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1–800–MEDICARE: IT'S TIME FOR A CHECK-UP

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

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CONTENTS

	Page
Opening Statement of Senator Gordon H. Smith	1
Opening Statement of Senator Herb Kohl	4

PANEL I

Statement of Kerry Weems, Acting Administrator, Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services	5

PANEL II

Statement of Naomi Sullivan, Medicare Beneficiary, Chico, CA	24
Statement of Michealle Carpenter, Deputy Policy Director and Counsel, Medical Rights Center	29
Statement of Tatiana Fassieux, Board of Directors Chair, California Health Advocates, Sacramento, CA	37
Statement of John Hendrick, Project Attorney, Elder Financial Empowerment Project, Coalition of Wisconsin Aging Groups, Madison, WI	49

PANEL III

Statement of John M. Curtis, President and Chief Executive Officer, Vangent, Inc., Arlington, VA	55

APPENDIX

Prepared Statement of Senator Robert P. Casey, Jr.	59
Kerry Weems Responses to Senator Smith's Questions	59
Michealle Carpenter's Responses to Senator Smith's Questions	62
Tatiana Fassieux's Responses to Senator Smith's Questions	63
John Curtis's Responses to Senator Smith's Questions	63
Statement by the Health Assistance Partnership	65
Testimony of Jettie Turner, Medicare Beneficiary, Tupelo, MS	67
Testimony of Colter McLellan, Medicare Beneficiary, Picayune, MS	77
Testimony of Dawn V. Crouse, full-time volunteer SMP Counselor, Mississippi Senior Medicare Patrol, Columbus, MS	86
Testimony of Frankie F. Ferguson, Medicare Beneficiary, Oxford, MS	92

(III)

1–800–MEDICARE: IT'S TIME FOR A CHECK-UP

THURSDAY, SEPTEMBER 11, 2008

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, DC.

The committee met, pursuant to notice, at 10:08 a.m., in room SR–325, Dirksen Senate Office Building (Hon. Gordon H. Smith) presiding.

Present: Senators Smith [presiding] and Kohl.

OPENING STATEMENT OF SENATOR GORDON H. SMITH

Senator SMITH. Good morning, ladies and gentlemen. We welcome you all to this very important hearing, 1–800–MEDICARE: It's Time for a Check-Up. We're met in this historic room of the Senate Russell Caucus Room. I don't know that Administrator Weems will regard this as anything like the Watergate hearings. We don't intend it to be. But a lot of historic things have happened here.

Certainly one of the more historic things that Congress has done in the last several years is the Medicaid reform, the update that includes Medicare Part D. Medicare Part D is a massive program to provide seniors with prescription drug care as part of their Medicare benefit.

When we began to put this legislation together to provide this reform and this new benefit, we recognized that it was a monumental task. CMS, through Health and Human Services, has certainly had an enormous job to do. Our focus here today is on how we can do that job even better. This is not designed to call into question anyone's motive or in any way to question their sincerity, and Kerry Weems, who is the Administrator of CMS, has been many times to my office. I appreciate that, Kerry, and I appreciate your attention to this issue, and we are grateful for your service to our country. You've spent a lot of time in the Federal Government trying to get these programs right, and that is the spirit in which we gather here this morning.

When we began to put 1–800–MEDICARE together as part of it, we did this because we heard predicted lots of problems that may emerge in terms of customer service as seniors try to navigate this very difficult path of getting enrolled and getting the benefit that comes with Medicare.

So today's hearing is the product of a 3½ year ongoing investigation into the performance of 1–800–MEDICARE. Since I will be spending quite a bit of time during today's hearing talking about findings from my investigation, I'm going to take a moment to pro-

vide an overview of the committee's work on this subject. To ensure operational readiness for the first Part D open enrollment season, we commenced an inquiry into the performance of call centers in early 2005. This investigation has entailed the following: 500 test calls to 1–800–MEDICARE; annual inspections of 1–800–MEDICARE call centers across the country; interviews with 150 consumer service representatives and management staff who work at the 1–800–MEDICARE call centers; monitoring 200 hours of inbound calls; correcting error-ridden scripts related to premium withholding errors; reviewing call center performance data; exchanging hundreds of phone calls and emails with CMS, its contractors, beneficiaries, and advocates, subpoena of call center records from the administration and Part D plans; exchanging hundreds of—meetings with three separate CMS administrators, including Administrator Weems who is here today, and we appreciate his presence, as well as a former Social Security Commissioner.

I also raised call center performance failures and resource issues at prior hearings of this committee and in the Finance Committee where I serve. I've convened today's hearing with the indulgence of the chairman. I appreciate Senator Kohl very much, whom I thank for his support in the committee's ongoing efforts to improve services at 1–800–MEDICARE.

To start the hearing on a positive note, I'll first comment on what seems to be working well with 1–800–MEDICARE. See, there's good to report as well, Kerry. My staff have consistently had the highest praise for the professionalism and courtesy of the customer service representatives and management who work in the 1–800–MEDICARE call centers. The reports that I have received reflect that on the whole the staff at 1–800–MEDICARE are earnest, professional, and courteous and care a great deal about providing the best service possible to beneficiaries.

I'll be discussing this in more detail during the hearing, but my conclusion is that the problems at 1–800–MEDICARE lie more with the training and resources provided to call center staff rather than with the staff themselves.

I have also been quite pleased with CMS's timely resolution of individual beneficiary cases that my office has referred to the agency. A further note. CMS recently implemented a dedicated access number for the State Health Insurance and Assistance Program, or SHIP, as it's known, and they did this to streamline SHIP's access to 1–800 services. CMS also recently hired an outside vendor to revise the training curriculum and call scripts used by 1–800–MEDICARE service representatives.

However, as you might conclude, if all were well we wouldn't be here today. So let's delve into what needs to be improved and what we're going to spend most of this morning discussing. My investigation has revealed persistent problems at call centers and they include:

One, confusing interactive voice response menu options, or IVR, as it's called.

Another is unacceptably long waiting times, up to one hour during peak call periods. I know that when you spread it, Kerry, over a 24-hour period it takes the average down. But if you look at the

8 hours of business calls, that period of time, that's where it gets really, really long, and that's when people are most likely to call.

Other problems are disconnected calls, technical and infrastructure failures, inappropriate referrals to SHIP and other entities, jargon-filled and error-ridden scripts that are used by customer service representatives to respond to caller inquiries, oversight inadequacies, training deficiencies, and incorrect information routinely being dispensed by customer service representatives.

Many of today's witnesses will share their firsthand experience in trying unsuccessfully to utilize 1–800–MEDICARE. These stories reveal much work remains to improve call center services. As we'll hear in testimony today, the problems at 1–800–MEDICARE are not mere inconveniences to beneficiaries. When 1–800–MEDICARE provides incorrect information, the result can be devastating to beneficiaries.

An Oregon transplant patient in California nearly died because 1–800–MEDICARE provided incorrect information about coverage of anti-rejection medications. A senior in Florida ended up in the emergency room after foregoing necessary oxygen treatments because 1–800–MEDICARE provided her with incorrect information about the durable medical equipment program.

Earlier this year I assisted beneficiaries who received incorrect information about the Part D enrollment process. These beneficiaries had been turned over to collection agencies for past due premiums for a plan in which they were no longer supposed to be enrolled. A cancer patient nearly died because he could not receive assistance in locating a facility for chemotherapy.

Hundreds of stories like these have been shared with my office by tearful beneficiaries and advocates who are completely exasperated by their experiences with 1–800–MEDICARE. I've previously related to Administrator Weems my belief that there are failures in the system that we need to fix. That conclusion is informed by these test calls that we have made and also by the Government Accounting Office and the Department's own Office of Inspector General, as well as information provided by the agency itself regarding call center performance.

The population served by 1–800-MEDICARE is comprised of our country's most vulnerable citizens. It is unacceptable to subject the sick, frail, and elderly to long waits, hour-long waits, disconnected calls, endless loops of referrals and call transfers, and erroneous information about benefits and services. It's imperative that we deliver this in a timely and accurate way.

I want to just say as an aside that I was contacted by Good Morning America on this hearing today and I basically told them what I just said in this statement, Kerry. You didn't say it, but I understand someone at CMS said that our investigations were outdated. I don't believe they're outdated. My staff placed 50 test calls over the past 4 weeks. On August 28 of this year I received call center performance data current through July 2008.

In June of this year my staff traveled with yours to the Richmond Call Center. At that time your staff and mine made test calls collaboratively onsite. During every single one of these test calls—let me repeat that during every single one of those test calls, CRS provided incorrect information. When asked to assign a letter grade

to those test calls, the call center management assigned grades ranging from B-minus to F.

During that site visit my staff also conducted side by side monitoring of live inbound calls. The service was less than stellar. My staff raised several concerns to yours onsite that day regarding what had transpired during those calls. After that site visit and after you'd been informed about what transpired during the June visit, I'm informed you made an emergency site visit of your own to a Phoenix call center to investigate, and I appreciate that.

Further, throughout this week of investigation my staff have interviewed Vangent, Briljent, and other contractors as well as 53 advocates and beneficiaries.

In any event, I very much hope that this will be a positive hearing. Part of our responsibility is to bring light and heat to issues and problems as we see them, not to denigrate but to build. So in that spirit, I thank you for being here, Administrator Weems, and I turn the mike over to my colleague Senator Kohl, the chairman of the committee.

OPENING STATEMENT OF SENATOR HERB KOHL

The CHAIRMAN. Thank you very much and good morning to all.

I thank Senator Smith for holding this hearing. Senator Smith, you and your staff launched an investigation into 1–800–MEDICARE nearly 4 years ago. Considering all your hard work and due diligence, I am confident that today's hearing will lead to improvements in the government's ability to help seniors get the health care they need.

Consumer service is a critical component of navigating the Medicare system. CMS currently estimates that 1–800–MEDICARE will receive 34.5 million phone calls in 2009. Older Americans use the help line to differentiate and decipher the overwhelming number of plan options available, to ask questions about coverage, to switch plans, and to file complaints.

Senator Smith's investigation shows that, in addition to lengthy wait times and a failure to call participants back when promised, much of the information disseminated by Medicare customer service representatives is incorrect and inconsistent. These can be grave errors. Misinforming Americans about their Medicare coverage can cause them to pay much more out of pocket than they should have to or, worse, leave them without the treatment or medications that they require.

This committee worked side by side with CMS on many issues and I appreciate the working relationships that we have. I hope that we can all learn lessons from today's hearing and continue to improve Medicare for older Americans.

I would like to particularly thank the Coalition of Wisconsin Aging Groups for offering their expertise this morning.

Once again I thank you, Senator Smith, for your leadership on this very important issue.

Senator SMITH. Thank you, Chairman Kohl.

Kerry Weems is the Acting Administrator of the Center for Medicare and Medicaid Services, which administers and oversees 1–800–MEDICARE. He's here to discuss CMS's efforts to ensure the overall success of the program and its working relationship with

Vangent, the company it contracts with to accept incoming beneficiary calls. Kerry, take it away.

STATEMENT OF KERRY WEEMS, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. WEEMS. Thank you, Senator Smith. Good morning, Chairman Kohl. I'm happy to be here to discuss 1–800–MEDICARE and how it serves our 45 million Medicare beneficiaries.

Just stepping back for a moment, the Medicare program has changed significantly since when I began my career in HHS in 1983. At that time the total number of Medicare claims processed was about 325 million and most of that was on paper. I'd just say parenthetically, at that time we didn't have PCs on our desks; we had ashtrays. A lot has changed since then. The total number of contractors that we had processing those claims was 104.

So if a beneficiary had a question about a claim or a bill or if they had questions about whether nursing home care or home health services were covered, they might have to make up to six phone calls, six different phone calls, to get answers to those questions. For example, for hospital or nursing home stay questions the beneficiary would have to make at least two phone calls to fiscal intermediaries to find answers, depending on what State they lived in. For physician questions, the beneficiary would have to make at least one call to a carrier. Some States, however, had two carriers, which would have required an additional call depending on the service. For a home health question, the beneficiaries would have to call the regional home health intermediary, and if there are questions about primary or secondary insurance they'd have to call the coordination of benefits contractor. This was not only time-consuming, it was frustrating and probably a poor business model.

So fast forward to today. Today Medicare processes nearly 1.1 billion bills, over 99 percent of which are electronic. We have about 49 contractors handling those bills now. That number continues to decline. Most important to note is that beneficiaries can call one number today to get the answer to any Medicare-related question, and that number is 1–800–MEDICARE.

By calling 1–800–MEDICARE, beneficiaries can check on claim status, find a provider or supplier in their area, and find out about primary or secondary coverage. So with few exceptions, a beneficiary can have almost all their Medicare-related questions answered by calling 1–800–MEDICARE, which also refers beneficiaries to plans and to SHIPs for more personalized service.

But the consolidation to 1–800–MEDICARE didn't occur overnight. It was an evolution of a vision to simplify Medicare processes under one roof, and it took hard work to get the operation that exists today.

The 1–800–MEDICARE arm of our outreach strategy is a toll-free number that beneficiaries can use to get help on all aspects of the Medicare program. Services are available around the clock 24 hours a day, 7 days a week. In fewer than 10 years we've increased the operational capacity of 1–800–MEDICARE almost eightfold. The phenomenal growth has been the result of significant changes

in the Medicare program and extensive outreach to beneficiaries to teach them to call 1–800–MEDICARE for their inquiries.

As it's matured, the number of calls handled by 1–800–MEDICARE has grown dramatically. From 1999 to 2003, yearly calls averaged 5 million or less. However, the enactment of the Medicare Modernization Act of 2003, which included the creation of a prescription drug benefit, changed forever the way that CMS interacts with its beneficiaries. The expansion of choices brought about by the drug benefit and by Medicare Advantage meant that CMS and our partners would have to respond to many more inquiries about a much greater range of topics.

As you can see from this chart on my left, with the implementation of the Part D program the call volume to 1–800–MEDICARE skyrocketed. In 2004 and 2005, call volumes were 20.2 million and 28.2 respectively. In 2004 the call volume was due to the issuance of the Medicare approved drug discount card. In 2005 the annual election period for the Part D prescription drug program significantly increased call volumes.

In 2006, the Part D program resulted in a dramatic spike in call volume, all the way to 37.5 million calls. In 2007 call volumes reached 30 million and we're on track to receive about 29 million calls in 2008.

As Medicare expanded and changed, so did our 1–800–MEDICARE operations. In September 2007 all beneficiary call services were consolidated into the beneficiary contact center, which encompasses all of 1–800–MEDICARE operations. 1–800–MEDICARE has existed in its current form for only one year.

Senator Smith, your review of the 1–800–MEDICARE operations has led to changes in the system that will enhance callers' experiences and ensure that callers receive accurate and up to date information. CMS is committed to decreasing caller wait times. Due to recent procedural and technological changes, the average monthly speed of answer for this coming year, the remainder of the year, will be 5 minutes or less.

As you can see from the next chart, we had contracted using the old technology at about 8 minutes of average speed of answer time. The implementation of that technology and those procedural changes, at your urging, has made a significant difference in our average speed of answer already. That will continue throughout the year. In addition, your concerns on the quality of answers callers receive have accelerated our review of call scripts and customer service representative training.

As we get ready for the upcoming annual election period for 2009, we're reviewing and updating call scripts with the help of a third party validator. As a result of this review so far, some of the scripts were deactivated and others were consolidated into a new Smart Script format. We've also made changes to the content and the flow of the scripts. Make no mistake, the Medicare program, the fee-for-service program, is a complex program and many times difficult to explain. The content and the flow are very important.

We've also given our customer service representative training a closer look, thanks to your feedback. We're in the process of expediting changes to the new hire training program to ensure that our

new customer service representatives are better prepared to assist callers.

In response to feedback from the committee and others, CMS has worked hard to improve all aspects of the caller's experience. By employing new technologies, callers are able to self-serve using the interactive voice response, or IVR, system. As with virtually all call centers, callers to 1–800–MEDICARE are greeted by an IVR. The new IVR provides callers the ability to access certain prerecorded information to answer basic questions, and it also routes callers who need specific information to the right customer service representative.

The IVR allows beneficiaries to look up claims information and hear their current deductible status, as well as last year's deductible status. In addition, beneficiaries can hear messages about a description of the various preventive programs Medicare provides, how to enroll in a Part D program, how to switch Part D plans, and how to apply for financial assistance.

Customer service representatives are charged with understanding and explaining the Medicare program to beneficiaries. We use a scripted content approach to provide beneficiaries with consistent and accurate information. This process assists customer service representatives to quickly and efficiently find information on a vast array of topics, from claims payment status to Medicare policies and procedures.

Like virtually all of our work, CMS uses contractor staff to answer calls and manage the infrastructure of 1–800–MEDICARE. You will hear from our contractor later. This strategy allows CMS to be highly responsive to call spikes that often accompany the annual election periods, various Medicare campaigns that require rapid shifts of resources or other special circumstances. We have the ability to reroute calls from less busy call centers as well as shift customer service representatives to phone duty who would otherwise be answering the mail.

Our 1–800 number has planned and announced closing dates on some Federal holidays. But, given contractor flexibility, three call centers were open this Labor Day in anticipation of greater call volumes due to the impending Hurricane Gustav. In addition, CMS had call centers open on July 4 of this year due to the expanded increase in call volume from the newly implemented durable medical equipment program.

Overall quality assurance and monitoring activities help ensure quality interactions occur between beneficiaries and their families across multiple channels. Our activities focus critical attention on customer service representative performance across all channels, including telephone, written correspondence, email, web chat. Calls are closely monitored and the quality monitoring that is performed is then used by the contractor to coach and teach and provide feedback to individual customer service reps.

In our effort to continue to improve 1–800, CMS is working to implement several enhancements to the system in order to better serve callers. These will come on line through this year and next. We're simplifying the prescription drug plan enrollment algorithms to better identify beneficiary eligibility during special election periods. A new virtual callback option is being deployed which will

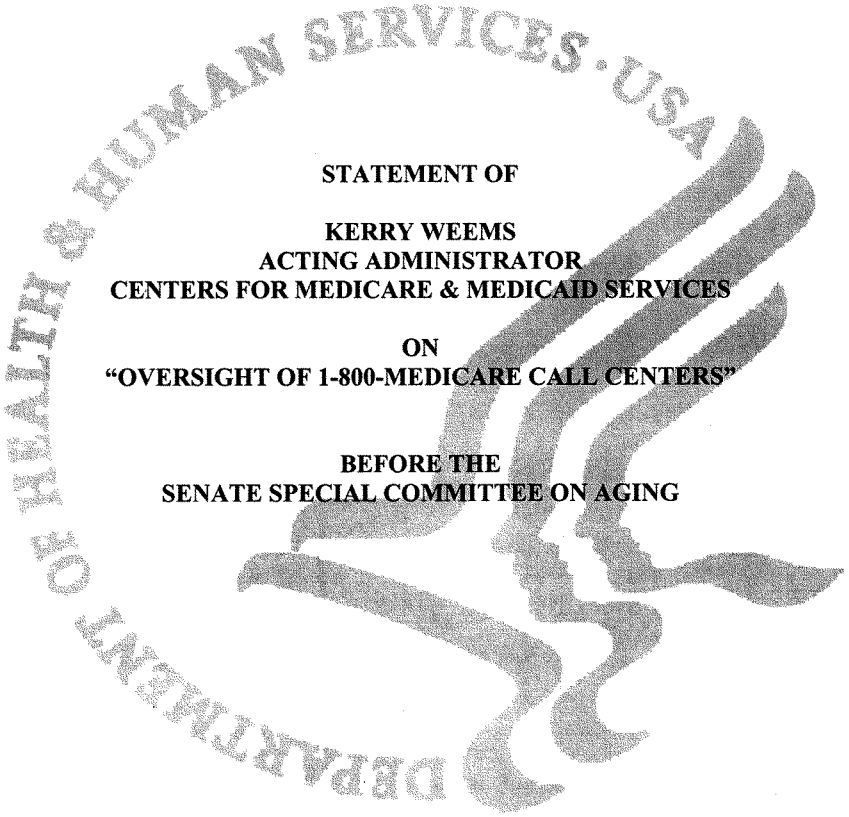
allow callers to call in to our system; if they have to wait, they can hang up and the system will call them back while holding their place in the queue. That way they can talk to a customer service representative and not just hang on the phone.

