the effect of ending any period of dual coverage at the end of the calendar year for many beneficiaries.

Marketplace issuers are responsible for determining whether renewing coverage changes the policy or contract of insurance. To help issuers comply with the Medicare anti-duplication provision, the Marketplaces using the federal eligibility and enrollment platform established a process for issuers to notify CMS at the end of the calendar year of which Marketplace policies should not be renewed. As CMS approached the 2020 Plan Year, we found that issuers were identifying dramatically fewer dual enrollees. This is an indication that CMS' multi-pronged efforts to help consumers transition from the Marketplace to Medicare is making significant progress.

CMS FACILITATION EFFORTS

Throughout this reporting period, the MBO continued to lead a multi-component CMS Medicare and Marketplace workgroup to assess challenges related to the transition between Marketplace and Medicare coverage. Internal CMS coordination plays a vital role in supporting the MBO's mission, and this workgroup allowed the MBO and CMS components the opportunity to better understand the scope of these concerns and strategize solutions. The workgroup provided input and direction on initiatives implemented by CMS components, including the PDM and issuer assistance efforts described above, as well as the limited equitable relief opportunity described below.

Offering Equitable Relief for Part B Enrollment

The Center for Medicare (CM) coordinated with the Social Security Administration (SSA) to offer time-limited equitable relief to individuals enrolled in Marketplace QHPs who misunderstood the Medicare enrollment requirements and therefore did not enroll

in Part B in a timely manner. As previously reported by the MBO, our internal analyses have shown that the majority of Marketplace consumers who become dually enrolled do so by aging into Medicare and likely forget to terminate their Marketplace QHP coverage during their Medicare Initial Enrollment Period. Prior to the implementation of the CMS PDM process, CMS did not notify dually enrolled beneficiaries to terminate their Marketplace QHP coverage, thus the beneficiary may not have known they needed to take action. This particular equitable relief aimed to address the results of the error or omission of the government that led to the lack of enrollment by certain individuals by providing an opportunity for individuals to enroll in Part B outside established enrollment periods and/or to request a reduction or elimination of the Part B late enrollment penalty, if assessed. The workgroup supported the implementation and extension of this equitable relief (as of the writing of this report, the equitable relief was extended through June 30, 2020), a decision that was widely supported by beneficiary advocates and partners^{iv}.

Moving forward, the MBO will continue to work across CMS components to highlight the customer experience and to support exploring system enhancements, clarifying guidance to Marketplace issuers, considering additional opportunities to relieve the beneficiary burden, and identifying solutions that will address beneficiary concerns.

Spotlight: Beneficiary Concern—Part D Drug Pricing

Throughout the reporting period, the MBO continued to hear concerns regarding the rising cost of prescription drugs when speaking with Medicare beneficiaries, partners, and advocates. A study by the American Association of Retired Persons indicated that retail prices for a combined set of 754 widely used brand name, generic, and specialty prescription drugs increased by an average of 4.2% in 2017, well above the general inflation rate of 2.1% for the same period.^v Additionally, Medicare beneficiaries informed the MBO that they are finding it harder to predict drug costs due to price fluctuations. The Medicare Plan Finder is CMS' primary tool for helping beneficiaries estimate medication costs for Medicare Advantage (MA) and Part D plans. The data in the tool is based on information the plans provide to CMS at a certain point in time; however, the tool is unable to predict and account for future U.S. drug market fluctuations. Medicare beneficiaries have reported to the MBO that they are concerned about the rising costs of their prescriptions, which are impacting their ability to maintain living on their fixed incomes.

The MBO has communicated stakeholders' concerns internally within CMS and recommends that CMS continue exploring opportunities to help beneficiaries better predict medication costs and further promote programs, such as the Part D Extra Help program, to help with out-of-pocket drug costs. The MBO also suggests that CMS continue to consider actions that could be taken to promote more consistency and affordability in medication costs, which would help to protect beneficiaries and the solvency of the Medicare Program.