An improved learning management system is being implemented which will help us to identify the training needs of customer service reps and disseminate information to those CSRs in call centers.

Finally, as we begin our next release of the IVR we'll begin playing proactive messages tailored to the beneficiary's particular plan and enrollment, also attuned to the time of the year that the beneficiary is calling.

We acknowledge that 1–800–MEDICARE is not perfect, but we feel that it's successful in meeting the needs of our beneficiaries and with continued attention on the part of CMS and of this committee it will continue to improve. I'm happy to answer any questions you have. Thank you for giving me the opportunity to appear today.

[The prepared statement of Mr. Weems follows:]



STATEMENT OF

KERRY WEEMS
ACTING ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON
"OVERSIGHT OF 1-800-MEDICARE CALL CENTERS"

BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

September 11, 2008

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Before the
Senate Special Committee on Aging
On
"Oversight of 1-800-MEDICARE Call Centers"

September 11, 2008

Good morning Senator Smith, Chairman Kohl and distinguished members of the Committee. I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS') outreach efforts in providing Medicare beneficiaries with accurate and up-to-date benefit information and explain the many avenues by which this information is disseminated. CMS uses a multi-pronged education and outreach strategy to enable people with Medicare to make informed decisions about their unique and individualized health care needs. CMS directly provides program information to Medicare beneficiaries through the *Medicare & You* Handbook which is sent every year to each Medicare beneficiary; through our Web site, www.medicare.gov, where beneficiaries can access a variety of information related to their benefits; and through 1-800-MEDICARE, where beneficiaries can speak with a Customer Service Representative (CSR) about their specific needs. In addition, CMS works collaboratively with our community partners to provide outreach to beneficiaries and their caregivers at the local level.

The 1-800-MEDICARE arm of our outreach strategy is a toll-free line that beneficiaries can use for help on all aspects of the Medicare program. Services are available 24 hours a day, 7 days a week in over 50 languages and Telecommunications Device for the Deaf (TDD). Our call centers are projected to handle over 29 million calls this year. In addition to oral conversations, CSRs provide written responses to emails and other beneficiary correspondence. 1-800-MEDICARE also refers more than 100,000 calls per month to other sources of information when appropriate, such as CMS Regional Office caseworkers and State Health Insurance Assistance Programs (SHIPs). Overall, the

operation makes an impressive array of services available to approximately 45 million Medicare beneficiaries in 2008. While beneficiary satisfaction rates with 1-800-MEDICARE are at least 80 percent, we continue to make improvements based on internal reviews of actual calls with beneficiaries, and feedback from Congress and other stakeholders. We welcome feedback that helps to identify any aspect of our call center operations or other outreach efforts that we can improve as we continue our mission to educate and protect Medicare beneficiaries.

History of 1-800-MEDICARE

1-800-MEDICARE was initially developed to respond to inquiries about the new Medicare +Choice program mandated by the Balanced Budget Act of 1997. Before that, Medicare beneficiaries were required to make calls to a variety of entities depending on the type of inquiry. In November 1998, the 1-800-MEDICARE call center operation began as a pilot program in five States. It was expanded nationally in March 1999, resulting in our first full year call volume in 2000 of 3.69 million calls.

Enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which included the creation of the Medicare Prescription Drug Program (Part D), changed forever the way that CMS interacts with beneficiaries. The expansion of choices brought about by the drug benefit and Medicare Advantage meant CMS and our partners would have to respond to many more queries about a greater range of benefit-related topics. Since early 2004, 1-800-MEDICARE has handled millions of inquiries on the initial drug discount cards and then subsequent drug benefit enrollment. The MMA also gave CMS the green light to consolidate the operations of our 70 fee-for-service claims processing contractors to implement standardized call center practices for beneficiary inquiries. In the past, these contractors had been responsible for responding to beneficiaries' questions that were specific to their claims.

In September 2007, all these services were consolidated into the Beneficiary Contact Center (BCC) which encompasses all 1-800-MEDICARE operations and is operated by one contractor. 1-800-MEDICARE has existed in its current form for only one year. The

BCC has become a huge operation with a projected call volume in 2008 at over 29 million calls. In fewer than 10 years, we have increased the operational capacity almost eight-fold. The phenomenal growth has been a result of significant changes in the Medicare program and extensive outreach to teach beneficiaries to call 1-800-MEDICARE for information on all aspects of their Medicare inquiries.

As it has matured, the number of calls handled by 1-800-MEDICARE has dramatically grown. From 1999 to 2003, yearly call volumes were approximately 5 million calls or less. With the implementation of the Part D program, the call volume skyrocketed. In 2004 and 2005, call volumes were 20.2 million and 28.2 million, respectively. The increased call volume was due to the issuance of the Medicare Approved Drug Discount Cards. In 2006, the implementation of the Part D program resulted in a dramatic spike in call volume to 37.5 million with calls leveling off at approximately 30 million in 2007 and 2008. 1-800-MEDICARE has evolved to move CMS from a passive bill payer to an active partner with our beneficiaries.

Call Center Operations

As with virtually all similar call centers, callers to 1-800-MEDICARE are greeted by an interactive voice response unit, or IVR. The 1-800-MEDICARE IVR provides callers the ability to access certain pre-recorded information and routes callers who need or wish to speak with a CSR. The IVR technology is designed to further improve the efficiency of our operations and enable a portion of our callers to "self-serve" and receive the information they need without having to speak with a CSR. Approximately 20 percent of beneficiaries have their questions answered through the IVR technology system.

In situations where we are not able to completely serve the caller in the IVR, the caller is seamlessly routed to the CSR who is best able to handle the specific topic. Further, the IVR technology is integrated with the computer desktop application in such a way that any time a caller chooses to speak with a CSR, his or her individual information is automatically populated on the desktop of the CSR to improve the efficiency of the call flow and reduce caller frustration.

CMS uses contractor staff to answer calls and manage the infrastructure at the 1-800-MEDICARE call centers. This strategy allows CMS to be highly responsive to call spikes that often accompany annual election periods and various Medicare campaigns that require rapid increases in resources. For example, in recent years, the CSR staff in our centers has ranged from as few as 400 individuals to as many as 7,800. With staffing swings of this magnitude, it is not cost effective to employ a federal employee staffing model.

CSRs are charged with understanding and explaining the Medicare program to beneficiaries. All new CSRs receive a minimum of three weeks classroom training, quality monitoring and follow-up coaching to ensure peak performance when interacting with beneficiaries. CSRs must pass a written examination and be certified using test calls prior to taking live calls. The call centers use a tiered system of responding to questions depending on call complexity, with specialized CSRs handling more complex questions.

We utilize a scripted content approach to provide beneficiaries with consistent and accurate information. Prior to implementing a scripted content approach in our call centers, we had problems maintaining the quality and consistency of our responses. By investing some of our resources into technology, we have designed a process to assist CSRs so they can easily find information on a vast array of topics ranging from claims payment status to Medicare policies and procedures. By marrying this type of technology with our Beneficiary Contact Center, we have been able to provide up-to-date and accurate answers to callers and achieve a level of consistency in our responses that until just recently was simply not possible.

There are five call center locations across the United States employing an average of more than 3,000 CSRs ready to assist Medicare beneficiaries. This year an additional call center will be opened in September to accommodate the increase in call volume generated by the Annual Election Period for 2009.

Business Strategy

The CMS 1-800-MEDICARE business model is designed to give the highest level of customer service to Medicare beneficiaries. In managing a call center operation of this magnitude, it is incumbent upon CMS to make business resource and operational decisions while carefully considering a multitude of other Medicare program needs. When making decisions about where and in what manner to best apply resources, CMS focuses on the broad needs of our beneficiaries, providers, plans, and partners. Following ongoing reviews of recorded calls with real beneficiaries, CMS strives to continuously improve service, lower costs, and provide answers to the public through the most cost-efficient channels possible. We believe that by focusing our resources on managing a carefully designed and closely integrated set of services and activities we can best serve the needs of our constituency. While the 1-800-MEDICARE call center is a valuable tool in educating and communicating with beneficiaries and their caregivers, it has never been our goal to meet the needs of all beneficiaries by attempting to provide each and every answer through a CSR. Instead, we have implemented an integrated set of technical systems and operational practices that when combined, provide information to our diverse population of beneficiaries in the most accurate and efficient manner possible.

We continue to explore and implement ways to more efficiently use existing resources allocated for 1-800-MEDICARE while improving the experience for beneficiaries. To that end, an increasing number of callers are now able to use the IVR to check claim status and receive basic information. Beneficiaries can search the www.medicare.gov Web site to find general information related to Medicare, or they can sign up for the www.mymedicare.gov portal in order to check on more personalized information.

Quality Assurance

CMS appreciates the Committee's interest in ensuring 1-800-MEDICARE meets the needs of people with Medicare. We strive to improve all aspects of a caller's experience and we welcome input into how the system can be improved. To that end, we are constantly evaluating ways in which to enhance the system and updating our CSR scripts to ensure information is clearly communicated. The BCC contractor performs ongoing

quality assurance and monitoring activities to help ensure quality interactions occur with Medicare beneficiaries, their families, and caregivers across multiple channels. These activities focus critical attention on CSR performance across all channels including telephone, written correspondence, e-mail, and Web chat. Calls are closely monitored and the quality monitoring that is performed is then used by the contractor to coach and provide feedback to individual CSRs. Additionally, an independent contractor examines calls to assess quality from a global perspective and identifies areas in need of particular attention.

If a CSR is not satisfactorily meeting work expectations, the BCC contractor provides various forms of coaching and feedback related to the area identified for improvement. If there is limited or no improvement after oral coaching, the CSR is placed on a written Performance Improvement Plan (PIP). If there is no improvement under the PIP, the contractor will work to release the CSR from the BCC.

Other Educational and Informational Resources

Although 1-800-MEDICARE is an important resource for many beneficiaries, CMS funds a variety of other resources to help beneficiaries and their caregivers obtain information about their Medicare benefits. For example, the *Medicare & You* Handbook, an annual publication mailed to approximately 40 million Medicare beneficiaries, provides both general information about the Medicare program as well as geographically specific information about plan offerings. The handbook contains important information about costs, covered services, beneficiary choices, extra help for those with limited income and resources, and beneficiary rights and protections. It is available in both English and Spanish.

CMS' comprehensive Web site, www.medicare.gov, allows individuals to search a variety of Medicare-related topics such as eligibility requirements, plan offerings, local provider comparisons, and Medicare billing and appeals. It also provides lists of helpful phone numbers and Web sites. This extensive Web site is updated regularly and is accessible 24 hours a day, 7 days a week.

We realize, however, not all beneficiaries have access to the internet, but more importantly, that some beneficiaries require additional, face-to-face assistance when they have questions about Medicare. That is why CMS works collaboratively with hundreds of partner groups that work with and serve beneficiaries in local communities to provide culturally competent information in a welcoming environment. At more than 30,000 events held nationwide in 2007, Medicare worked closely with such organizations a network of state, local and community service providers to offer enrollment counseling and sign-up opportunities.

In June 2008, CMS announced that it was providing an additional $15 million for a total of $54.3 million in fiscal year 2008 to SHIPs to help people with Medicare get more information about their health care choices. SHIPs are state programs that use community-based networks to provide Medicare beneficiaries with local, personalized assistance on a wide variety of Medicare and health insurance topics. A significant accomplishment of the SHIPs has been their wide success in helping to educate many of the nation's 45 million Medicare beneficiaries about Medicare including their prescription drug coverage options so that they can make health care choices that best meet their needs.

In support of the Annual Election Period for the 2008 benefit year, the 2007 CMS Mobile Office Tour visited 128 communities across the nation reaching out to beneficiaries and sharing information about Medicare and other health promotion activities. The Tour highlighted the personalized assistance provided by the many thousands of partners across the country that helps beneficiaries compare drug and plan options and change enrollment if necessary.

In an effort to reach individuals who may qualify for the Part D low-income subsidy (LIS), CMS launched a 2008 Spring LIS Campaign to increase awareness and applications submitted to the Social Security Administration for the Medicare Part D LIS. This special outreach was aimed at individuals without Medicare Part D coverage who

potentially qualify for the LIS. On May 16, 2008, CMS hosted a LIS Partnership Summit to share outreach plans and ideas to effectively engage individuals who may qualify for extra help.

CMS is launching an initiative this fall to begin a conversation with people who provide care for a loved one, friend or neighbor. The *Ask Medicare* initiative will provide information, tools and materials to assist caregivers and their loved ones in making informed health care decisions. This launch will take place on September 18th, through a live webcast in conjunction with a number of key partner organizations at the Newseum in Washington, DC.

Enhancements to 1-800-MEDICARE

In our effort to continue to improve 1-800-MEDICARE, CMS is working to implement several enhancements to the system in order to better serve callers. These should all be operational within the next year. We are simplifying the Prescription Drug Plan Enrollment algorithms to better identify beneficiary eligibility for special election periods. A virtual callback option is also being deployed which will allow callers to have an automated system call them back while maintaining their place in the queue to speak with a CSR. An improved Learning Management System is being implemented which will allow us to identify training needs of CSRs and disseminate information to those CSRs and call centers. Finally, as part of our next release in the IVR, we will begin playing proactive messages tailored to both the beneficiary's particular plan enrollment and also to the time of year the beneficiary is calling.

Conclusion

Thank you for the opportunity to speak with you today about the Committee's ongoing interest in ensuring that 1-800-MEDICARE provides effective and timely answers to callers.

No 1-800 number system can be designed to perfectly meet the varying needs of 45 million possible users, but CMS has intentionally built 1-800-MEDICARE as a fluid

resource that can evolve and be responsive to the current needs of beneficiaries, their families, and caregivers. Feedback from advocates, community partners, and Congress is welcome and incorporated on a regular basis in order to improve and sustain our call center operations. CMS will continue to work with our partners in the coming months to ensure that 1-800-MEDICARE maintains its place as a valuable resource for all people with Medicare.

I welcome any additional questions that you may have.

Senator SMITH. Thank you very much, Kerry. What I heard you describe was an acknowledgment that we're making progress, but we've got a way to go, and that you and CMS take responsibility for that.

Mr. WEEMS. That's correct.

Senator SMITH. I appreciate that, and that's the point of this hearing, is just so the relationship we have between the Legislative and Executive Branch is we're on the same page and we're going the same direction.

Kerry, as I related in my opening statement, there are some of the problems I'd like to get your response to. For example, you've spoken to it a bit, but I'm worried that the scripts are too technical and they presuppose programmatic expertise that a caller won't have. I'm aware that this is contracted out and I want to relate to you information that one of the new contractors is providing.

The beneficiary in this scenario calls 1–800–MEDICARE with a question. A tier one representative answers the call and requests the beneficiary's Medicare number. The beneficiary tells the first representative that he has lost his card and all his paperwork and does not have his Medicare number available. The beneficiary is then transferred to a tier two representative, to whom he once again has to explain his issue. The beneficiary also states numerous times throughout the exercise that he has lost his paperwork and doesn't have his Medicare number.

The tier two representative continues to tell the gentleman that he needs to locate other documents that might contain his Medicare number, even though he has already stated he does not have these documents.

At the end of the call, the beneficiary never gets his original question answered due to the fact that he does not have his Medicare number available. Remarkably, throughout the 50-plus pages of this interactive training exercise, not once during the mock call does the representative provide the beneficiary with instructions on how to obtain a new Medicare card. Instead, the beneficiary is sent on a scavenger hunt throughout his house trying to locate documents that he has already told the representative he does not have.

That scenario to me doesn't sound like the best response.

Mr. WEEMS. No, clearly it's not. Under the circumstances where a beneficiary may not have access to their Medicare number, one of the things that we are extraordinarily careful about and I think you'll appreciate is disclosure of information to people who are not the beneficiary. In fact, that's one of the primary checks on a customer service representative: Are they in fact talking to a beneficiary? Are they talking to their representative? Has their representative been designated?

Obviously, the situation that you describe is not ideal. There are other ways that a beneficiary can show who they are and receive the information that they need. Obviously, an area where we need to improve.

Senator SMITH. Kerry, are you persuaded that there's a sufficiently robust training program for those on the consumer service end?

Mr. WEEMS. Sufficiency is always in the eye of the beholder, and in this case in the eye of the experiencer.

I think we can do better. Part of the third party validation contract we have is to look at the training program and provide additional training—provide targeted training to customer service representatives.

One of the things that we've discovered with customer service representatives, they come in and they get 3 weeks of classroom training. Classroom training only works so well for adults. Classroom training works well for other age groups, but for adults you need to get them on the phone, you need to get them to where they're starting to handle calls. That is our training model, 3 weeks of classroom training, demonstrate competency, move to the phones, but be closely monitored and closely supervised until they're able to work on their own.

Senator SMITH. Kerry, you and I have talked privately about whether or not there is sufficient funding for 1–800–MEDICARE. I have urged the agency to make the requests to the administration to get whatever funding is sufficient to get this job done, because my concern is that if seniors aren't given prompt, decipherable, accurate information it may cost them a lot in terms of late enrollment penalties that stay with them for the rest of their lives. It may cost them, more importantly, in terms of their health. We've seen many instances where people were given wrong information or no information and they suffered sometimes catastrophic health consequences.

Yet you related to me something I think is important to get on the record. You said to me that if we just give you blanket more money, this wouldn't be the first priority.

Mr. WEEMS. No.

Senator SMITH. I believe you said the fraud program would be first.

Mr. WEEMS. Yes.

Senator SMITH. What was the other one?

Mr. WEEMS. Survey and certification. Senator Kohl every year works very closely with us to try and get the survey and certification budget and the nursing home budget to where it should be. Over the last 4 years, that budget has fallen $40 million short of our request.

Our total budget for the past 4 years has fallen about 900—this is our operational budget—about $928 million short of the dollars that we requested, and over half—

Senator SMITH. Is this because OMB is not asking for it or because we're cutting it?

Mr. WEEMS. This is the difference between the President's budget and what the Congress actually appropriates.

Senator SMITH. So the President is requesting it?

Mr. WEEMS. Yes.

Senator SMITH. But we have not been granting it?

Mr. WEEMS. That's correct.

Senator SMITH. That's a very important thing. But what I want to do, because I'm focused on 1–800–MEDICARE, is to say that this shouldn't be the third priority. What I'm saying is that all of those are important and what we need to make sure is that you ask for what you need to do the job in a superior way. Then we've

got to get the job done and get the money to you, because again this can be literally life and death issues for seniors.

Mr. WEEMS. Yes.

Senator SMITH. I appreciate you sharing that publicly for the record because I think it's very, very important.

Chairman Kohl.

The CHAIRMAN. Thank you, Senator Smith.

Mr. Weems, as you know, I have long fought to improve the safety of nursing home residents by requiring criminal background checks of the workers who care for them. I was pleased by the success of a recent CMS-sponsored pilot program that enabled States to expand their screening programs, which has kept thousands of known criminal offenders away from our most vulnerable citizens.

However, I was disappointed to discover that the findings of the report by CMS soon to be issued describing the success of the pilot program have been fundamentally altered by your agency. The report's estimates of the total costs of requiring background checks for all current and prospective long-term care workers was inflated by a factor of ten. How do you explain such an extreme revision of the first report, one that is at odds with the initial views of the report's authors?

Mr. WEEMS. Thank you for the question. CMS received this draft report in May of this year. As is common for reports of this nature and of this magnitude, the report is peer reviewed by CMS among senior career officials within CMS. One of our components noted that the report itself did not fully address the potential costs of the background survey, and other components looking at that peer review information agreed and asked the contractor to take another look.

Importantly, CMS did not specify what that other cost algorithm should look like. Instead, they said: We think you've missed some things; take another look. The contractor took another look, provided a methodology that they worked on themselves—it was their own original methodology—brought that back to CMS.

That methodology was again peer reviewed by the same career CMS staff in CMS, and agreed to. The contractor then completed the estimate using both methods, and both of those methods are in the report. I'm satisfied that this is the work of senior career employees using their best intellectual resources and judgment available to them.

The CHAIRMAN. Well, the version of my background check legislation was passed unanimously out of the Finance Committee, as you know, yesterday. It does fall in line with all of the points of consideration made in the soon-to-be-released CMS report. Based on this, do you support the bill that was passed yesterday out of the Finance Committee?

Mr. WEEMS. We certainly support the intent of the bill. We have not taken a formal stance on it. The thing that we're going to have to look closely at is how the costs of the background checks would be allocated between the Federal Government, State government, Medicare, and Medicaid.

The CHAIRMAN. Mr. Weems, as you're aware, I have a continuing concern about the information conveyed to Medicare recipients by Medicare Advantage sales agents. Yesterday in my home State of

Wisconsin a company was fined for selling products with unlicensed agents. What measures have been taken to specifically address questions about Medicare Advantage marketing practices at the call centers?

Mr. WEEMS. At the call centers, a couple of things happened. First of all, we have revised our scripts for the enrollment-disenrollment process. Previously they had suggested that enrollment would only be prospective. Now we ask a question about, do you think that you'd like this to be—I'm not quoting directly from the script—do you think you would like this to be retroactive? So now a beneficiary has that choice of actually being able to begin their disenrollment retroactively.

Our customer service representatives are also trained to ask questions about, did you know what you were getting into, did you actually sign the paperwork—anything that might suggest any kind of marketing misrepresentation. If they get those answers, then the beneficiary can disenroll and enroll in a plan that they wish. Further, that complaint is forwarded to our complaints tracking module for follow-up by our regional office. That's exactly what happened in that case.

I completely share your concern, Senator. As you know, earlier in this year CMS proposed a new set of tough regulations to deal with fraudulent marketing practices. The Congress took those regulations, put them into law, and I will tell you in the next couple of days, not weeks, those laws will be ensconced in a new set of regulations that will make it clear that that law and those regulations apply to the coming marketing period.

Mr. WEEMS. Thank you.

Thank you, Senator Smith.

Senator SMITH. Thank you, Senator Kohl.

Kerry, a couple follow-ups. To the timing on call waits, you indicated CMS is going to reduce wait times to 5 minutes for the remainder of the year.

Mr. WEEMS. Yes, or better.

Senator SMITH. Is that 5 minutes calculated on a 24-hour period or on the basis of an 8-hour work day?

Mr. WEEMS. It's calculated on a 24-hour period.

Senator SMITH. So if you calculate it on an 8-hour work day, what does it mean if somebody's calling during a work day?

Mr. WEEMS. I can give you an approximation of that, but one of the reasons that you see this reduction here is actually better management of calls during the peak periods. In the June-July period we implemented a command center enrichment, which I believe your staff had the opportunity to see, and actually I've made a visit to Richmond subsequently. It's really quite impressive and it's able to route calls from busy call centers to less busy call centers. It's able to move customer service reps who are doing other things, who might be in training, to quickly move them from training to a tier one line to start answering that phone call.

The contractor—and they can talk to you more about this also—implemented a real-time compliance with the employees. So we know, they know, what employees are doing at any given moment.

Interesting: One of the things you can see in the command center—and you've written me inviting us to go and you and the chair-

man are welcome at any time and I'd love to do that. You can see if a customer service rep has been on the phone for an extended period of time, so you can go to them: Do you need help? Why is this call—and either move the call to somebody that can handle it, give them the help they need so that they can shorten that call volume, give them the right answer, and move on to another call.

Those are the kind of technological changes we've implemented. Also a new smarter interactive voice unit, so that it does ask you to put in your Medicare number, but it will also ask you if it's a doctor claim or a hospital claim. So when you get to the customer service rep—and I saw this in Richmond—their name comes up, the name of the beneficiary comes up on the screen, even before the call begins in the CSR's ear. They can see the claim and they can begin working with them the instant the call begins.

Senator SMITH. We obviously want to get that wait time as low as we can during that 8 hours of the regular work time.

Mr. WEEMS. Yes.

Senator SMITH. If you can calculate what I think that would be for us, I'd sure appreciate receiving that.

[The information referred to follows:]

Mr. WEEMS. The daily average speed of answer (ASA) is calculated by adding up the wait times for each individual call and dividing it by the total number of calls. When calculating ASA on any timeframe, we county the total wait time spent in queue for the time period over the total calls answered by agents for the time period.

The ASA during the 8-hour workday for the month of August 2008 was 3 minutes, 58 seconds and for September 2008 was 1 minute, 20 seconds. (We defined the 8-hour workday as Monday - Friday, 9:00am ET to 5:00 pm PT.) The overall ASA for the month of August 2008 was 3 minutes, 44 seconds and for September 2008 it was 1 minute 16 seconds.

Mr. WEEMS. We can estimate it, and then I would be happy to report it as our experience continues.

Senator SMITH. You have the budget sufficient to get it down to an average of 5 minutes in a 24-hour period?

Mr. WEEMS. Yes.

Senator SMITH. OK. Obviously, you're dealing with Vangent as the prime contractor on this. My understanding is that below them there are a myriad of subcontractors.

Vangent subcontracts to a company named Sensure, and it in turn subcontracts to Palmetto. I don't know how much more complicated it gets beyond that.

But my question to you is, what are you doing to ensure oversight not just of Vangent, but their subcontractors? Are they looped into this and do you have confidence that this isn't so distantly removed in relationships that you're losing control of it?

Mr. WEEMS. They are looped into it, and in fact some of those arrangements that you mention have been concluded as a matter of consolidation. The staff that exerts oversight over this program I have not only considerable confidence in, but considerable respect for. They speak to the contractor—they will validate this—not just daily, but I think hourly. It is an extraordinarily closely supervised contract.

Senator SMITH. Kerry Weems, thank you so much for your time and your public service. I do appreciate your acknowledgment, the acknowledgment of CMS, that there are real problems. The agency understands they need to come forward with real solutions, and

we're just here to encourage that, because we're accountable as well.

I think I've heard your commitment today that you'll work with us, with me, my staff, Senator Kohl and his, the entire Aging Committee. We want to work with you, not at you, and that's the spirit in which we need to get this right if we're going to get it done for America's seniors.

So thank you very much.

Mr. WEEMS. Thank you for the opportunity to appear, sir. Thank you, Senator. Good to see you.

Senator SMITH. We'll now call up our second panel. We welcome Naomi Sullivan, a dual-eligible Medicare beneficiary from Chico, CA, who will offer her on-the-ground perspective and experiences calling 1–800–MEDICARE. Then we'll have Michealle Carpenter, the Deputy Policy Director and Counsel of the Medicare Rights Center, who will discuss her experience offering information and assistance with health care rights to Medicare beneficiaries. Then Tatiana Fassieux, who will testify in her capacity as the Board Chair for California Health Advocates, also a program manager for the California Health Insurance Counseling and Advocacy Program. Tatiana will share with us her experiences in helping beneficiaries to navigate 1–800–MEDICARE.

Would you like to introduce your Wisconsin witness?

The CHAIRMAN. John Hendrick is a Staff Attorney at the Coalition of Wisconsin Aging Groups, where he directs the Elder Financial Empowerment Project and also works with the Wisconsin Prescription Drug Help Line in the Elderly Benefits Specialist Program.

Prior to joining the coalition, he was a managing attorney for 16 years of a statewide legal education agency, teaching thousands of non-lawyers about their legal rights. He has given numerous presentations throughout Wisconsin relating to elder rights and Medicare and presented at the 2004 and 2006 National Aging and Law Conference.

We're very happy to have you with us this morning, Mr.

Hendrick.

Senator SMITH. Well, thank you. Why don't we start with Naomi and we'll just go in that order. We'll be informal. We may even break in and ask a question or two. But you've all obviously heard Administrator Weems discuss recent changes at the call centers and I'm hoping to hear if you've actually seen those improvements and what you think of the testimony you've heard.

Take it away, Naomi.

STATEMENT OF NAOMI SULLIVAN, MEDICARE BENEFICIARY, CHICO, CA

Ms. SULLIVAN. I'd like to thank you, Senator Smith and Senator Kohl, for allowing me to come before the Senate and explain my experience with Medicare. My name is Naomi Sullivan. I'm 57 years old. I live in Chico, CA. I'm on disability and am what is called a dual-eligible beneficiary. I am here today to share my story, to give voice to those who don't know how to speak for themselves. My hope is that the government will understand that there are beneficiaries like me all over the country who lack resources,

are in dire straits, have turned to 1–800–MEDICARE for help, and aren't getting the assistance they so desperately need.

A few years ago I was making over $60,000 per year salary. I now live on less than $700 per month social security disability and have had to make choices whether to eat or pay my premiums and medications. A while back I went on what I call a refugee diet because I couldn't afford to buy groceries and pay all of my bills.

I am here today because in 2007 I decided to switch my Medicare D plan from Humana to Blue Cross. I received an information card in the mail from Blue Cross, returned it, and shortly after received an application in the mail. I filled out the paperwork to enroll in a Part D plan and thought I was good to go. Little did I know what I was in store for.

It turns out that somewhere along the way I was inappropriately enrolled in a PPO—you call it a Medicare Advantage plan—instead of a Part D plan. I found out about that the hard way when my doctor started to ask me for copays. I never had to pay copays because I also had MediCal. Then I started to get premium notices and billings, and throughout the year I also got many bills from my doctors. I couldn't understand why Medicare and MediCal weren't paying my medical expenses the way they used to. But I knew I had to get this straightened out as quickly as possible.

So I called 1–800–MEDICARE to get some answers and to try to get out of the PPO, into a Part D plan I had enrolled with in the first place. I called 1–800–MEDICARE over a dozen times. I can't afford both a home phone and cell phone, so I have just a cell phone. When I would call 1–800–MEDICARE, I was sometimes on hold for up to 45 minutes at a time, and then I'd get transferred and disconnected and have to start all over again.

Meanwhile, I was going over my cell phone plan minutes and having to pay for minutes that I couldn't afford. Eventually it got to the point where I simply could not afford to make one more call to 1–800–MEDICARE.

All I can say is thank goodness I found Tatiana at HICAP because honestly I do not know what I would have done. I just wanted to give up. I felt like less than nothing. I felt like the people at 1–800–MEDICARE did not have any interest in helping me. I told them my story, that I was on disability and barely making it on less than $700 per month and could not afford the premiums for the plan that I had been inappropriately enrolled it. One Medicare representative suggested that I get a part-time job to help pay the premiums, but they didn't offer any help. They didn't tell me about any resources and they didn't tell me because of my situation I can switch plans at any time. They just kept telling me to call my plan and work it out.

I just needed a little help and some direction on how to get things sorted out. I didn't get that from Medicare. So many bills got turned over to collections, I subsisted on my refugee diet and I couldn't get anyone to help me.

At last I went to my local Social Security office. They referred me to Tatiana. She's helping me to get things straightened out. I'm now enrolled in a Part D plan. I don't have a clue how I'm going to pay for all the bills that mounted up while I was on the wrong plan. I know that Tatiana is working on that. But at least hope-

fully now I won't have to worry about going to my doctor or getting my medications.

I feel that 1–800–MEDICARE should have an easier way for people to live—I'm sorry. I feel that 1–800–MEDICARE should have an easier way for people to get a live person, that they should have proper training so that they can provide accurate information, or at least refer callers to their local HICAP, because I know they have the ability to help.

[The prepared statement of Ms. Sullivan follows:]

TESTIMONY OF NAOMI SULLIVAN
SEPTEMBER 11, 2008

My name is Naomi Sullivan. I am 57 years old and live in Chico, California. I am on disability and am what is called a "dual eligible" beneficiary. I am here today to share my story to give voice to those who don't know how to speak for themselves. My hope is that the government will understand that there are beneficiaries like me all over the country who lack resources, are in dire straights, have turned to 1-800-Medicare for help, and aren't getting the assistance they so desperately need.

A few years ago I was making over $60,000 per year salary. I now live on less than $700 per month Social Security disability and have had to make choices about whether to eat or pay for my premiums and medications. A while back I went on what I call a "refugee diet" because I couldn't afford to buy groceries and pay all of my bills.

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It turns out that somewhere along the way, I was inappropriately enrolled in an PPO, you call it a Medicare Advantage plan, instead of a Part D plan. I found out about that the hard way when my doctors started to ask me for co-pays. I never had to pay co-pays because I also had Medi-Cal. Then I started to get premium notices and billing. And throughout the year, I also got many bills from doctors.

I couldn't understand why Medicare and Medi-Cal weren't paying my medical expenses they way they used to. But I knew I had to get this straightened out as quickly as possible. So I called 1-800-Medicare to get some answers and try to get out of the PPO and into the Part D plan I had enrolled with in the first place. I called 1-800-Medicare over a dozen times. I can't afford both a home phone and a cell phone, so I have just a cell phone. When I called 1-800-Medicare, I was on hold sometimes for up to 45 minutes at time. And then I'd get transferred, and disconnected, and then have to start the call all over

again. Meanwhile, I was going over my cell phone plan minutes and having to pay for minutes that I couldn't afford. Eventually, it got to the point where I simply could not afford to make one more call to 1-800-Medicare.

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So, many bills got turned over to collections. I subsisted on my "refugee diet." And I couldn't get anyone to help me. At least until I went to my local Social Security office, and they referred me to Tatiana. She's helping me get things straightened out. I'm now enrolled in a Part D plan. I don't have a clue how I'm going to pay for all the bills that mounted while I was on the wrong plan. I know that Tatiana is working on that. But at least hopefully now I won't have to worry about going to my doctor or getting my medications.

I feel that 1-800 Medicare should have an easier way for people to get to a "live" person, and that they should have proper training so that they can provide accurate information, or at least refer callers to their local HICAP – because I know that they have the ability to help.

Senator SMITH. Thank you very much, Naomi. That's firsthand experience why we're having this hearing today, to try to get better response.

Ms. SULLIVAN. Thank you.

Senator SMITH. Michealle.

STATEMENT OF MICHEALLE CARPENTER, DEPUTY POLICY DIRECTOR AND COUNSEL, MEDICARE RIGHTS CENTER

Ms. CARPENTER. Good morning, Chairman Kohl and Senator Smith.

Senator SMITH. You want to hit your button there.

There you go.

Ms. CARPENTER. Good morning, Chairman Kohl and Senator Smith. I thank you for your longstanding and bipartisan commitment to the common good and welfare of people with Medicare.

The persistent failures of the Medicare consumer hotline, 1–800–MEDICARE, cause daily harm to the health and wellbeing of older Americans across the Nation. The volunteers and staff of the Medicare Rights Center confront the human hardship caused by these breakdowns daily. We appreciate your efforts to shine light on the hotline's failures as a necessary step toward correcting them.

In recent years Medicare has become a daunting challenge for consumers to navigate. Since enactment in 2003 of the Medicare Modernization Act, a Wild West marketplace for Medicare coverage was launched and a system rich with opportunities to exploit people with Medicare has been established. To no surprise, the older, frailer, and most impoverished people with Medicare are most vulnerable to exploitation. Without safety nets, they are the most harmed by this exploitation.

Regrettably, the Centers for Medicare and Medicaid Services has failed to provide the most basic tools to protect people from the danger of this marketplace. Even as the market became significantly more complex, repeated reorganizations of CMS's bureaucracy have left CMS with neither a centralized consumer education office nor a coordinated approach to consumer education. At times CMS has mixed consumer education with ideological propaganda. Consumers are harmed by information that is colored by a preference for Medicare Advantage plans and a political imperative to paint the prescription drug program in the best light regardless of reality.

In addition to long hold times, callers often spend well over an hour while a poorly trained operator tries to find an answer to a simple question or resolve a problem. CMS's customer service representatives lack proper training to answer callers' questions or assist in resolving problems. The scripts from which representatives read often lack meaningful information. Even accurate information is often delivered in a way that few people can understand. Representatives provide false, misleading, and inaccurate information. While callers often call with complex problems that require the representative to have technical knowledge, representatives are unable to answer even basic questions.

One area where 1–800–MEDICARE customer service representatives consistently fail to provide accurate information and assistance is when a beneficiary has been a victim of fraudulent or mis-

leading marketing by a private Medicare Advantage plan. Because this problem is so widespread, CMS has assured us that all customer service representatives are well trained to handle these kinds of cases. This is not the case.

In discussions with CMS last year, we were assured that every caller who has been fraudulently enrolled in a private Medicare plan will be assessed for retroactive disenrollment. The importance of this cannot be overstated as thousands of dollars may be at stake for a client who's left with unpaid medical bills because they were enrolled fraudulently in a plan.

In our experience, representatives are aware of the exceptional circumstances special enrollment period which allows people with Medicare to disenroll from a plan any time during the year under certain circumstances. Unfortunately, representatives appear only to understand how to help people disenroll from the plan prospectively. On most occasions, callers are not assessed for retroactive disenrollment. Even more concerning, a representative recently told one of our caseworkers that Medicare does not provide retroactive disenrollment even for marketing fraud cases.