CONSIDERATIONS FOR STREAMLINING THE ENROLLMENT PROCESS FOR INDIVIDUALS TRANSITIONING TO MEDICARE

The decision to enroll or delay enrolling in Medicare is complicated and cannot be addressed by a one-size-fits-all approach. Inappropriately delaying Medicare enrollment may result in lifelong financial penalties, gaps in coverage, and/or reduced access to care. Transition and enrollment challenges continue to be one of the top five leading causes of inquiries to CMS. The current health care landscape, coupled with the complex rules and requirements related to Medicare enrollment and eligibility, can lead to misunderstanding and unintended consequences for Medicare beneficiaries.

Many individuals receiving Social Security benefits are automatically enrolled in Medicare at age 65 or upon Medicare eligibility due to disability. As the full retirement age increases, we can anticipate more individuals

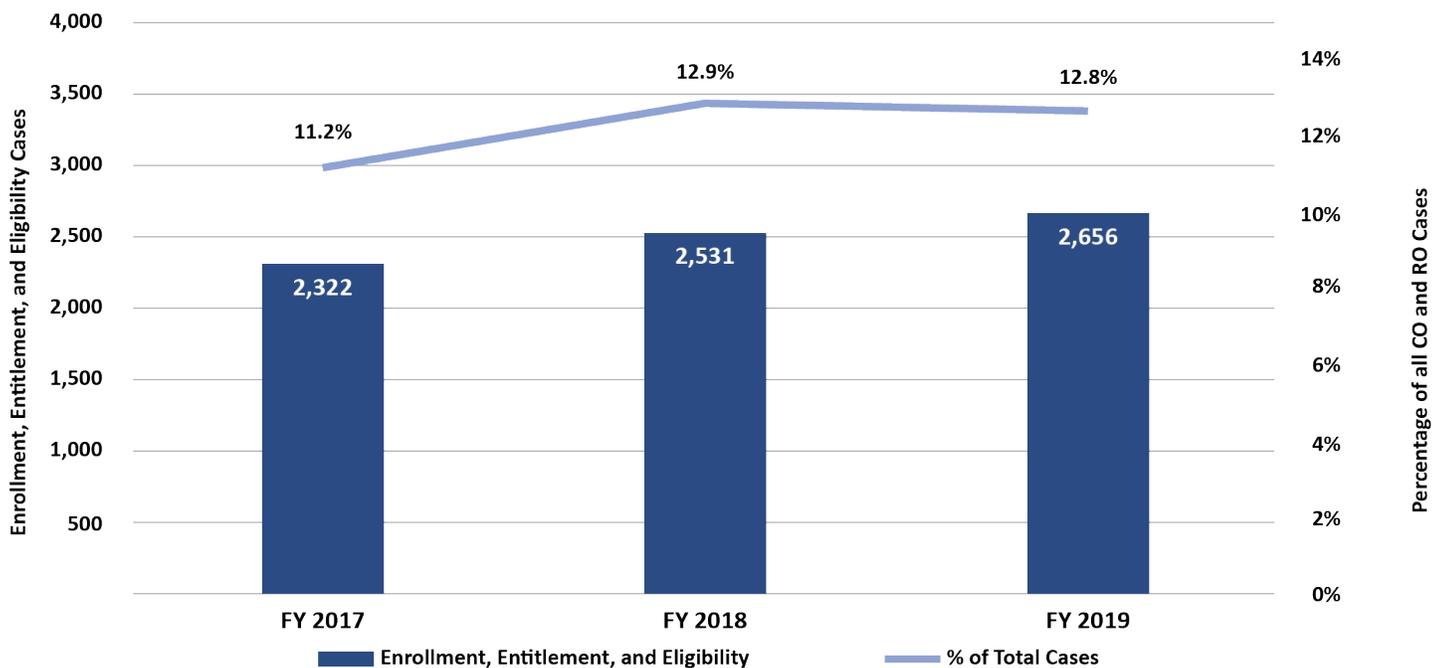
will choose to delay taking their retirement benefits. Individuals who have chosen not to take their Social Security retirement benefits will not be enrolled automatically and may not understand the implications of delayed Medicare enrollment.

Many of the Medicare enrollment policies were established when the program was initially implemented. Since then, the U.S. health care landscape has changed and there can be challenges with understanding the complex rules and requirements related to Medicare. CMS could consider future efforts to simplify the Part B enrollment process, continue improving notifications and outreach materials, and provide a targeted approach to advise those transitioning to Medicare coverage from other health insurance (e.g., employer group coverage, Medicaid, or the Marketplace), based on feedback received from stakeholders regarding this process.

DATA HIGHLIGHT: ENROLLMENT, ENTITLEMENT, AND ELIGIBILITY CASES, FY 2017–FY 2019

The volume of CMS casework relating to enrollment, entitlement, and eligibility increased 14.3% from FY 2017 to FY 2019 (see Figure 1).^{vi} Between FY 2018 and FY 2019, the overall volume of CMS casework increased at a greater rate than the volume of enrollment, entitlement, and eligibility cases (5.7% compared to 4.9%). This explains the slight decrease in the percentage of all cases represented by the enrollment, entitlement, and eligibility category. The data represent cases from beneficiaries, beneficiary representatives, advocacy groups, and Congressional offices.

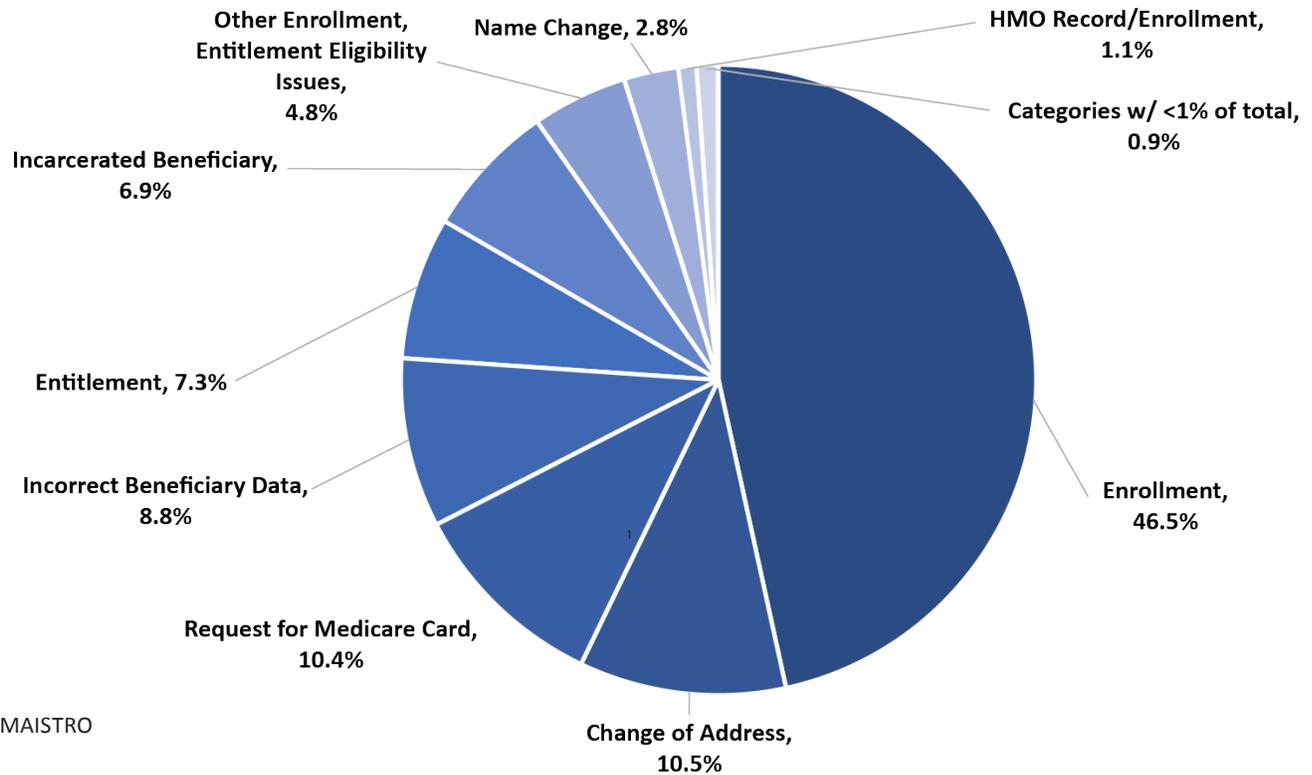
Figure 1. Enrollment, Entitlement, and Eligibility Cases, FY 2017–2019