When our caseworkers attempt to help clients request a retroactive disenrollment through an exceptional circumstances SEP, we are transferred from one representative to another and often stay on the phone for more than an hour awaiting a resolution. In the end we are usually told this issue will be transferred to the regional office for a decision and that the client will receive a call within a week. More often than not, that call never comes.

So what should be done? For starters, CMS must increase oversight of the 1–800–MEDICARE contractor. CMS must reestablish an independent office focused on communication with people with Medicare that reports directly to the CMS Administrator. This office should have direct oversight over 1–800–MEDICARE and should be responsible for developing training materials and scripts for 1–800–MEDICARE operators.

It is our understanding that representatives are not trained on Medicare policy, but rather on how to search a database for the proper script to read to a caller. Customer service representatives must have at a minimum a basic understanding of Medicare. All representatives should have regular training on topics callers most frequently call about. This is how we train our volunteers and staff that answer our hotlines. This training must be reinforced with more frequent testing to ensure continued understanding and ability to answer questions accurately.

In addition to providing better training and scripts to 1–800–MEDICARE customer service representatives, CMS needs to make a concerted effort to fix the data exchange systems problems that plague the privatized sectors of Medicare. Admittedly, these data exchange systems are complicated and the solution is not an easy one. But it's been 3 years since Medicare Part D began and 5 years since the expansion of Medicare Advantage.

Simplifying and standardizing Medicare choices is absolutely necessary. But 1–800–MEDICARE cannot wait for that day to come. People with Medicare must be allowed the helping hand that we pay 1–800–MEDICARE to offer.

Thank you.

[The prepared statement of Ms. Carpenter follows:]

Medicare Rights Center

Testimony of Michealle Carpenter, Deputy Policy Director and Counsel
Medicare Rights Center
On
"1-800 Medicare: It's Time for a Check-Up."
Before the
United States Senate
Special Committee on Aging
September 11, 2008

Good morning Chairman Kohl, Ranking Member Smith, and other distinguished members of the Committee. I thank you for your long standing commitment to the common good and the welfare of people with Medicare. The persistent failures of the Medicare consumer hotline, 1-800-Medicare, cause daily harm to the health and well being of people with Medicare. The volunteers and staff of the Medicare Rights Center confront the hardships caused by these breakdowns daily. We are grateful for your efforts to shine light on the hotline's failures as a first step toward correcting them.

The Medicare Rights Center is a national, non-profit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives that are drawn from our work with people with Medicare. We provide services through six different hotlines to individuals, care givers, and professionals who need answers to Medicare questions or help securing coverage and getting the health care they need. Our hotlines go well beyond 1-800-Medicare: we offer people with Medicare accurate information and, beyond that, needed advocacy and support to help them meet their health care needs.

We also teach people with Medicare and those who care for them, such as health care providers, social workers, and family members, about Medicare benefits and rights. Our primary tool in doing this is our free and publicly available web based consumer counseling tool, Medicare Interactive available at www.medicareinteractive.org.

In recent years Medicare has become, to put it mildly, more challenging for consumers to understand and navigate, particularly since enactment in 2003 of the Medicare Prescription Drug Improvements and Modernization Act (MMA). A wild west marketplace for Medicare coverage was launched and a system rich with opportunity to exploit people with Medicare was established. Regrettably, the Centers for Medicare and Medicaid Services (CMS) has failed to provide the most basic of tools to help people with Medicare navigate that marketplace.

As you know, in addition to the expanded Medicare Advantage marketplace, consumers faced both the opportunities and challenges of a dizzyingly complex drug benefit in January 2006. At

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520 Eighth Avenue, North Wing, 3rd Floor, New York, NY 10018 · Tel: (212) 869-3850 · Fax: (212) 869-3532
www.medicarerights.org

the same time, repeated reorganizations of CMS' bureaucracy have left CMS with neither a centralized consumer education office nor a coordinated approach to consumer education. Even worse, CMS at times has mixed notions of consumer education with ideological propaganda. Consumers are poorly served by information that is colored by a preference for Medicare Advantage plans and the political imperative to paint Part D in the best light. Consumers are left, all too often, with nowhere reliable to turn.

Since 2004, reports by the U.S. Department of Health and Human Services Office of Inspector General and the U.S. Government Accountability Office have demonstrated on-going problems with long wait times and difficulty accessing accurate information about Medicare.[1,2] A 2007 HHS OIG report even shows that over time 1-800-Medicare has gotten worse, not better. For example, in 2007, 71 percent of callers reported being satisfied with their calls to 1-800-Medicare, compared to 84 percent in 2004. In addition, in 2007 more callers reported hanging up before receiving an answer to their call than in 2004. While improvements to 1-800-Medicare have been made since these investigations were conducted, our day to day experience shows that these problems still remain and that more must be done to ensure that people with Medicare have a reliable, accurate source of information and assistance.

Callers often spend long periods waiting on hold. Once they finally reach a representative, callers can spend well over an hour while the poorly trained operator tries to find an answer to a simple question or resolve a problem. Callers are often transferred to a number of different operators and must explain the problem over each time. After all of this, callers often hang up the phone with wrong information or without any answer.

Representatives lack proper training to answer callers' questions or assist in resolving problems. The scripts from which representatives read lack meaningful information and are not written in a way that most people can understand. Representatives often provide false, misleading or inaccurate information. While callers often call with complex problems that require the representative to have technical knowledge, representatives are unable to answer even basic questions accurately. Unfortunately, we hear this problem frequently:

- One client from New York, who is a Medicare Part D Low-Income Subsidy recipient, received a letter indicating that her Extra Help coverage was going to be terminated because she no longer met the criteria for coverage. The letter indicated that she should call 1-800-Medicare if she believed she received the letter in error. When she called, the operator did not understand why she was calling. The beneficiary had to read the letter to the representative. Even after that, the representative did not understand why the beneficiary was calling. Every year hundreds of thousands of people improperly lose their deemed status for Extra Help and receive a letter like this notifying them of the problem. 1-800-Medicare representatives should be well aware of this situation and very familiar with this letter, so that they can properly advise callers on the steps to take.
- Another client from New York called 1-800-Medicare to enquire about enrolling in Medicare Part B. She is 70 years old, enrolled in Part A, and has employer sponsored

[1] U.S. Government Accountability Office, Accuracy of Responses from 1-800-Medicare Help Line Should Be Improved, GAO-05-130, December 2004.
[2] U.S. Department of Health and Human Services Office of Inspector General, 1-800-Medicare: Caller Satisfaction and Experiences, OEI-07-06-00530, September 2007.

insurance. The customer service representative told the client that she would not be able to enroll in Part B until the following January, that coverage would not begin until July, and that she would be subject to a late enrollment penalty. All of the information provided by the representative was wrong. After calling the Medicare Rights Center and being given accurate information, the client went to her local Social Security Office to begin the process of enrolling in Medicare Part B.

- One of the most egregious cases we have seen involved a client from New York who wanted to enroll in a prescription drug plan. She called 1-800-Medicare to request enrollment in a prescription drug plan. Instead, the representative enrolled her in a Medicare Advantage Private Fee-for-Service plan. As a result, the client incurred out of pocket expenses because her doctors did not accept the plan and she was unable to fill prescriptions because of the cost. After enlisting the assistance of the Medicare Rights Center, the client was enrolled into original Medicare with a prescription drug plan.
- Recently, one of our clients from Pennsylvania called 1-800-Medicare to determine whether a drug she takes will be covered by a Medicare prescription drug plan. The woman is 65 years old and currently has insurance through her employer. She will enroll in Medicare next year. The 1-800-Medicare representative told her that three plans in the area cover the drug. However, the representative based that answer on 2008 formularies. The representative failed to explain that formularies change and there is no assurance that a drug covered in 2008 will also be covered in 2009. In addition, the representative did not explain that the beneficiary could request an exception for a medically necessary drug, if it is not covered by the plan. Further the representative inaccurately explained the coverage gap and did not provide any information about catastrophic coverage.
- Approximately a month ago, one of our clients from New York called 1-800-Medicare and asked if Medicare would cover the cost of "Life Line" – a medical emergency alert system – and was told that if she paid for the system, Medicare would reimburse her at least 50 percent of the cost. This information was just wrong. These systems are not covered by Medicare and never have been.

Another area where 1-800-Medicare customer service representatives consistently fail to provide accurate information and assistance is when a beneficiary has been a victim of fraudulent or misleading marketing by a private "Medicare Advantage" plan. Because this problem is so widespread, CMS has assured us that all customer services representatives are well trained to handle these kinds of cases. This is not the case. In discussions with CMS last year, we were assured that every caller who has been fraudulently enrolled in a private Medicare plan will be assessed for retroactive disenrollment. The importance of this cannot be overstated, as thousands of dollars may be at stake for a client who is left with unpaid medical bills because they were enrolled fraudulently in a plan. In our experience, representatives are aware of the Exceptional Circumstances Special Enrollment Period (SEP), which allows people with Medicare to disenroll from a plan any time during the year under certain circumstances. Unfortunately, representatives appear only to understand how to help people disenroll from the plan prospectively. On most occasions, callers are not assessed for retroactive disenrollment. Even more concerning, a representative recently told one of our caseworkers that Medicare does not provide retroactive disenrollment, even for marketing fraud cases. When our caseworkers attempt to help clients request a retroactive disenrollment through the Exceptional Circumstances SEP, we are transferred from one representative to another, and often stay on the phone for more than an hour, awaiting a resolution. In the end, we are usually told the issue will be transferred to the regional office for a decision and that the client will receive a call within a week. More often

than not, our client never receives a call, and we are forced to advocate through other channels, channels not available to most people with Medicare.

The Medicare Rights Center has contacted CMS on multiple occasions explaining the problems with this process. The scripts used by 1-800-Medicare representatives for disenrollment from plans were improved and problems with prospective disenrollment have decline. But, retroactive disenrollment is still fraught with difficulties. This is particularly problematic because we have been told on a number of occasions when we call the CMS regional office that we must contact 1-800-Medicare. We can no longer circumvent 1-800-Medicare by working directly with the CMS regional office to effectuate a retroactive disenrollment.

Customer service representatives from 1-800-Medicare are also unable to assist callers when they call to determine why a Medicare Part A or Part B claim was denied. Prior to 2004, people with Medicare could call the Part A or B contractor – the private entity paid by Medicare to administer claims – and ask why a particular claim was denied. The customer service representative at the contractor could provide a reason for the denial, such as the improper code was used, and the beneficiary could take the necessary steps to resolve the problem to have the claim paid. Now, beneficiaries can no longer call the contractor, but must instead call 1-800-Medicare. However, customer service representatives at 1-800-Medicare can only tell the caller that the claim was denied and that they may file an appeal. Representatives do not have access to information that indicates why the claim was denied. If 1-800-Medicare is the only resource that beneficiaries have to resolve the problem, the operators at 1-800-Medicare must have access to this information. This was a sad step back for consumers.

Customer service representatives at 1-800-Medicare are also typically unable to address data exchange problems. Data exchange problems occur when the Centers for Medicare and Medicaid Services and some outside entity, such as a Medicare Advantage plan sponsor, must share information about a beneficiary and his or her coverage, but they do not do so properly or in a timely manner. This problem occurs in a variety of ways.

- A client from Florida joined a Medicare Advantage plan that, as part of its benefit package, paid the Medicare Part B premium on the beneficiary's behalf. However, the Part B premium continued to be deducted from his Social Security check. The client called the plan to determine why this was happening. The plan told him that the problem was on the Medicare side, that they had provided CMS with all the necessary information to stop the premium withholding from his Social Security benefits. According to the plan, CMS is supposed to approve enrollment in the plan and notify the Social Security Administration to stop deducting the premium. The plan told the client to contact 1-800-Medicare to resolve the problem. He called 1-800-Medicare three times, each time he was told that the problem would be referred and that he would receive a return call within one to two days. To date he has not received a phone call and the Medicare Part B premiums continue to be deducted from his Social Security benefits.
- Another of our clients from Indiana was enrolled in SecureHorizons, a Medicare Advantage plan with prescription drug coverage, through the end of the year. At the beginning of the next year she decided to enroll in a new plan, Today's Options. Soon after her enrollment, she realized that her doctors did not accept Today's Options. Still within the Open Enrollment period, she disenrolled from Today's Options and reenrolled in SecureHorizons. SecureHorizons told her that she was successfully reenrolled. A few

> months later, she began receiving bills from her providers. She called 1-800 Medicare to find out why this was happening and was told that she was still enrolled in Today's Options. A customer service representative told her that someone would investigate the issue and call her back. She never received a call back.

Another typical data exchange problem occurs when a person with Medicare switches from one prescription drug plan to another during the Annual Coordinated Enrollment Period. The new plan does not have the beneficiary's Medicare Part D Low-Income Subsidy information; therefore, the beneficiary is charged the full co-payment for prescription drugs – a copayment that is unaffordable. When the beneficiary contacts 1-800-Medicare, the representative is able to confirm LIS enrollment, but is not able to resolve the problem because the representative is unable to update the plan's information or explain the best available evidence policy, which allows the beneficiary to provide evidence of Medicaid coverage or some other documentation that they qualify for the Low-Income Subsidy in order to receive the benefit of the subsidy. In these situations, beneficiaries contact us and we are able to help them make use of the best available evidence policy to access their medications at the LIS co-payment level immediately.

These cases highlight the types of data exchange problems that occur regularly and that 1-800-Medicare should be able to address, but cannot. This problem causes a great deal of harm to people with Medicare, because it prevents them from accessing services or results in financial hardship. To resolve these problems, people with Medicare cannot turn to 1-800-Medicare, the resource that was created to answer questions and resolve problems for people with Medicare; instead they must work with organizations like the Medicare Rights Center.

To improve the service provided by 1-800-Medicare and ensure its reliability for people with Medicare, the Centers for Medicare and Medicaid Services should increase oversight of the 1-800-Medicare contractor. CMS should re-establish an independent office focused on communication with people with Medicare that reports directly to the CMS Administrator. This office should have direct oversight over 1-800-Medicare. To ensure the quality of information provided, the office should be responsible for providing training materials and scripts for 1-800-Medicare operators. Currently, customer service representatives are not trained on Medicare policy, but rather on how to search a database for the proper script to answer the caller's question. This training model should be changed. Customer service representatives must have, at a minimum, a basic understanding of Medicare. All customer service representatives should have annual training on topics callers most frequently call about. This is how we train the volunteers and staff that answer our hotlines. This training should be reinforced with more frequent computer testing, or some other model of periodic training, to ensure continued understanding and ability to properly answer questions.

The office should also be responsible for conducting and coordinating quality control measures, including ensuring proper and on-going training of 1-800-Medicare staff. Further, a satisfaction survey should be developed and made available at the end of each call to 1-800-Medicare. This will provide information on a timely basis of the beneficiaries' experience with 1-800-Medicare.

In developing training materials and scripts, the office should seek feedback from a fully staffed and independent Medicare Ombudsman who can provide insight into systemic problems that people with Medicare experience, which will ensure that the materials truly address the needs of people with Medicare. Further, the office should vet consumer education and training materials

with community organizations that help people with Medicare. These organizations have staff members that are expert in assisting people with Medicare make coverage choices and navigate coverage issues. They have kept up with Medicare coverage rules and figured out what they mean for their clients. They are skilled in translating complex rules and regulations into "what does this mean for you" information.

To improve the retroactive disenrollment process through 1-800-Medicare, CMS must require that operators use CMS-approved scripts. In addition, 1-800-Medicare must be required to use a decision algorithm for responding to requests for both prospective and retroactive disenrollment. It is vital that 1-800-Medicare handle this process effectively, as CMS Regional Offices will no longer take requests for retroactive disenrollment from beneficiaries or their advocates.

In addition to providing better training and scripts to 1-800-Medicare customer service representatives, CMS needs to make a concerted effort to fix the data exchange systems problems. These data exchange systems are complicated and the solution is not an easy one. However, it has been three years since Medicare Part D began and five years since the Medicare Advantage program was expanded. It is time to acknowledge this problem exists and work to resolve it. Enough is enough.

The complicated systems that have been established to allow private companies compete for Medicare consumers make the operation of an effective and reliable hotline imperative. Providing such a hotline requires proper training and quality control measures that are focused on ensuring consumers get the information they need when they need it.

Senator SMITH. Michealle, did you take much comfort in what you heard the Administrator say this morning?

Ms. CARPENTER. I think a lot of the changes that are to come will be beneficial. They seem to be mostly about the technology and less about the training, which is where most of our concern lies.

Senator SMITH. So yours is technology, not the training?

Ms. CARPENTER. No, ours—we believe the training.

Senator SMITH. The training, not the technology.

Ms. CARPENTER. We are heartened by the technological improvements that will be made and we think they will be helpful to people with Medicare.

Senator SMITH. Very good.

Tatiana.

STATEMENT OF TATIANA FASSIEUX, BOARD OF DIRECTORS CHAIR, CALIFORNIA HEALTH ADVOCATES, SACRAMENTO, CA

Ms. FASSIEUX. Good morning. Good morning, Chairman Kohl, Senator Smith, and other distinguished members of the committee. My name is Tatiana Fassieux and I am the Board Chair of California Health Advocates and also a Program Manager. I represent the boots on the ground of Medicare beneficiaries in California.

California Health Advocates is a nonprofit organization dedicated to education and advocacy on behalf of California Medicare beneficiaries. I've been in that role for about 4½ years. But I also represent the 24 HICAPs, the SHIPs, in California serving more than 4 million Medicare beneficiaries. In my neck of the woods, northern California, I serve five counties, rural counties, with about 45,000 Medicare beneficiaries under our program.

But I do want to thank the committee for inviting me for the opportunity to speak. I do want to focus on some of the topics discussed, the 1–800–MEDICARE, of course, the myriad of problems with the call centers' performance, the resulting impact on the SHIPs, and of course in California in particular, and above all the impact on Medicare beneficiaries, and I'll suggest some recommendations.

We believe that 1–800–MEDICARE reflects the credibility of the agency it represents, that is CMS, and the regulatory process that established it. So that credibility must be upheld quite at a very high standard.

The SHIP network has come to rely frequently on the help of 1–800–MEDICARE and we have the expectation that our Medicare beneficiaries will have accurate and timely information. In many instances both clients and SHIP counselors have had good successful contacts. We must agree to that.

We are also pleased by the recent implementation of the special SHIP direct, or I should say back door, number into 1–800–MEDICARE. We still have to go through the protocols and the IVR system, but we have a pseudo-back door way, and California has just now implemented that.

However, as I will illustrate, credibility has been shaken frequently. Medicare beneficiaries and SHIPs have had unreasonable wait times, frequent disconnects, misinformation, and what troubles us is the difficulty in resolving hard cases. That lack of faith in prompt resolution is what concerns us.

Beneficiaries continue to complain about the IVR system. They say: I wish I could get a live person, because they're very frustrated by that technological feature. We're still dealing with 1930's, 1940's seniors, who technology is just frightening to them. On a good day, it takes us about 10 to 15 minutes to get to the first level of CSRs.

The disconnects are particularly egregious, especially when we as SHIP counselors are trying to assist clients with the assistance of 1–800–MEDICARE. Where that first level cannot help, we get transferred to the second level, and during that transition we get cutoff.