Source: MAISTRO

When categorizing an enrollment, entitlement, and eligibility case, we also categorized each case at more granular levels, when possible, to better understand the types of inquiries CMS was receiving, with the secondary level being the next level down, and the tertiary level being the most granular level. As shown in Figure 2 below, Enrollment was the most frequently reported secondary category among enrollment, entitlement, and eligibility cases from FY 2017–FY 2019. The same pattern was observed in each individual year of the review period.

Figure 2. Secondary Categories for Enrollment, Entitlement, and Eligibility Cases, FY 2017–2019



Source: MAISTRO

Other observations related to these secondary categories include:

- Among cases with a secondary category of “Enrollment,” “General Enrollment Period/Special Enrollment Period” was the most common tertiary category (34.2%), followed by “Withdrawal/Refusal of Part B” (23.8%) and “Other” (22.4%).
- Among cases with a secondary category of “Entitlement,” “Aged” was the most common tertiary category (59.3%), followed by “Disability” (31%) and “ESRD” (9.8%).
- Among cases with a secondary category of “Incorrect Beneficiary Data,” “Date of Entitlement” was the most common tertiary category (30.6%), followed by “Other” (21.9%), “Date of Death” (19.6%), and “Date of Birth” (13.4%).
- No tertiary categories were provided for cases with a secondary category of “Change of Address,” “Request for Medicare Card,” or “Incarcerated Beneficiary.”
- The percentage of cases with a secondary category of “Incarcerated Beneficiary” increased from 4% in FY 2017 to 5.9% in FY 2018 and 9.8% in FY 2019.
- The percentage of cases with a secondary category of “Request for Medicare Card” increased from 7.6% in FY 2017 to 11.1% in FY 2018 and 13% in FY 2019.
- The percentage of cases with a secondary category of “Change of Address” fluctuated most significantly, increasing from 8.5% in FY 2017 to 16.2% in FY 2018 before decreasing to 6.8% in FY 2019.

CUSTOMER ACCESSIBILITY RESOURCE STAFF ACTIVITIES IN FY 2017–2019

In FY 2017, CMS formed the Customer Accessibility Resource Staff (CARS) team within OHI to help improve the accessibility of CMS external communications for disabled individuals in compliance with Section 504 of the Rehabilitation Act. During this reporting period, the CARS team not only made progress on improving the accessibility of external CMS communication materials but also reduced associated costs by developing centralized enterprise solutions. CMS also launched the annual, mandatory Section 504 training for all employees. This training helps employees understand Section 504, learn how the requirements apply to them in their jobs at CMS, and discuss the importance of providing information that is accessible to individuals with disabilities. Additionally, CARS partnered with CMS' Disability Employee Resource Group to host a series of Lunch and Learn Seminars for CMS staff to explain Section 504 compliance standards.

Throughout the reporting period, CARS coordinated with CMS components to implement the automated delivery of several routine Medicare communications, such as the Medicare Summary Notice (MSN) and Medicare Premium Bills, in an accessible format, such as large print, braille, audio, or data CD. CARS also coordinated with the CMS Office of Communications to participate in CMS' National Training Program conferences in multiple cities across the country to increase awareness about the availability of accessible formats and accessibility of other CMS resource materials. To support Medicare health and drug plans' Section 504 compliance, CARS participated in the CMS 2017 Medicare Advantage & Prescription Drug

Plan Spring Conference & Webcast to provide further guidance and share additional resources. Additionally, CMS released multiple Health Plan Management System (HPMS) memos to all Medicare plans, which contained Frequently Asked Questions and a "best practices" document entitled "Communications Accessibility for Individuals with Disabilities - Best Practices for Medicare Health and Part D Prescription Drug Programs."

The MBO worked collaboratively with the CARS team throughout the reporting period, leveraging feedback from CARS to help ensure that Medicare information is available in multiple formats to meet customer needs.

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against individuals with disabilities in programs or activities that receive federal financial assistance. An individual with a disability cannot be excluded from a program or activity, be denied benefits of a program or activity, or be offered a benefit that is not equal to what is offered to others. Section 504 also requires that covered entities provide auxiliary aids to individuals with disabilities at no additional cost when necessary to allow the individual to benefit from the program. Section 504 also prohibits discrimination against individuals with disabilities in programs or activities conducted by the United States Department of Health and Human Services.

Section 508 of the Rehabilitation Act requires that electronic and information technology developed, procured, maintained, or used by HHS, with limited exceptions, allows individuals with disabilities comparable access to information and data.

APPENDIX: CENTER FOR MEDICARE, MEDICARE PARTS C & D

ONLINE COMPLAINT DATA, FY 2017–FY 2019

Introduction

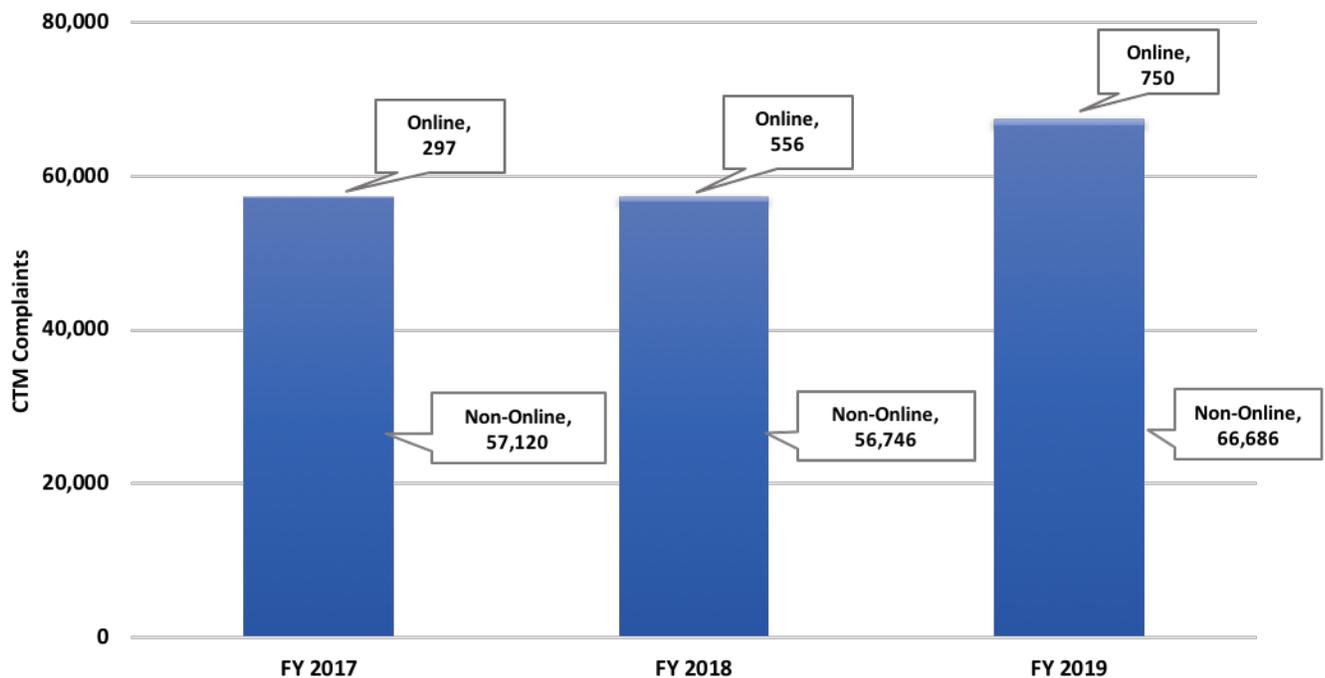
Among other customer service tasks, CMS operates the Complaint Tracking Module (CTM), CMS’ mechanism for collecting complaints about Medicare Part C (Medicare Advantage [MA]) and Part D Prescription Drug Plans (PDPs). One of its functions is to support the online electronic complaint form for Medicare Parts C and D, which is called the “Improved Medicare Prescription Drug Plan and MA–PD Plan Complaint System” and is required by law.^{vii} This electronic complaint form for Part D drug plans must be displayed in a prominent location on the Medicare.gov and Medicare Beneficiary Ombudsman (MBO) websites.^{viii} It was created and posted in December 2010 and can be found at <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. CMS is also required to provide an analysis of complaints registered through this system in an annual Report to Congress.^{ix} This Appendix fulfills the CMS reporting requirement for the FY 2017–FY 2019 reporting period.