Misinformation of course can do tremendous harm. Clients have told us that, I wish Medicare had told us that I could change plans any time, when they discovered that they were in a plan that they should not have belonged in. They were locked in, according to the Medicare representative, but in reality they were not.

In an instance where you mentioned, a southern California transplant patient was incorrectly told by a CSR that nobody gets lifetime anti-rejection medication, and it was because of our persistence we escalated and we were able to assist the client.

As you heard with Naomi, her case—I am personally handling her case—the reason she is on such low income is because she felt she had to get a job and Social Security reduced her income, which was sort of a double whammy.

Another counselor had reported that when we were trying to file a complaint we were actively discouraged, saying that a complaint is serious.

Now that 1–800–MEDICARE is the single point of entry for all issues dealing with Medicare, including our efforts in dealing with very complex issues, we may have to contact a subcontractor. It just particularly gives us a little more problems in getting to the right people.

So we appreciate that we have been given additional funding, but of course in California with the budget that funding hasn't come through yet, and in my neck of the woods it'll just be a few thousand dollars. $15 million globally sounds like a lot of money, but when you break it down to the individual HICAPs it's just a little bit of money.

So we would like to propose the following actions. Definitely additional training, better scripts. It has been inferred also that they get State-specific information. Absolutely better CMS oversight. Who knows, a better friendly system in responding.

It was good to hear from Mr. Weems about that new response system. The California CALPERS instituted that and it's working quite well.

But one more thing I would like to suggest is that we form a task force that includes SHIPs, beneficiaries, CMS, and any other advocacy organizations to review those scripts, to review the training, because sometimes I think that the SHIP counselors definitely know more than the CSRs.

Thank you for letting me speak.

[The prepared statement of Ms. Fassieux follows:]

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1-800 MEDICARE: CONTINUING PROBLEMS for SHIPs and MEDICARE BENEFICIARIES

Written Testimony of

Tatiana Fassieux

Board Chair
California Health Advocates
And
Program Manager, Health Insurance Counseling & Advocacy Program (HICAP)
Of PASSAGES, Chico, CA

Hearing: "1-800 MEDICARE: It's Time for a Check-Up"
Senate Special Committee on Aging
September 11th, 2008

I. INTRODUCTION

Good morning Chairman Kohl, Ranking Member Smith and other distinguished members of the Committee, my name is Tatiana Fassieux. I am Board Chair of California Health Advocates (CHA) and Program Manager for the Health Insurance Counseling & Advocacy Program – HICAP, of PASSAGES, in Chico, CA.

California Health Advocates (CHA) is an independent, non-profit organization dedicated to education and advocacy efforts on behalf of Medicare beneficiaries in California. As Board Chair for the past 4 1/2 years, I have provided direction and support of the organization's mission of Medicare beneficiary advocacy and education for Californians, and the work of 24 HICAPs – California's State Health Insurance Assistance Program, or SHIP.

As a HICAP manager for more than 9 years, I have been responsible for the Medicare counseling program serving more than 45,000 Medicare beneficiaries in 5 Rural Northern California counties offered by PASSAGES, which also is a designated Area Agency on Aging, PSA 3. This non-profit agency is a project of the Research Foundation of California State University, Chico.

I want to thank the committee for inviting me to testify on behalf of CHA and California's Medicare beneficiaries about experiences we have had with 1-800-MEDICARE.

This written testimony will focus on 4 issues:

1. The importance of 1-800-MEDICARE;
2. The myriad problems with 1-800-MEDICARE's performance;
3. The resulting impact on SHIPs and Medicare beneficiaries; and
4. Recommendations for improvement.

II. IMPORTANCE of 1-800-MEDICARE

Since the introduction of Part D, the Medicare prescription drug benefit, and the expansion of Medicare Advantage plans, we have worked hand-in-hand with 1-800-MEDICARE in providing the "local" support that beneficiaries needed during these challenging times. We have had clients referred to the HICAPs by 1-800-MEDICARE customer service representatives (CSRs), and frequently we have reciprocated because we knew that 1-800-MEDICARE was a 24-7 benefit that should be taken advantage of. When we refer clients to 1-800-MEDICARE, though, we should be able to expect that they will be provided with accurate and timely information.

HICAPs routinely call 1-800-MEDICARE to verify beneficiaries' records, to file complaints on behalf of beneficiaries, etc. – that is, to do the work that the HICAPs are expected to do. And we have had improved experiences with the introduction of

counselor unique ID numbers and the new SHIP-only telephone number to access CSRs at 1-800-MEDICARE. However, as discussed below, our confidence in the ability of 1-800-MEDICARE has been shaken frequently based upon our experiences as well as those of our clients.

III. PROBLEMS WITH 1-800-MEDICARE

Many calls to 1-800-MEDICARE result in a positive outcome, and it is our understanding that the performance of this phone line is, overall, gradually improving. Sometimes callers get good service and accurate answers. Due to the nature of our work, however, we are less likely to hear about success stories with 1-800-MEDICARE than problems experienced by our clients. Based upon the experience of SHIP programs and the clients they serve, the rate of unsuccessful calls – in terms of getting through, obtaining accurate information, and resolving problems – is still far too high. In short, it is still hit or miss whether a caller will receive accurate information and/or have their problem resolved.

The following section breaks down ongoing 1-800-MEDICARE problems into two general categories: access to services; and the resolution of individual beneficiaries' problems.

A. ACCESS

The first challenge for callers is to get through to someone who can help them. Medicare beneficiaries and SHIP programs alike experience ongoing difficulties accessing assistance through the 1-800-MEDICARE phone line due to issues such as long wait times, disconnected calls, and frustrations with the interactive voice response (IVR) system.

Long wait times

When calling 1-800-MEDICARE, both SHIP counselors and their clients report wait times of varying length. According to one HICAP counselor, it typically takes 30 minutes to 1 hour to reach someone who can help with an issue. Another reports that it usually takes 15-20 minutes to get to the 1st layer of CSRs, and an additional 15-30 minutes to reach the second layer of help (Tier 2 CSRs). A third HICAP manager reports that "extended delays in responses during the day are still occurring, depending on the day or time of the week."

Disconnected Calls

Although less rampant than in the past, disconnects or dropped calls (on the 1-800-MEDICARE end instead of a caller hanging-up) are still occurring with regularity.

Disconnects occur during the initial wait to speak with a CSR as well as during transfers to Tier 2 CSRs.

Example: According to some SHIP counselors, sometimes disconnects seem to occur when CSRs are unable to answer particular questions posed to them. Many cut-offs occur when supervisors are asked for. One SHIP manager reports speaking with a 1-800-MEDICARE supervisor who admitted that he was aware that such purposeful disconnects or hang-ups occurred among hotline CSRs.

Interactive Voice Response (IVR) System

In an attempt to provide callers with the ability to have certain questions answered or questions redirected automatically, 1-800-MEDICARE instituted the interactive voice response (IVR) system. Out of a need to preserve valuable time, SHIPs have learned how to bypass the IVR by saying "agent" or pressing "0." Most beneficiaries, however, are unaware of how to bypass or navigate the IVR, and many express frustration with the system. Medicare beneficiaries often complain about long wait times for a "live" person, and don't like dealing with voice prompts. Common beneficiary complaints about the IVR include:

- it is too complicated for seniors; if one doesn't know to press zero or ask for agent, 3 cycles go by before you are put in queue for a CSR;
- it is not sensitive to individuals who speak with accented English, and the Spanish IVR doesn't always recognize various Spanish dialects (let alone provide services to individuals who speak languages other than English or Spanish);
- some individuals who have hearing aids have trouble hearing or dealing with the IVR.

Limited English Proficient (LEP) Individuals

Despite CMS assurances that 1-800-MEDICARE CSRs can assist beneficiaries in any language, 1-800 MEDICARE continues to provide insufficient support for limited English proficient callers.

Example: According to the National Senior Citizens Law Center and the California Medicare Part D Language Access Coalition, a Chinese-speaking caller was recently transferred by a Part D plan to 1-800-MEDICARE, where she said, "Chinese, please" several times. The operator was quite disrespectful, asked her to speak in English, and then hung up on her. According to the Coalition, examples such as this, as well as a broader failure to accommodate LEP callers, are all too common.

In a similar vein, one of our colleague organizations that works with the Deaf Community reports complaints about 1-800-MEDICARE hanging up on individuals

trying to use a phone relay service, and concern that 1-800-MEDICARE lacks videophone relay service.

B. PROBLEM RESOLUTION

In addition to challenges with accessing the services of 1-800-MEDICARE, beneficiaries and SHIP counselors often face difficulties with trying to have questions answered and problems resolved. All too often, 1-800-MEDICARE callers are unable to: obtain accurate information; troubleshoot various issues that impede access to Medicare services; speak to the right person/entity relating to an individual problem; and lodge complaints.

Misinformation

Although many questions are answered correctly by 1-800-MEDICARE CSRs, sometimes they are unable to answer simple questions. SHIP counselors report inconsistent answers on the same issues, and sometimes false, misleading, or inaccurate information provided.

Examples of misinformation given by 1-800-MEDICARE CSRs, as reported by HICAP managers, include:

- *enrollees of Medicare Advantage Prescription Drug plans (MA-PDs) can change plans at any time (resulting in clients being locked-in or locked out of plans);*
- *incorrect timing of Medicare enrollment periods (resulting in beneficiaries missing opportunities to enroll in or change plans); and*
- *erroneous information about rights to purchase Medicare Supplemental Insurance (Medigap) policies.*

In the words of one experienced HICAP manager in California, *"those who answer the phone [at 1-800-MEDICARE] have not had enough training to really understand Medicare and associated parts. When beneficiaries call and try to describe what they want help with, the CSRs don't know the questions to ask them to find out more specifically what the other aspects of their problem and/or situation is. Unless the right trigger words are used, the caller is likely to get "automatic" answers and be referred to the wrong department. More often than not, they refer them to their SHIP, which is OK, but certainly an extra step for the caller, who probably had to wait a while to get to the referral. Let's face it, the CSR's are unable to perform the retroactive disenrollments, and answer the difficult questions that require research ..."*

Access to CMS and Other Contractors

Over the last year or so, CMS turned 1-800-MEDICARE into a single point of entry for access to their myriad contractors (such as Part B carriers, intermediaries, Medicare Administrative Contractors (MACs) – collectively referred to as fee for service (FFS) call

centers). In addition, CMS largely cut off SHIPs' access to local CMS Regional Offices, which had previously assisted SHIPs with resolving complex cases. When 1-800-MEDICARE became the main point of entry, SHIPs lost much of their ability to handle and correct their clients' problems in a timely manner.

Instead of direct access to CMS contractors, SHIPs and their clients must contend with 1-800-MEDICARE CSRs who now try to handle complex questions that normally require resolution by a contractor, or wait for 1-800-MEDICARE to email the appropriate claims contractor about the caller's inquiry (hopefully resulting in a return email or call back from the contractor). Other barriers arise when SHIPs and beneficiaries are referred between 1-800-MEDICARE and private Part D and Medicare Advantage plans that claim that the other is the appropriate entity to contact.

Example: According to one HICAP counselor who was able to reach representatives from a Part B carrier through backdoor channels, the carrier informed her that information forwarded to them by 1-800-MEDICARE CSRs is sometimes wrong and/or incomplete which prevents the carrier from resolving the client's issue.

Sometimes misinformation coupled with the inability to resolve problems can be life threatening for Medicare beneficiaries.

Example: A HICAP counselor in Southern California assisted a transplant patient who was informed by her pharmacy that she would no longer be eligible for her anti-rejection medication. The counselor called 1-800-MEDICARE to invoke an escalated or expedited emergency procedure, but the CSR—following an erroneous script—insisted that no Medicare beneficiaries are entitled to lifetime coverage of anti-rejection medication, and also claimed that there was no "expedited" complaint resolution process, and that normal case resolution takes 30 days. After 4 or 5 separate phone calls to 1-800-MEDICARE and several conversations with supervisors, the counselor finally found a CSR who both recognized the severity of the client's situation, and acknowledged that there was indeed an expedited complaint resolution process. The CSR collected the information provided by the counselor and explained that the case would be forwarded to the local CMS Regional Office (RO). Following protocol provided by CMS, the counselor waited a few days and contacted the local CMS RO, only to learn that there was no record of the client's complaint in the computer system.

Some Medicare beneficiaries run into barriers even speaking with CSRs when trying to resolve problems.

Example: A HICAP client, a widow, called 1-800-MEDICARE about her late husband's Medicare account relating to some billing questions. The CSR at 1-800-MEDICARE said that she had to have a signed authorized representative form in order to proceed.

Enrollment/Disenrollment Processing

SHIPs regularly complain that 1-800-MEDICARE is unable to accurately process enrollments into and disenrollments from Medicare Part D and Medicare Advantage plans, particularly retroactive disenrollments. In order to successfully help their clients with enrollment and disenrollment issues, SHIP counselors often must spend hours on the phone; other times, counselors are only able to obtain prospective disenrollments on behalf of their clients.

Example: A HICAP counselor was told by a 1-800-MEDICARE CSR that she couldn't get a retroactive disenrollment for a client until the client received a disenrollment letter from her plan. The counselor also was told conflicting information about whether to subsequently contact 1-800-MEDICARE or the local CMS Regional Office.

Example: The daughter of a deceased Medicare beneficiary reported to her local HICAP that she had to work for months in order to get her mother retroactively disenrolled from her Medicare Advantage plan.

Example: A HICAP counselor from Central California recently tried to assist a husband and wife with disenrolling from the same Medicare Advantage plan, but 1-800-MEDICARE CSRs only processed the wife's disenrollment, leaving the husband needing – but unable to find – medical care. As a result of marketing misconduct by a Medicare Advantage agent engaged in unsolicited door-to-door sales, Mr. and Mrs. M. were enrolled in an MA plan they did not want. A HICAP counselor phoned 1-800-MEDICARE with the couple in an attempt to help them get out of their MA plan. The HICAP counselor gave the details to the first CSR. After being transferred, she gave the same details to the 2nd CSR who then requested to speak with Mrs. M., who in turn responded to duplicative questions as to the allegation that the she did not understand what she had purchased. The CSR then enrolled her into a PDP. Mr. M. was then requested to provide his testimony to the very same issue, however his primary language is Spanish so they were put on hold again for a Spanish speaking CSR. Mr. M. underwent the same litany of questions, however, according to the HICAP counselor, he is not as articulate as his wife so the questioning was exceedingly lengthy. By this time, Mr. M. was sweating profusely and appeared very anxious before the CSR started the enrollment process into a PDP for him as well. ***The total call time was an hour and forty minutes.*** *Together the HICAP counselor and couple had encountered the same line of questioning four times. While Mrs. M. was successfully enrolled in a stand alone PDP, Mr. M. remained in the MA plan. A subsequent call to 1-800-MEDICARE revealed that the PDP plan had not processed the application. Follow up calls (****totaling 115 minutes****) to the MA plan finally revealed that 1-800-MEDICARE did not approve the PDP Special Enrollment Period (SEP) therefore prompting* ***another 55 minute call*** *to 1-800-MEDICARE. The CSR insisted that Mr. M had to complete the enrollment process into the plan all over again. The CSR further stated that she didn't 'think it would be possible to get a retroactive enrollment date of 8-1-08' (even though the original enrollment occurred 7-24-08). In the meantime, Mr. M. has been postponing necessary medical care until the disenrollment from the MA plan occurs. Although he needs*

medical attention, he has been unable to find a provider who is willing to accept the MA plan he is stuck in.

Lodging and Monitoring Complaints

As part of efforts to centralize and streamline various Medicare functions, 1-800-MEDICARE has been tasked with recording complaints that come to their attention through the Complaint Tracking Module (CTM). Based upon the experience of SHIP programs, though, we are concerned that the full scope of problems experienced by Medicare beneficiaries are not being accurately recorded, if at all, in the CTM system, resulting in a failure to accurately track systemic problems. Many callers report that they must use "magic words" in order to get a complaint lodged (including firmly stating that they want to "lodge a complaint in the Complaint Tracking Module"). Some SHIPs encounter CSRs who are ignorant about the role of SHIP programs themselves, begging the question whether beneficiaries who need help from SHIP programs are being referred correctly.

Example: One HICAP counselor reports that while trying to lodge a complaint about marketing misconduct surrounding the sale of a Medicare plan a 1-800-MEDICARE CSR claimed that there is nothing wrong with an insurance agent enrolling a beneficiary who has Alzheimer's.

Example: A HICAP counselor who also works on anti-fraud efforts through the Medicare Senior Medicare Patrol (SMP) program tried to report fraud impacting one of her clients but encountered a CSR who argued with her about what constituted Medicare "fraud." The CSR told her – "well, that's just you're version, so how are you going to prove it?" In other words, the CSR was making determinations about what is fraud and what isn't, and refused to lodge a complaint concerning alleged fraud. The same HICAP/SMP counselor reports that in general, 1-800-MEDICARE CSRs aren't providing information on MEDICs (CMS fraud contractors) and typically won't accept fraud-related complaints.

Example: A HICAP counselor who called 1-800-MEDICARE to lodge a complaint about a Medicare plan was discouraged from doing so by a CSR and was told that "a complaint is serious."

IV. IMPACT on SHIPs and MEDICARE BENEFICIARIES

The problems getting through to and obtaining accurate, timely assistance and information from 1-800-MEDICARE amplifies problems faced by beneficiaries and SHIP programs trying to assist them. When an individual's Medicare problem is not addressed by knowledgeable people, the problem often snowballs into a much larger, more time consuming problem than if it had been addressed at the outset.

SHIPs

At a time when SHIPs are being asked to do more and more with fewer resources, problems with 1-800-MEDICARE increase the burden on SHIPs. When 1-800-MEDICARE fails to adequately assist a Medicare beneficiary, SHIP counselors must step in and pick up the pieces, stretching limited resources even further. Frustration with 1-800-MEDICARE has forced some SHIPs to find alternate ways of dealing with their clients' problems, if available (e.g. if relations are good with their local CMS RO).

The California SHIP program was recently given access to a special direct SHIP line the last week of August 2008, so we have not yet had extensive experience with it. Feedback so far, though, is mixed – for those whose unique ID numbers are in the system, it has seemed to work well; others who don't have their numbers in the system are unable to access this line. While access to a designated SHIP line will likely improve the ability of SHIPs to perform their casework, the existence of and need for special designated SHIP lines – both for 1-800-MEDICARE as well as individual Part D and Medicare Advantage plans – highlight the shortcomings of all of these phone lines for the general public.

Medicare Beneficiaries

SHIP counselors are generally able to tell when they get bad information from a 1-800-MEDICARE CSR, but the general public is less able to do so, and more likely to rely upon bad information. We continue to be concerned about how many beneficiaries are still struggling either financially and/or with accessing medical benefits because their questions or problems were not resolved through 1-800-MEDICARE. If these individuals are unable to find a SHIP program to assist them, they are largely without recourse.