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

FY 2017–FY 2019 DATA ANALYSIS AND RESULTS

During the FY 2017–FY 2019 period (October 1, 2017–September 30, 2019), 9,377 online submissions were received, and 1,603 (approximately 17%) were determined to be true complaints^{xii} related to Parts C and D. These 1,603 online complaints represented less than one percent of all (182,155) CTM complaints received during the reporting period. However, online complaints related to Parts C and D did increase from 297 in FY 2017 to 556 in FY 2018 and further increased to 750 in FY 2019. As shown in Figure 3, online complaints relating to Parts C and D increased both in absolute terms and as a percentage of total complaints relating to Part C and D.

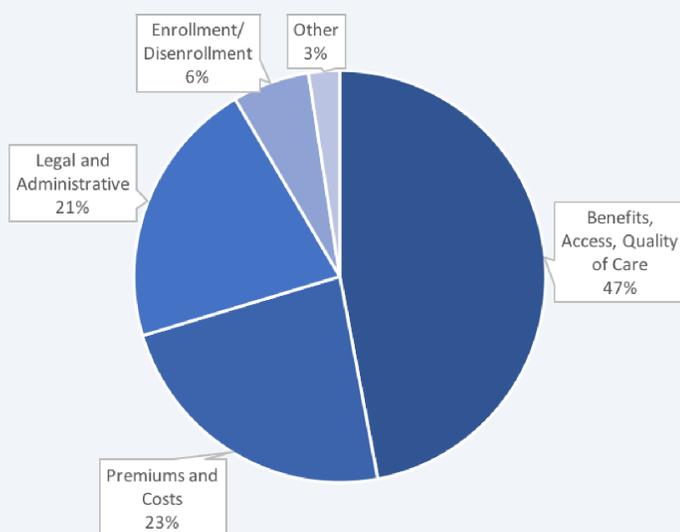
Figure 3. Total CTM Complaints by Fiscal Year, FY 2017–2019



Source: Complaint Tracking Module

Complaints are categorized in CTM for casework and resolution. Most true online complaints reported during the FY 2017–FY 2019 period were related to (1) benefits, access, and quality of care; (2) premiums and costs; (3) legal and administrative issues; and (4) enrollment/disenrollment, as shown in Figure 4. These top four complaint categories accounted for more than 97% of all true complaints during FY 2017–FY 2019. Comparable proportions of online complaints fell into each category in each of the three years analyzed.