1-800-MEDICARE is a lifeline for many Medicare beneficiaries. Many of them, though, are frustrated by long wait times and simply hang up before they are able to speak with a CSR, or are stymied by the IVR. Some that get through are not well served by the information and assistance they receive. Rural beneficiaries in particular need to be assured that they can get accurate and prompt information, because many don't have access to a Social Security office or a nearby SHIP counseling site. In short, while SHIPs encounter problems assisting their clients, Medicare beneficiaries on their own are far more vulnerable and susceptible to the shortcomings of a system that is inconsistent in its performance.

V. CONCLUSION & RECOMMENDATIONS

While 1-800-MEDICARE is able to handle many calls appropriately, there are still far too many performance problems encountered by SHIPs and their clients. Barriers to problem resolution impact the ability of SHIPs to do their work, and more importantly, has negative consequences for beneficiaries whom they are trying to serve.

In order to improve the 1-800-MEDICARE phone line so that it better serves the Medicare program, we offer the following recommendations:

CMS must employ stronger oversight of the contactor administering the hotline, including:

- better training of CSRs; they must:
    - be able to answer basic questions
    - be able to adequately triage cases
    - be able to identify when they are unable to answer a question

- strengthen and revise CSR scripts
    - including instances where callers should be referred to SHIPs for more state-specific information (e.g. Medigap rights)

CMS should form a taskforce consisting of SHIPs and other advocates to help review and/or write 1-800-MEDICARE scripts and training materials.

The IVR system must be improved, including giving callers the option to bypass the prompts once they enter their Medicare number.

CMS should explore the performance and experience of other hotlines. For example, the California Public Employee Retiree System (CalPERS) operates a phone system whereby if a caller does not get a live person during an initial call, s/he will receive an electronic instruction informing them that a live representative will call them back in "X" number of minutes – and such calls actually occur.

SHIPs should be provided with more access to other contractors and more information in order to properly assist their clients, including:

- SHIPs should be able to find out what happens with complaints lodged, including calls back
- SHIPs should be provided with direct access to CMS contractors, such as carriers and intermediaries
- absent significant improvement for all callers to 1-800-MEDICARE, all SHIPs should be provided with access to a direct SHIP line and CMS should make frequent updates to SHIP unique ID numbers.

Thank you for the opportunity to provide these comments.

Senator SMITH. Thank you very much. That's excellent.
John Hendrick.

STATEMENT OF JOHN HENDRICK, PROJECT ATTORNEY, ELDER FINANCIAL EMPOWERMENT PROJECT, COALITION OF WISCONSIN AGING GROUPS, MADISON, WI

Mr. HENDRICK. Thank you, Senator Smith, Chairman Kohl. My name is John Hendrick. I'm a staff attorney with the Coalition of Wisconsin Aging Groups and it's my privilege to speak to the committee on behalf of the coalition and share our experiences with Medicare's toll-free consumer service. We supervise a network of over 100 trained staff throughout the State of Wisconsin and as part of their duties they help older adults with the Medicare program through the State Health Insurance Assistance Program. For some reason that's abbreviated "SHIP." So we have a lot of experience with 1–800–MEDICARE.

Based on our experience, we have found that 1–800–MEDICARE service has improved since 2006 and we appreciate that. Wait times outside the busy annual enrollment period can be as little as 5 to 10 minutes and there are many knowledgeable and experienced customer service representatives who are able to resolve most beneficiary problems in a timely and accurate manner. Many are doing a good job. Some are not. Also, in our experience we've had a high level of success with what I guess they call the tier two representatives that are able to deal with the more complex problems, and so we appreciate that success.

We do have some serious continuing concerns. I would say our greatest concern is representatives providing consistently accurate information, and we have found that that is not always the case. There are a couple recurring problems with specific issues, but our biggest concern is that the bad information doesn't seem to relate to the complexity of the issue. It's just which representative you get. So if you get the wrong person you get the wrong answer. That makes it hard to predict and it's very hard for us to deal with.

The second area of concern would be technological problems. For example, at busy times the average waits are over 30 minutes. There's occasional buzzing on the line, which makes it difficult for beneficiaries to hear the representative. As has been mentioned repeatedly, senior beneficiaries have difficulty dealing with the telephone prompt system.

Lastly, the area of programmatic problems, which appear to result either from management decisions or from training. For example, the customer service representatives do not leave a phone number when they return a call. They don't leave any information. They just say they're returning a call. Unless the beneficiary happens to pick up the call at that moment and get that call directly, they have to start all over again and go through the wait time and explain their situation all over again.

At times we find as many as one-fourth of the cases have to be forwarded to the tier two representatives because the customer service representatives can't resolve the issues. That seems like a high percentage to us. Beneficiaries when they file a complaint about Part D enrollment or Medicare Advantage enrollment are

told that they will be called back within 5 days, and that is not the case. In our experience those calls never come.

Senator SMITH. Not later than 5? They just never come?

Mr. HENDRICK. Never.

Finally, the customer service representatives frequently don't know that they can talk to the SHIP representative. As everyone here has mentioned, a way of resolving problems is for a well-informed SHIP representative to get on the phone with 1–800-MEDICARE and sometimes that's what works it out. But unfortunately the tier one representatives sometimes will refuse to talk to the person unless the beneficiary is actually present, and that's not what the rules are. So that's an important mistake.

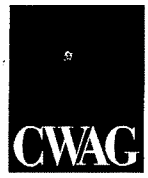
I'd just like to mention a couple of our suggestions for improvement. I think you could increase the number of customer service representatives. The increased training which has been mentioned would improve the quality of the information. You should continue the SHIP-dedicated phone number. That has helped a lot to allow the SHIP representatives to get through and to resolve some of these problems.

I believe the General Accounting Office secret shopper program was mentioned earlier. That should be continued. That is helping to evaluate the quality of the service and the accuracy of the information.

Our final point, which isn't actually about 1–800–MEDICARE: We believe that all prescription drug and Medicare Advantage plans should be required to have their own SHIP-dedicated contacts. With the plans that have a separate contact for SHIP counselors to contact, those plans are resolving problems with their own plans in a much more effective way and taking the burden off 1–800–MEDICARE.

In conclusion, we'd like to thank you for this opportunity. We hope for further improvements in 1–800–MEDICARE, and I'd be happy to answer any questions.

[The prepared statement of Mr. Hendrick follows:]



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Testimony on September 11, 2008 of
Attorney John Hendrick of the
Coalition of Wisconsin Aging Groups before the
U.S. Senate Special Committee on Aging

Introduction

Good morning, my name is John Hendrick and I am a staff attorney with the Coalition of Wisconsin Aging Groups, or as we refer to it, "CWAG". I first want to thank you for giving CWAG the opportunity to testify before the U.S. Senate Special Committee on Aging regarding the 1-800-MEDICARE telephone service. We applaud the Committee's efforts and we hope that our input will assist the Committee in ensuring that 1-800-MEDICARE is a quality service for beneficiaries. Before discussing 1-800-MEDICARE, however, I thought some background regarding CWAG might be useful.

CWAG description

CWAG is a membership non-profit started in 1978 and our current membership includes over 560 groups, 119 businesses and 8,300 individuals. Our mission is to pursue justice and quality of life for people of all ages through legal and legislative advocacy, education and leadership development.

One of CWAG's primary services is to provide free legal assistance to 75,000 Wisconsin seniors annually through programs such as the Elderly Benefit Specialist Program (which is a federal and state mandated advocacy program) and the Medicare Part D Helpline Project. As part of their duties, all our specialists function as SHIP counselors under the Wisconsin State Health Insurance Assistance Program (SHIP). They assist beneficiaries in dealing with 1-800-MEDICARE.

1-800-MEDICARE is improving

Based on our experience, CWAG believes that the 1-800-MEDICARE service has improved since 2006. Wait times outside of the Annual Enrollment Period can be as little as 5-10 minutes long. Knowledgeable and experienced 1-800-MEDICARE Customer Services Representatives (CSRs) are usually able to resolve most beneficiary problems in a timely and accurate manner. Successful recent examples include a situation where a CSR resolved a prescription drug plan problem within 15 minutes and a CSR fixing a coordination-of-benefits problem within 48 hours so that a beneficiary was able to receive desperately needed prescription drugs. In addition, we have also had a high level of success when utilizing Medicare "benefit specialists" in situations where CSRs could not solve the problem. CWAG believes, therefore, that 1-800-MEDICARE is moving in the right direction in solving some of its past problems.

Problems with 1-800-MEDICARE

CWAG believes, however, that there are still are three areas where 1-800-MEDICARE needs improvement, these being: 1) Accuracy of information given to beneficiaries; 2) Technical problems with the service; and 3) Programmatic issues. The first problem, accuracy of information, detracts from the quality of the service. The second two problems, technical and programmatic, create barriers for beneficiaries accessing services. All three, obviously, lessen the value of 1-800-MEDICARE.

1. Accuracy of information

CWAG believes that the area of greatest concern for 1-800-MEDICARE is the lack of consistency in the accuracy of information dispensed by CSRs to beneficiaries. The inaccuracy of information does not result from of the complexity of the issue but rather which CSR is providing advice. There are, however, areas where we frequently encounter errors such as the rules regarding Special Election Periods (SEPs) for Part D and CSRs omitting important Part D details such as "step therapy" restrictions which require beneficiaries to prove they have tried other drugs before Part D will provide coverage. Since the inaccuracy of information appears to be less a product of issue complexity and more a function of the individual CSR, it is widely unpredictable.

2. Technical problems

The second area that needs improvement is technical problems with 1-800-MEDICARE which include problems such as:

- Average wait times of being on hold when calling can be up to 30 minutes;
- Occasional buzzing on the line so that beneficiaries cannot hear the CSR; and
- Senior beneficiaries having difficulty with the telephone prompt system.

These types of technical problems can obviously create significant barriers to beneficiaries using the service.

3. Programmatic issues

The final area that needs improvement is programmatic issues which appear to be a result of a management decision and/or training. These include items such as:

- CSRs not leaving return phone numbers so beneficiaries must start the process over unless they are available for a return call;
- One fourth of cases are being forwarded to a Medicare "benefit specialist" because they cannot be solved by the CSR;
- Beneficiaries are not called back when filing a complaint about Part D or Medicare Advantage enrollment although 1-800-MEDICARE promises a call back within 5 days; and
- CSRs frequently not knowing that they can (and should) discuss problems with SHIP counselors without beneficiaries being in the room with the SHIP counselor.

CWAG believes that while these problems are significant, they can be fixed.

Recommendations for improving 1-800-MEDICARE

As a result of the problems we have experienced in Wisconsin, CWAG would respectfully submits the following recommendations for improving 1-800-MEDICARE:

- Increasing the number of CSRs to decrease wait times;
- Increasing training for CSRs to improve accuracy of information;
- Continuing with SHIP-dedicated 1-800-MEDICARE line;
- Increasing the number of "benefit specialists" at 1-800-MEDICARE so they can use their higher level of knowledge and competency to resolve complex issues and lift that burden from CSRs;
- Maintaining U.S. Government Accountability Office oversight by evaluating the quality and accuracy of information through the "secret shopper" program; and
- Requiring all Prescription Drug and Medicare Advantage plans to have SHIP-dedicated contact lines and representatives. While this isn't necessarily part of the 1-800-MEDICARE issue, we believe it crucial to furthering the above recommendations and improving overall service.

We believe that these recommendations would go a long way towards ensuring a quality service experience for those using 1-800-MEDICARE.

In conclusion, I want to thank you again on behalf of CWAG for allowing us the opportunity to participate in this hearing and I am happy to offer our organization as a resource in the future should the U.S. Senate Special Committee on Aging have further questions.

Respectfully submitted,
John Hendrick, Attorney
Coalition of Wisconsin Aging Groups.

Senator SMITH. When you heard the Administrator, do you have more reason to hope?

Mr. Hendrick. Certainly some of the things that he described sounded promising, and I'm always amazed by what computers can do today. The training I think would still be a concern to us. The customer service representatives that are taking those calls, if they are not correctly trained, are not able to give out the correct information, and I don't think that what we heard today is going to fix that.

Senator SMITH. Senator Kohl.

The CHAIRMAN. Thank you, Mr. Hendrick, and we appreciate all that you've done with the Coalition of Wisconsin Aging Group for the people of our State.

Would you offer the observation if you were asked that, if 1–800–MEDICARE were in competition with another organization providing the kind of service that we find in competition in the private sector of our country, they'd be out of business?

Mr. HENDRICK. Well, Senator, I often say in regard to many government programs and people who are complying with regulatory requirements: What would you do if you really wanted this to work? If your intention was to run a business and to provide good customer service so that people would come back, I think you would get these problems solved.

The CHAIRMAN. Mr. Hendrick, your testimony identified a number of problems with Medicare call centers. If you could name one, which is the single worst and most persistent problem, and what is the most important improvement that CMS could implement to enhance the service of the call center for the recipients?

Mr. Hendrick. I think our biggest concern is the apparently random provision of incorrect information. This happens with the tier one customer service representatives. I don't know the exact solution, but it seems to me that if people knew that they didn't know the answer and they could refer it to someone who could and then that call got through without being disconnected during the transfer, I think that would solve a lot of the problems that we see.

The CHAIRMAN. Thank you so much.

Senator SMITH. Very good suggestion.

Thank you all very much. I think that concludes our questions. You've added human context, put a human face on this problem, faceless problem of 1–800–MEDICARE. Naomi, your story will be remembered. So thank you all.

Our third panel and our only panelist is John M. Curtis. He goes by "Mac" and Mac is the President and CEO of Vangent, the company contracted by CMS to accept incoming beneficiary calls. He'll discuss his company's efforts to ensure Medicare recipients are receiving accurate and timely information when calling 1–800–MEDICARE.

Mr. Curtis, thank you for coming.

STATEMENT OF JOHN M. CURTIS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VANGENT, INC., ARLINGTON, VA

Mr. CURTIS. Thank you, Senator, Mr. Chairman. Good morning. My name is Mac Curtis and I am President and CEO of Vangent. For over 30 years we've been a provider of mission-driven systems and strategic business process outsourcing services for the Federal Government in the U.S., and around the world, Fortune 500 companies, health care organizations, and educational institutions. Our company is headquartered in Arlington, VA.

I was invited here today to talk about Vangent's role in the 1–800–MEDICARE program. I'm not here to say that problems never occur or to refute the experiences described here today. But I can tell you about our steadfast commitment to quality service for all Medicare beneficiaries and offer some context for the issues described by the previous panel. Of the 30 million calls received each year, the vast majority work fine. But we're focused on the small minority of calls that don't.

First let me explain how the system works. Our job is to manage the call center facilities and the workforce that answers the calls that come in to 1–800–MEDICARE. Vangent has been working with CMS on this program for over 6 years and we're proud of the work we do.

Callers into the system are prompted by the interactive voice response unit to provide their Medicare number and to select the issue they're calling about. If a customer service representative is not immediately available, a call is routed to the queue where, depending on when they call, they may have to wait a few minutes, sometimes longer, for the next available CSR qualified to answer their question. The caller is then connected to the CSR, who works with them to answer their question.

Our contract with CMS provides that we maintain an average speed to answer at or less than 8½ minutes, which we consistently meet. Our average speed to answer during the month of August was 3 minutes and 40 seconds. Do we always hit the mark? With 30 million calls a year into the system, not every call is perfect. But the hard work to continuously improve and make the system and experience better is what we're dedicated to.

Our workforce is well trained, closely monitored, and highly motivated to help people. CSRs undergo continuous and rigorous training based on industry standards and best practices. Vangent, in partnership with CMS, has successfully trained thousands of CSRs, who answer millions of beneficiary inquiries using this training program. Instructor-led classroom training is combined with multiple forms of recurring on-the-job training to ensure continuous improvement. Every CSR is regularly monitored to identify trends and to measure individual performance. Responses are evaluated by multiple checkpoints for quality and accuracy, which again are based on industry standards and best practices.

We also survey our callers to measure their satisfaction with the service they receive. What are the results of the monitoring and the surveys? Of the thousands of calls evaluated each month, over 90 percent meet the requirements of our rigorous quality reviews for accurate responses and customer interaction. In the customer satisfaction survey, the results we receive show that 85 percent of the

callers are satisfied with the service, a score that's above the industry average of about 70 percent for contact centers.

We're continuously working to improve the people, the process, and the technology that drives the 1–800–MEDICARE program.

Today we've heard from the SHIPs and other advocates about concerns they have with the 1–800–MEDICARE system. We appreciate the difficult job the SHIPs have. They assist the neediest beneficiaries with very complex problems. We've worked with CMS to provide the SHIPs with tools such as—and we've heard about it this morning—a customized IVR and a dedicated 800 number to make their jobs a little easier. We want to continue working with CMS to find additional ways we can improve our service to the SHIPs and their clients.

We spent a lot of time with your staff in our call centers discussing how the system works and how it can be improved. We applaud the dedication and the zeal, Senator, they have shown toward improving 1–800–MEDICARE. There's no question about it.

In summary, the vast majority of the 30 million calls received by 1–800–MEDICARE are handled well and correctly. But the issues identified here today are very important to us. Continuous improvement is a hallmark of this program and we strive to provide Medicare beneficiaries the quality of service they deserve.

Thank you, Senator. I'm happy to answer your questions.

Senator SMITH. Mac, your surveys show that 85 percent like the service they got?

Mr. CURTIS. Yes, sir.

Senator SMITH. Eighty-five percent. So we're really dealing with 15 percent. Can you tell when you get a call whether it's a person without any agenda just needing help or one of my staff calling and testing you?

Mr. CURTIS. Well, normally—let me answer your question this way, Senator. With regard to someone calling with a specific question of the 30 million inquiries that come in a year, 98 percent—

Senator SMITH. Are we the 15 percent?

Mr. CURTIS. We're working on that, Senator. [Laughter.]

That's good because we're trying to improve. There's no question about the value that your staff has provided.

But back to my answer, Senator, of the 30 million inquiries we receive a year that come in to the IVR, 98 percent of those inquiries come with their Medicare number. So as we've talked about, one of the improvements that CMS has made is the beneficiary gets on the line, reaches the IVR, and they're asked their Medicare number. They put their Medicare number in and the record shows up on the screen for the CSR. The CSR goes through and they validate the beneficiaries birthday, their Medicare number, and then deals with the callers specific issue.

So that's really where the balance of the calls come from with regards to a specific issue associated with the Medicare number. So what we are dealing with here today is the percentage that have very complex calls. I think your staff will attest to this, that the typical call is with a Medicare number, and it's also maybe one issue or one question. The reason why we know this, Senator, is that when we look at, on an annual basis, the number of scripts

the CSRs actually go to to provide the scripted response, on an average call it's 1.2 scripts per call.

So what we're really focused on are the multiple question calls, where sometimes we're going to 4 to 12 times the number of scripts or the number of questions, and also those calls that don't have the Medicare number.

Senator SMITH. It is possible that someone has called in not from my office without a Medicare number?

Mr. CURTIS. That happens. Yes, sir, it does happen. That's about—from our record, that's about 2 percent that call without a Medicare number, that's correct.

Senator SMITH. So the other 13 percent are my staff?

Mr. CURTIS. The other 13. Well, one of that percent is probably my mother.