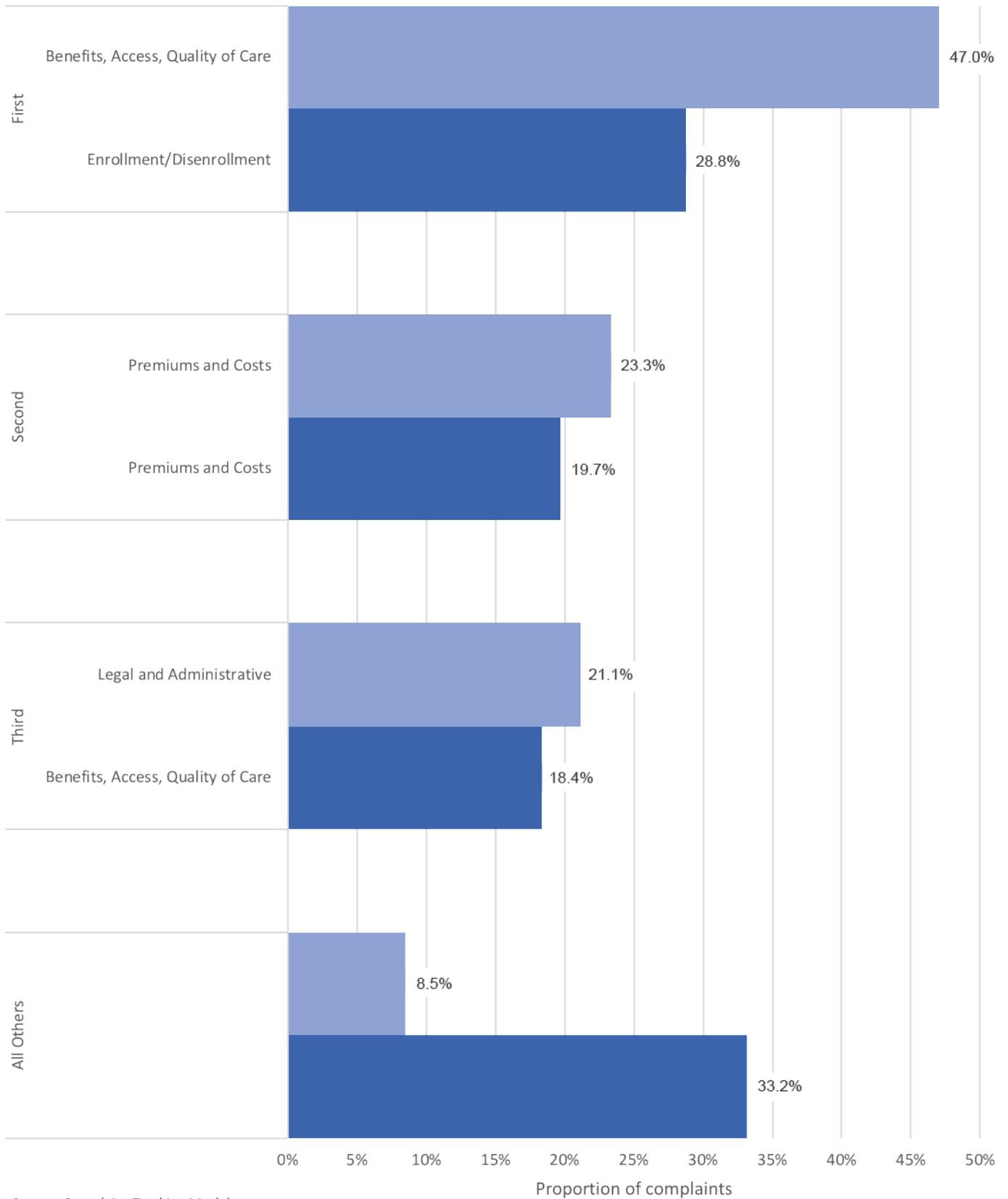
Figure 4. Online Complaints by Category, FY 2017–FY 2019