Senator SMITH. But what you're telling me is if my staff calls with a Medicare number they're going to be completely satisfied?

Mr. CURTIS. You know, Senator, I'm not going to tell you that out of 30 million transactions every one of them is perfect. I'm certainly not going to tell you that. But what I will tell you in all sincerity is we want all of those 30 million transactions to go well. But no, I'm not going to say every one is perfect. I'm not going to say every CSR always gives the right answer. We've heard situations today that, a) are heartbreaking and, b) that's the percentage that we've got to get right. Every one of these calls has got to be right.

But I think what we do focus on is the quality monitoring. When we're at spike we're talking about close to a little under 4,000 customer service reps, and the quality monitoring we do on a monthly basis—we record calls. They're evaluated in three areas: Are they dealing with Privacy Act data correctly, what was the completeness and the accuracy of the answer on their call, and what are their customer soft skills?

So it's thousands of calls a month that are recorded. The calls are evaluated and there's a side by side discussion with each CSR. We go through how well they performed.

Now, the independent TQC contractor that Administrator Weems is talking about is also now evaluating additional calls. So we're trying, like the CSRs, to make sure that there's quality there and that they're answering accurately and completely.

Not everyone's perfect and clearly from what we've heard today there are some issues. We like to get the feedback. By the way, I agree, establishing an organization with the SHIPs and the beneficiaries and CMS to support the content review I think is a very good idea.

Senator SMITH. The timing of this hearing, Mac, is intentional because we're coming up to a new enrollment period. That new enrollment period, for any seniors watching that want to enroll, starts in November. Are you representing to us that you're ready for this enrollment period? Because if a senior gets trumped up in the enrollment period and they have to start—they start assessing about a 1 percent penalty a month, and that could be a 12 percent penalty, and that 12 percent penalty stays with them. It's not a 1-year penalty. It's just they made a mistake and they live with it the rest of their lives.

Even more important than the money is obviously if they're given the wrong information and that may have a health consequence to them that I know you don't intend. But we've got to get it right.

So you're representing to us that you're ready for this next enrollment period?

Mr. CURTIS. We are getting ready, absolutely, Senator. As you know, the enrollment period is November 15 through December 31. Your staff has been to our centers. One of the things I do want to represent is, in all of our the facilities our CSRs have other opportunities and other places to work. We have a workforce that is passionate about helping people. So I think the attitude is certainly one we should all be proud of and reassured by.

I think you've heard about improvements in the training. One of the things I think that CMS has indoctrinated into the training curriculum is the whole notion of Medicare Advantage and how to deal with that. I think we're always looking at ways to improve that training to make sure we have the right answers.

So we are getting ready, Senator. We're doing the recruiting, we're doing the training, and we've begun and we'll be ready for the spike.

Senator SMITH. Well, it's very important. Obviously, Naomi's case is an example that it isn't just my staff that's calling. Those are the people who are the focus of this hearing and Naomi puts a human face on it. So I want to in the strongest but friendliest terms as possible emphasize just how important it is to get systemically right all these things, get the training, get the processes worked out in the system, so that those even who are technically or high tech challenged—I'd include myself in that number—can manage this system. I think that it's a huge challenge, but you took the contract.

Mr. CURTIS. Yes, sir, we did. Yes, sir, we did.

Senator SMITH. My admonition is do it, get it right.

We want to be your cheerleaders, not your critics.

Mr. CURTIS. We're committed to doing that, Senator.

Senator SMITH. Well, thank you all very much. This has been a most informative hearing. We hope it helps. We're not here to pick a fight. We're here to find a solution.

Thank you, Mac, for your presence, and I hope that you got a handle on all your subcontractors, too.

Mr. CURTIS. One comment. We are the prime contractor we would only use the subcontractors if we had to in a spike.

Senator SMITH. But you feel like you've got control of it?

Mr. CURTIS. Absolutely, there's no question about it. It's simpler now than it was before CMS consolidated the contract center operations.

Senator SMITH. So you're managing them, too? You're accountable for that?

Mr. CURTIS. Absolutely, if we use them.

Senator SMITH. Ladies and gentlemen, thank you.

We're adjourned.

[Whereupon, at 11:35 a.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY, JR.

I would like to thank Senator Smith for organizing this important hearing on the 1–800–Medicare number and the service it offers Medicare beneficiaries and their families. This hearing is the product of an extensive investigation that Senator Smith and his staff began in 2005 into 1–800–Medicare and the concern that our older citizens and other Medicare beneficiaries are not receiving accurate information from the customer service representatives who answer these calls.

1–800–Medicare, the general customer service number all Medicare beneficiaries call with questions or problems, is often both the first and last resort for many Medicare beneficiaries. Sometimes these calls involve life and death issues. Accordingly, we must ensure that beneficiaries and their families receive accurate and timely information.

There are currently almost 45 million Medicare beneficiaries in this country, including almost 2.2 million in Pennsylvania. Millions more are on Medicaid. Many of these individuals are easily confused by the choices Medicare offers and the multiple choices and decisions they must navigate to enroll in various plans and programs. As result, they call 1–800–Medicare looking for simple answers to often complex questions. The results can be far from helpful.

While 1–800–Medicare is available 24 hours a day, seven days a week, callers can experience lengthy wait times before speaking to a customer service representative. Once they speak to a person, beneficiaries have reported representatives can be difficult to understand because they are too technical or presume knowledge about the Medicare program the caller does not have. At times callers are simply given wrong information.

Hubert Humphrey used to say that one of the things we and society should be judged on is how we treat our older citizens. Are we providing them with appropriate help in their time of need? From the evidence before us at this hearing, it seems we are not.

Bottom line, Mr. Chairman, our older citizens, and all Medicare and Medicaid beneficiaries who utilize the 1–800–Medicare number need timely answers to their questions and they need accurate answers. It is estimated that 1–800–Medicare will field 34.5 million calls in 2009. CMS and Congress should strive to make this process better, shorten wait times and provide customer service representatives with the tools they need to give accurate and complete information to callers.

We all know Medicare is a complex program. Our older citizens call this number with the expectation that the customer service representative on the other end will be able to provide them with correct and helpful information be it explaining the difference between traditional Medicare and Medicare Advantage or helping them choose which prescription drug plan best meets their needs. It is our job to ensure they find the answers they are looking for and that those answers are correct. I look forward to hearing the testimony of Administrator Weems and our other witness. Thank you, Mr. Chairman.

KERRY WEEMS RESPONSES TO SENATOR SMITH'S QUESTIONS

Question 1. The New 5 Minute ASA

It was encouraging to hear the plans that CMS has for reducing wait times at the call centers. Will CMS be formally revising the call center contract to require a 5 minute average speed of answer (ASA)?

Answer: CMS modified the contract with Vangent effective October 1, 2008 to lower the ASA from 8 minutes down to 5 minutes through the current option year which ends May 31, 2009.

Question 2. Hiring of Briljent

In December 2007, CMS contracted with Briljent to revise the training curriculum and call scripts. Why did CMS remove these responsibilities from Vangent and reassign them to a new contractor?

Answer: We conducted a full and open competition for the 1–800–MEDICARE contract and its support services as the prior contracting vehicle was expiring. As part of the competitive bid process, we set aside certain activities for small businesses. The training, quality, and content support services were determined to be appropriate for a small business set aside. Therefore, Vangent was not eligible to compete for those activities. Briljent, as a small business contractor, was successful in its bid for this work.

Question 3. Taskforce

I have serious concerns that CMS and its contractors are unable to assess call center performance from a beneficiary's perspective and do not understand the challenges confronting beneficiaries when they try to use 1–800–Medicare. Though I was initially encouraged to hear that CMS had contracted with Briljent to revise CSR training and scripts, I remain concerned that this contractor's work product thus far does not adequately address the problems identified by my investigation. Therefore, to provide better feedback to CMS and its contractors in developing call center training curricula and scripts, is CMS willing to implement the advisory taskforce recommended by witnesses at the September 11, 2008 hearing? If no, why not? If yes, by what date can we expect to have that taskforce in place?

Answer: CMS does not believe an advisory taskforce is necessary for 1–800–MEDICARE training materials and scripts. The quality, scripting and training development contractor works very closely with CMS staff and subject matter experts to ensure materials are relevant and up-to-date. We also obtain feedback from our CSRs to ensure scripts and training materials provide CSRs with subject matter knowledge and address the caller's need. CMS has consistently made available 1–800–MEDICARE Part D scripts to CMS Partners via the *www.cms.gov* website.

Additionally, CMS already has two committees that provide feedback on beneficiary education, including 1–800–MEDICARE. The Advisory Panel on Medical Education (AMPE) is governed by the Federal Advisory Committee Act and exists for the broader purpose of advising CMS on beneficiary education matters. In the past the APME has given general suggestions and comments about 1–800–MEDICARE, which have included topics such as wait times and non-English language issues. The National Medicare Education Program (NMEP) Coordinating Committee has also addressed partner questions and comments regarding 1–800–MEDICARE at its meetings.

We believe that these combined efforts provide sufficient opportunity for feedback and forming an advisory taskforce would duplicate our existing efforts.

Question 4. Other Items that Need to Be Improved at 1–800–Medicare

Despite CMS' plans to reduce the ASA from eight minutes to five, I did not hear much at the hearing by way of planned improvement that would address other technological issues and adequately address problems with respect to the accuracy of responses provided to callers. Can you please explain CMS' plans for improving the following:

The interactive voice response system, or IVR as it is called, is challenging for seniors to navigate.

I would ask that CMS revise the IVR to provide an option to go directly to an agent.

Answer: We do not currently offer a prompt that sends a caller directly to an agent and have no plans to implement such a change. As it is currently set-up the IVR technology improves the efficiency of our operations and enables some callers to "self-serve" and receive the information they need without having to speak with a CSR. In situations where we cannot serve the caller via the IVR, the caller is seamlessly routed to the CSR who is best able to handle the specific topic.

It also should be easier to reach an agent and obtain service for beneficiaries who do not have their Medicare number at hand.

Further, the IVR should provide choices that better align with callers inquiries.

Answer: While a Medicare beneficiary does not need to have a Medicare number at hand in order to obtain information from 1–800–MEDICARE, having this number allows both the IVR and CSRs to quickly access the beneficiary's specific information and more efficiently serve the caller. Less than 2% of calls coming into 1–800–MEDICARE are from callers without a Medicare number.

The new 5 minute ASA is encouraging. But I still feel strongly that CMS should contract for wait times specific to peak call periods.

By what date can we look for CMS to revise the call center contract to reflect an ASA specific to peak call periods?

What resources will it take (including additional funding) to accomplish this?

Answer: No, CMS will not be revising the call center contract to mandate an ASA specific to peak call periods.

Scripts still are too technical and presuppose program expertise that most beneficiaries likely do not possess. Scripts also tend to be siloed by issue and do not provide common-sense responses for questions that cut across multiple issues.

What steps does CMS and its contractors undertake to ensure content is comprehensible by beneficiaries?

Further, is CMS willing to implement focus group testing on scripts?

Answer: We recently completed an extensive review and update of all the 1–800–MEDICARE Part D scripts. As a result of our review, we have reduced the number of Part D scripts from 53 to 25. Notably, we have updated the overview script that CSRs use to help triage caller issues and quickly access the most appropriate Part D script. We expanded the questions/linkages on that script and incorporated examples to help CSRs assist callers. We have completed a similar review of all of the MA scripts and have reduced the number of MA scripts from 28 to 2. In addition, we have reduced the previous 10 Low-Income Subsidy (LIS) scripts into one consolidated script to make it easier for CSRs to respond to various LIS questions. All 1–800–MEDICARE scripts are scheduled to be reviewed and updated by the end of January 2009.

We have implemented a process by which 1–800–MEDICARE scripts are reviewed and focus tested by CSRs before being fully implemented.

1–800–Medicare customer service representatives (CSRs) have complained to my staff that their three week general training does not adequately equip them for the scenarios that they encounter on the phone during live calls. What specific improvements can we look for in CSR training and oversight over the next six months? Specifically:

CMS might consider incorporating a more robust program of test calls in to its quality assurance program.

Answer: As part of the 1–800–MEDICARE quality assurance program, our contractors will continue to conduct test calls to examine readability, content flow and logical placement of content. Vangent regularly conducts test calls by topic with its CSRs for implementing comprehensive script updates. In addition, both Vangent and Briljent perform calls for new or key initiatives such as the Prescription Drug program to determine whether the script addresses the caller's need and provides a consistent answer. When making test calls, Briljent and Vangent test callers are provided specific call instructions and use pre-written scenarios. As before, CMS staff members will continue to listen to actual recorded calls, but will not make test calls.

On the topic of training, customer service representatives currently have four calls per month reviewed. Call center management have referred to this review process as "a routine mechanical checklist that lacks common sense and does not provide adequate insight in to whether a representative has appropriately identified a caller's issues, answered those questions and closed the loop for a caller." CMS must do a better job ensuring that representatives are appropriately identifying and resolving callers' issues.

Answer: Each fall as we near the Annual Enrollment Period, a Readiness Plan is developed and implemented. As part of this Readiness Plan, all drug plan scripts are reviewed and updated and specific Readiness training is provided to the CSRs. We model our scripts and Readiness Plan on how Medicare beneficiaries and their caregivers ask questions. Based on prior years experience, we use a combination of instructor-led and self-paced refresher training. The complexity of the subject determines whether CSRs receive instructor led or self-paced training.

As part of our script review, we updated several scripts, which improved the CSRs' ability to navigate within the script. We also updated terminology in the script to match the 2009 Medicare & You handbook language.

CMS also must drastically improve the process by which information is captured and recorded by the 1–800 Medicare system. Each time a beneficiary is transferred to a new representative, and each time a beneficiary calls to follow up on a prior call, they are forced to recount their entire story over and over again to each person with whom they speak. Further, customer service representatives rarely seem to be able to provide any useful information on the status of complaints and other inquiries. What improvements can we look for regarding the foregoing?

Answer: CSRs have access to caller activity and history through the CSR desktop application. CSRs can also determine what scripts were used during the call. Where applicable, CSRs provide additional insight through the use of the CSR comment field in the CSR desktop application.

Additionally, effective September 19, 2008, CMS implemented a more streamlined approach for the retro-disenrollment process, minimizing the number of CSR transfers.

Currently, 1–800–MEDICARE CSRs have the ability to determine whether a Part D complaint has been filed, and whether the complaint has been resolved or is pending. We are trying to obtain more information on the status of complaints and have made a formal request for additional data. The request is currently being reviewed within CMS.

What additional levels of funding will CMS require to accomplish the foregoing improvements?

Answer: Given CMS's competing priorities, such as claims payments, program oversight, and quality improvement, the FY 2009 requested funding level for 1–800–MEDICARE is appropriate within that context. In fact, we've ensured that 1–800–MEDICARE spending has remained steady despite budget cuts in other areas. In addition, we have identified efficiencies in call center operations that have achieved savings in the past year. These savings are allowing us to bring down our caller wait times.

MICHEALLE CARPENTER'S RESPONSES TO SENATOR SMITH'S QUESTIONS

Question 1. What Is the Top Priority Fix

Based on your experience, what is the one item that is the most pressing priority that you would ask CMS to first address to ensure seniors get reliable answers and prompt service during the 2009 plan enrollment period, which starts in November.

Answer. 1–800–Medicare Customer Service Representatives (CSRs) hold great responsibility and, in this key role, they are affecting people's lives significantly. For this enrollment period, beginning November 15, 2008, CSRs must be given a standard operating procedure that allows them to assess how callers are currently receiving their coverage and whether they need to make a choice going forward. CSRs must be able to determine whether the caller had creditable coverage and whether the caller wishes to continue with that coverage. If the caller needs to choose a plan, because he or she does not have creditable coverage, is new to Medicare, or needs to evaluate whether his or her current MA–PD or PDP plan will continue to meet his needs, only then should the CSR begin to research available options. To do this, the CSRs must be able to use the plan finder websites to assist callers in selecting the most appropriate plan. This will also require the CSR to know how to find important information on the plan finder website. These websites are not often easy to use, requiring people with Medicare to look through pages of information before they locate which doctors are in a MA plan's network or which services are excluded from an out of pocket maximum. CSRs should also be cautioned against steering callers to any particular type of plan, such as a Medicare Advantage plan over original Medicare. This will require that the CSR have a basic understanding of Medicare, the available options, and the benefits and consequences of each.

Question 2. It has been represented to the Committee that most calls to 1–800–Medicare are simple, single-question calls. In your extensive work with seniors, do you find that to be the case?

Answer. The simple answer to the question is no, people almost never call with just one simple question. The very nature of the Medicare program makes a single, simple questions unlikely. Even if someone does call with what appears to be a simple question, the answer is rarely simple and often requires additional follow up questions. But beyond that, we have found that CSRs often are unable to handle what should be straight forward questions.

Question 3. Complaints About 1–800–Medicare

CMS and Vangent have represented that that they are not aware of significant complaints about service at 1–800–Medicare. My office has received numerous complaints regarding difficulties in filing complaints at 1–800–Medicare—either complaints about service at 1–800–Medicare or complaints about plans or other issues. In your casework with seniors, have you experienced these problems? Further, in your experience, after a bad experience with 1–800–Medicare, are seniors going to take the time to call back in to 1–800–Medicare to file a complaint about their service at 1–800–Medicare?

Answer. Generally, people with Medicare are unaware that they are able to make a complaint about 1–800–Medicare or about their plans or other issues. In our experience, by the time a person with Medicare comes to us, they are very frustrated with 1–800–Medicare and do not want to call the number again if they do not have to. To resolve this problem, 1–800–Medicare should institute a quality improvement

measure that allows seniors to automatically complete a satisfaction survey after the call or to have they survey sent to them via the mail to complete and return.

TATIANA FASSIEUX'S RESPONSES TO SENATOR SMITH'S QUESTIONS

Question 1. What Is the Top Priority Fix

Based on your experience, what is the one item that is the most pressing priority that you would ask CMS to first address to ensure seniors get reliable answers and prompt service during the 2009 plan enrollment period, which starts in November.

Answer. During the upcoming Annual Coordinated Election Period (AEP), many Medicare beneficiaries will be seeking information about their options to change Part D and Medicare Advantage plans. One of the most frequently requested types of information will be an analysis of Part D options in a given state based upon a beneficiary's drug needs. When a beneficiary calls 1–800–MEDICARE for such information, usually a response is mailed to the caller that includes the "top three" or so plans that best meet an individual's drug needs. Instead of relying upon this information, though, 1–800–MEDICARE customer service representatives (CSRs) must be able to explain specific formulary issues, such as when a prescription is shown as "not on formulary." This type of analayis is necessary, as it could give beneficiaries the opportunity to choose different plan options. In addition, CSRs must be able to explain additional Medigap rights that might be available to callers from different states, or, alternatively, affirmatively refer callers to a local SHIP in order to obtain such information.

Question 2. It has been represented to the Committee that most calls to 1–800–MEDICARE are simple, single-question calls. In your extensive work with seniors, do you find that to be the case?