Source: Complaint Tracking Module

The top complaint categories among the CTM online complaints differed from the top categories among all CTM complaints (Figure 5). While nearly half of all online complaints related to benefits, access, or quality of care, less than one in five of all CTM complaints fell into that category. Enrollment and disenrollment issues were the most common reason for all CTM complaints, comprising over one quarter of all complaints, whereas just 6% of online complaints fell into that category. There were few changes in the main causes of all CTM complaints over time, with the exception of marketing issues, which accounted for an increasing portion of all CTM complaints, reaching 20.5% (and the number 2 ranking) by 2019.

Figure 5. Top Categories for Online and all CTM Complaints, FY 2017–FY 2019



Source: Complaint Tracking Module

■ Total CTM ■ CTM Online

CMS ACCESSIBILITY & NONDISCRIMINATION FOR INDIVIDUALS WITH DISABILITIES NOTICE

Non-Discrimination Notice

The Centers for Medicare & Medicaid Services (CMS) does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of age; disability (mental, physical, or sensory); genetic information (including family medical history); national origin; pregnancy; race or color; religion; sex (including gender identity and sexual orientation); or retaliation for opposing discriminatory practices or participating in the discrimination complaint process, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

CMS Accessible Communications

CMS provides free auxiliary aids and services including information in accessible formats like braille, large print, data/audio files, relay services, and TTY communications.

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

1. Call us:

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

For the Health Insurance Marketplace^{®xiii} : 1-800-318-2596. TTY: 1-855-889-4325

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

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

4. Send us a letter:

Centers for Medicare & Medicaid Services

Offices of Hearings & Inquiries

7500 Security Boulevard, Room S1-13-17

Baltimore, MD 21244-1850

Attn: Customer Accessibility Resource Staff

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

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

How to File a Complaint:

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

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

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

By email to OCRComplaint@hhs.gov.

In writing: Send information about your complaint to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

CMS Accessibility & Compliance with Section 508

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

Additional Information

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

REFERENCES

ⁱ CMS.gov. (August 2019). Patients Over Paperwork. Retrieved on November 11, 2019, from <https://www.cms.gov/About-CMS/story-page/patients-over-paperwork>.

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

ⁱⁱⁱ Social Security Act § 1882(d)(3)(A), 42 U.S.C. § 1395ss(d)(3)(A).

^{iv} CMS.gov. (October 2019). Assistance for Individuals with Medicare Part A and Exchange Coverage Information for SHIPs and Exchange Assistants. Retrieved on February 13, 2020, from <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/SHIP-Navigator-Fact-Sheet-2019.pdf>.

^v AARP.org. (September 2019). New Report Shows Retail Drug Prices Have Increased Faster Than Inflation for at Least 12 Straight Years. Retrieved on October 16, 2019, from <https://press.aarp.org/Rx-Price-Watch-Retail-Drug-Prices-Increased-Faster-Than-Inflation-12-Years>.

^{vi} Data were obtained from the Medicare Administrative Issue Tracker and Reporting of Operations (MAISTRO) system, where caseworkers record FFS case details, on November 15, 2019. Date was generated based on “Component Received Date.” Inquirer types other than beneficiaries, beneficiary representatives, advocate groups, and Congressional offices were excluded.

^{vii} §42 U.S.C. 7, §1395w-154(a).

^{viii} §42 U.S.C. 7, §1395w-154(b).

^{ix} §42 U.S.C. 7, §1395w-154(c).

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

^{xi} 42 CFR §§ 422.504(a)(15) and 423.505(b)(22).

^{xii} See definition of “true complaint” above.

^{xiii} Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.