Answer. In our work, we find that often the question is simple but the answer can be complex. Many questions that we receive require analysis, including a rephrasing of the original question (e.g. "I want to know if I can change my drug plans turns into "What are my options to change plans, what should I look for when comparing coverage between plans, etc."). Medicare beneficiaries regularly seek our assistance with complex issues, and presumably, also call 1–800–MEDICARE with similar issues. While we are unable to provide a breakdown of simple vs. complex calls that either we or 1–800–MEDICARE receive, we strongly urge CMS to give more attention to the calls it deems to be complex.

Beneficiaries and SHIP counselors alike are frustrated with their inability to get back to the same 1–800–MEDICARE CSR, requiring starting the process/explanation all over again each time a call is transferred or dropped—with no assurances that all notes are being taken. CSRs do little check of callers' understanding, and there is still an ongoing frustration with the IVR; beneficiaries need to get a live person on the phone at the outset.

Question 3. Complaints About 1–800–Medicare

CMS and Vangent have represented that that they are not aware of significant complaints about service at 1–800–MEDICARE. My office has received numerous complaints regarding difficulties in filing complaints at 1–800–MEDICARE—either complaints about service at 1–800–MEDICARE or complaints about plans or other issues. In your casework with seniors, have you experienced these problems? Further, in your experience, after a bad experience with 1–800–Medicare, are seniors going to take the time to call back in to 1–800–Medicare to file a complaint about their service at 1–800–MEDICARE?

Answer. As discussed in our testimony, we are more prone to hearing about problems with 1–800–MEDICARE than successes. In our experience, we have certainly encountered many complaints about the difficulties in filing complaints at 1–800–MEDICARE—both about the hotline itself and plan or other issues. After a bad experience with 1–800–MEDICARE, we have found that Medicare beneficiaries often do not take the time to either call them back or file a complaint. All too often, beneficiaries will reach their local SHIP program after a frustrating experience with 1–800–MEDICARE and a subsequent referral from Social Security or a non-Medicare related agency. Such contacts often occur after much time has elapsed following a caller's initial attempt to reach 1–800–MEDICARE, which can further exacerbate the individual's problems.

Thank you for the opportunity to provide these follow-up comments.

JOHN CURTIS'S RESPONSES TO SENATOR SMITH'S QUESTIONS

Question. What problems have you identified that need immediate attention, and what steps do you plan to take to remedy these problems and deliver drastic im-

provements before the start of the 2009 enrollment period, which starts in November?

Answer. Vangent takes its responsibility to Medicare beneficiaries seriously, and is approaching the 2009 Annual Election Period with a strong emphasis on continuous improvement and quality service.

Each summer, Vangent develops and implements a readiness plan to ensure that we are prepared to meet the increased demand of the Annual Election Period. This plan covers all aspects of the BCC operation and is a cornerstone of our approach to providing high quality service during the fall "spike" period.

The following are just a few examples of the steps we are taking to improve service:

Lowering Wait Times and Supporting Our Infrasture

We have implemented a number of operational technology improvements to minimize the time required for a beneficiary to reach a CSR trained to answer his or her question. In September, we opened an additional call center to accommodate the increase in call volume associated with the Annual Election Period.

We have also implemented a BCC "Command Center" that monitors wait times 24 hours a day, seven days a week, and shifts workforce as needed to meet incoming call volumes.

The Command Center monitors network and phone systems at each site to quickly identify and address any problems that may arise.

As stated by Acting Administrator Weems, we are committed to maintaining an average monthly speed of answer of 5 minutes or less through the remainder of the year.

Training and Scripting

In preparation for the Annual Election Period, CMS works with Vangent and the Training, Quality and Content contractor to review and update all drug plan scripts, and provide specific training to CSRs.

We are also taking every opportunity to review "frequently asked questions" with CSRs to ensure that they are prepared to respond accurately and effectively to these questions.

Finally, CMS has implemented an improved Learning Management System that will allow us to better identify training needs of CSRs and disseminate information to those CSRs and call centers.

Quality

Throughout the Annual Election Period, we will reinforce our commitment to quality. We will continue to closely monitor calls and aggressively address any opportunities for improvement identified by our Independent Quality contractor.

We recognize the important role that 1–800–MEDICARE plays in helping Medicare beneficiaries make informed decisions about their benefits. We take that responsibility seriously, and are committed to providing high quality service not only during the Annual Election Period, but throughout the year.

HealthAssistance
PARTNERSHIP

Senate Special Aging Committee
1-800 Medicare: It's Time for a Check-Up
September 11, 2008

Statement by the Health Assistance Partnership

The Health Assistance Partnership (HAP), a project of Families USA, a non-profit organization in Washington, D.C., partners with State Health Insurance Assistance Programs (SHIPs) on capacity building initiatives in the areas of Medicare education and program development. For the past six years, HAP has worked closely with state and local SHIPs across the country on issues affecting SHIPs and the Medicare beneficiaries they serve, including 1-800-MEDICARE.

HAP is particularly pleased by the recent implementation of the special SHIP access number to reach 1-800-MEDICARE CSRs. SHIPs have reported greatly reduced hold times, increasingly knowledgeable CSRs, and improvements to general customer service. However, the need for this type of solution (as well as the SHIP-specific access numbers for plans) highlights the fact that regular access to 1-800-MEDICARE as it currently exists is faulty. Many others, including beneficiaries and others who assist them, must rely on the accuracy and timeliness of information provided by their only resource—the CSRs at 1-800-MEDICARE. While HAP recognizes that improvements have been made to the hotline, other improvements still are needed before SHIPs, Medicare beneficiaries, and caregivers embark on another Annual Enrollment Period.

Our recommendations include the following:

- All CSRs need to be aware that SHIPs may use different program names. Not all programs are called SHIP. For example, some SHIPs are referred to as SHIBA (Statewide Health Insurance Benefits Advisors) or SHINE (Serving Health Information Needs of Elders). It is imperative that CSRs are made aware of these differences, and that they have easy access to a document that provides the specific program name to avoid confusing beneficiaries, and to make it easier for SHIP counselors who identify themselves as being from the "SHIBA" program, for example.

- All CSRs must have access to updated lists of SHIP unique ID numbers. CMS provides unique ID numbers to each SHIP counselor through the state SHIP. The unique ID numbers serve as a password for the special SHIP access number for 1-800-MEDICARE. SHIPs have reported to HAP that many times CSRs acknowledge using two-year-old lists of unique ID numbers. A simple solution is to provide updated lists of unique ID numbers regularly to CSRs.

- At a minimum, all CSRs need to be able to answer basic questions about Original Medicare, Medicare Advantage or Health Plans, and Medicare Prescription Drug Coverage (Part D). It is frustrating for beneficiaries who call 1-800-MEDICARE, and may wait up to 20-30 minutes to speak to a CSR, to then be referred to a different number for the answer to a relatively straightforward question such as "when can I enroll in a new prescription drug plan?" In addition, by ensuring that the CSRs are able to answer these basic questions, SHIPs are afforded the opportunity to handle more complex cases that often require extensive research, as well as engage in community education and other services that benefit Medicare beneficiaries and their caregivers.

TESTIMONY OF JETTIE TURNER

MEDICARE BENEFICIARY
TUPELO, MISSISSIPPI

CLIENT
MISSISSIPPI SENIOR MEDICARE PATROL

1-800-MEDICARE: IT'S TIME FOR A CHECK-UP

SEPTEMBER 11, 2008

My name is Jettie Turner. I live in Tupelo, Mississippi. I am a Medicare Beneficiary and a victim of an insurance agent's fraudulent enrollment into a Medicare Advantage plan. That fraudulent situation has a profound effect upon the level of assistance that I needed when I began to phone 1-800-MEDICARE for help.

My story actually began long before I even knew that it had started. The same insurance agent sold me both my 2003 Medicare Supplement and my 2006 Medicare drug plan. In April 2007, that agent phoned to discuss a new Medicare option called Today's Options. I did not understand everything the agent told me, but I did agree to consider the plan. Within a few days, I decided to continue with my original Medicare Supplement instead of the new plan the agent was promoting. I phoned the agent with my decision. Little did I know that my life was about to become very complicated. I had already been enrolled into Today's Options **without my knowledge**. In fact, it was several months before I realized that I had a major problem.

Large amounts of mail began arriving from Today's Options, a plan offered by Pyramid. At first I thought that I was just receiving junk mail from Today's Options. I simply threw away all of the mail from Pyramid. I complained to the agent and asked him for help. The agent assured me that he would take care of everything. However, the "junk mail" never decreased.

I continued to leave messages for the agent. The agent was very slow in responding to my calls. The agent always said, "I'll take care of everything." I finally learned that all that **junk mail** was actually **membership mail**. Then I was horrified to be told by my doctor's insurance person that I was no longer on Medicare and that my Medicare Supplement would no longer work.

I immediately phoned 1-800-MEDICARE. The Medicare representative said that Medicare could not help me and that I had to call Pyramid. Pyramid kept referring me to Medicare, and the representatives at 1-800-MEDICARE kept telling me to call Pyramid.

In addition to my calls to Pyramid and to 1-800-MEDICARE, I continued to complain to the insurance agent who had, without my knowledge, enrolled me into the Pyramid plan. The agent always told me that he would "take care of everything." Eventually, I got out of Today's Options and back on my original Medicare. I was uncertain how I got rid of Today's Options, but I was very extremely happy.

My happiness did not last long. For the three months that I was "enrolled" in Today's Options, I soon discovered that I was faced with three months of medical expenses that were not totally covered by my Medicare and my Supplement. A medical insurance billing person at my doctor's office suggested that I phone Dawn Crouse with Mississippi Senior Medicare Patrol. The billing person told me that Ms. Crouse had been successfully in assisting other people in my situation. I immediately phoned Ms. Crouse.

When Ms. Crouse became my advocate on May 6, 2008, my problems with 1-800-MEDICARE did not immediately stop. Ms. Crouse and I phoned 1-800-MEDICARE on three occasions.

- On May 6, 2008, Ms. Crouse helped me file an **agent misrepresentation complaint**.
- On June 4, 2008, Ms. Crouse helped me file a **second agent misrepresentation complaint** when 1-800-MEDICARE could not give us an update on my May 6th complaint. Ms. Crouse also requested that the Medicare representative file a **complaint against Pyramid** because the company had failed to send me the requested copies of my Today's Options application and my disenrollment letter.
- On August 11, 2008, Ms. Crouse helped me file a **fourth complaint against the agent and Pyramid**, the company who offered the Today's Options plan.

As of today, September 11, 2008, Ms. Crouse and I have not had a single response from any of the above four complaints we filed with 1-800-MEDICARE.

Ms. Crouse and I were concerned that my problems evidently were not being addressed by the four complaints which were filed with 1-800-MEDICARE between May 6th and August 11th. Ms. Crouse did not simply sit back and wait for the 1-800-MEDICARE complaints to work. Ms. Crouse had previously worked with a special investigator at Today's Options so Ms. Crouse helped me file an **internal misrepresentation complaint against the agent**. I have been told that the agent has now admitted that the signature on the application was not my signature. I was also informed that Today's Options is in the process of notifying Medicare of my **retroactive disenrollment**.

I doubt that many people know just how difficult it is to resolve Medicare enrollment problems. I made **absolutely no progress** on my own. Without Ms. Crouse as my advocate, I probably would have given up, paid the outstanding premiums, and paid the co-pays under Today's Options, the plan offered by Pyramid.

I want everyone to read my intake from Mississippi Senior Medicare Patrol. Every word is true. Every word represents its own horror story. Please read the intake and ask yourself the following questions:

- How many thousands of Medicare beneficiaries are in the same sad status?
- What if this happened to me?
- Would I know how to climb out of the sewer?
- Who would be there to help me climb out of the sewer?

Partial Intake from Mississippi Senior Medicare Patrol

Here are highlights from my intake at Mississippi Senior Medicare Patrol.

Date: 05/06/08

MS SMP Counselor: Volunteer Dawn V. Crouse

Caller/Reporter: Jettie Sue Turner (Referred by medical provider)

Beneficiary Name: Jettie Sue Turner
Age at time of intake: 69

Beneficiary Info:
One of Jettie Sue Turner's medical providers referred Ms. Turner to Mississippi Senior Medicare Patrol for assistance.

Ms. Turner has no idea how her name was enrolled into Today's Options from Pyramid. To the best of her knowledge, Ms. Turner does not believe she signed any application for any MA plan.

In 2003, an insurance agent sold Ms. Turner a Medigap policy. On 05/16/06, the same insurance agent enrolled Ms. Turner into a Part D plan. Therefore, the insurance agent had ample access to Ms. Turner's personal info that the insurance agent could have used to complete a fraudulent Today's Options application.

Ms. Turner remembered hearing the insurance agent say he had another plan that was cheaper than Ms. Turner's then current Medicare Supplement. Ms. Turner said she was content with her Medical Supplement but would think about the new plan.

Later Ms. Turner told the insurance agent that she did not want to pursue Today's Options. To her surprise, Today's Options membership info arrived for Ms. Turner. Ms. Turner called the agent to complain. Every time Ms. Turner received mail from Today's Options, Ms. Turner called the insurance agent. The insurance agent kept telling Ms. Turner that he would take care of the problem with membership-related correspondence from Today's Options.

One of Ms. Turner's medical providers discovered that Ms. Turner had a Today's Options enrollment instead of her original Medicare. That was a big surprise to Ms. Turner. The provider referred Ms. Turner to Mississippi Senior Medicare Patrol.

Ms. Turner has consistently maintained her Medicare Supplement throughout the Today's Options enrollment.

MS SMP Plan:
MS SMP Counselor and Ms. Turner phoned Today's Options to research Ms. Turner's supposed enrollment. The Pyramid CSR gave the following info. Later, MS SMP Counselor and Ms. Turner spoke with another Pyramid CSR.

- Plan Premier PRP0P00
- Application date 04/27/07; received at Pyramid 05/04/07
- ID (info per additional call to second CSR)
- Payment method -- direct bill (info per addition call to second CSR)
- Enrollment 05/01/07 - 07/31/07
- Reason for disenrollment - letter of disenrollment from beneficiary

During the 05/06/08 call to Customer Service at Today's Options, MS SMP Counselor requested copies of Ms. Turner's application and disenrollment letter. (The copies would take 7 - 14 business days.)

MS SMP Counselor and Ms. Turner later phoned MS SMP Counselor's investigative contact at Today's Options. MS SMP Counselor left a message for the investigator to return the call.

MS SMP Counselor and Ms. Turner phoned 1-800-MEDICARE to file complaints against the plan and agent for fraudulent enrollment.

- 2007 Today's Options $72.00/mo. premium being billed to Ms. Turner
- Filed agent complaint and requested retroactive disenrollment back to 05/01/07

Update 05/08/08: Pyramid's investigator left a message for MS SMP Counselor.

Update 05/09/08: MS SMP Counselor left a message for Pyramid's investigator.

Update 05/14/08: Pyramid's investigator called to discuss Ms. Turner's enrollment into Today's Options. MS SMP Counselor gave the investigator details from Ms. Turner's MS SMP intake. MS SMP Counselor told the investigator that MS SMP Counselor and Ms. Turner had requested copies of Ms. Turner's application and disenrollment letter when the original agent complaint was filed with Pyramid's Customer Service. When the copies arrive, MS SMP Counselor and Ms. Turner will review the 2 documents (copies of application and disenrollment letter) and will contact the investigator. The investigator will begin an investigation.

Update 06/04/08: In a 05/20/08 letter, Today's Options sent Ms. Turner a past due notice for $216.00 premiums for 2007 charges. The letter stated that the 2008 premiums would be billed separately.

In a 05/30/08 letter, Today's Options confirmed Ms. Turner's 07/31/08 disenrollment but requested payment for past due premiums of $216.00.

MS SMP Counselor and Ms. Turner phoned 1-800-MEDICARE to check the status of Ms. Turner's retroactive disenrollment. The Medicare Benefits Specialist filed a second complaint for retroactive disenrollment. The Medicare Benefits Specialist filed a second, separate complaint because the plan's Customer Service Dept. had failed to provide the requested copies of the application and disenrollment letter.

MS SMP Counselor and Ms. Turner left a message for the investigator for Pyramid. MS SMP Counselor and Ms. Turner requested copies of the questionable application and the mystery disenrollment letter that Ms. Turner said she did not write and/or sign.

Update 06/14/08: On 06/12/08, Ms. Turner received a phone call from a Pyramid representative who said that Ms. Turner had a premium payment due and an outstanding premium balance. Ms. Turner told the rep that she had never enrolled into the plan. (Ms. Turner's Caller ID - PRCLLC, 1.954.838.4000, 2:30 PM)

The plan never fulfilled the original 05/06/08 request for copies of Ms. Turner's application and disenrollment letter. These documents were finally provided by the Today's Options investigator. MS SMP Counselor and Ms. Turner prepared a written list of discrepancies in signatures/initials and other issues for Ms. Turner to sign and fax to the investigator. In mid June, that information was sent to Pyramid's investigator.

Update 08/11/08: MS SMP Counselor and Ms. Turner phoned 1-800-MEDICARE. MS SMP Counselor explained the lack of retroactive disenrollment. The Medicare CSR filed a complaint with the plan to do a retroactive disenrollment back 05/01/07. MS SMP Counselor and Ms. Turner also spoke with the 1-800-MEDICARE Supervisor.

Update 09/02/08: The investigator for Today's Options, Special Investigations, emailed two telephonic enrollment recordings to MS SMP Counselor. The investigator explained that the first call was dropped so the Today's Options representative had re-established contact with Ms. Turner via a second call.

MS SMP Counselor listened to the email recordings. The Medicare beneficiary's voice was very faint. Counselor heard enough to recognize the "beneficiary's" voice as female. MS SMP Counselor noticed that the *agent* gave all the beneficiary's personal info and plan info prior to adding the beneficiary to the call.

MS SMP Counselor also realized that the second call originated with Today's Options. During this call, MS SMP Counselor immediately recognized that an enrollment was in process. However, MS SMP Counselor was unable to clearly discern that the female beneficiary was aware that an enrollment was in process.

Finally, MS SMP Counselor heard Ms. Turner ask the Today's Options rep if Ms. Turner should call the agent and provide the confirmation number that the rep had just given Ms. Turner. (If the agent had been at Ms. Turner's residence, there would have been no need for Ms. Turner to phone the agent.)

Because MS SMP Counselor was unable to clearly hear the first recording and because Ms. Turner lives over an hour away from MS SMP Counselor, the investigator burned a CD of the telephonic "enrollment." The investigator sent the CD to Ms. Turner via Federal Express Next Day Air.

Update 09/03/08: The investigator emailed MS SMP Counselor the following info.

- The paper application was dated 04/27/07.
- The paper application's proposed effective date was to be 08/01/07.
- The paper application was received at Today's Options on 05/04/07.
- The enrollment became effective on 05/01/07.

Update 09/04/08: Ms. Turner received the CD of the telephonic enrollment. Ms. Turner confirmed that it was her voice on both recordings. However, Ms. Turner still maintained that she had not knowingly enrolled into Today's Options.

Ms. Turner played the recording for MS SMP Counselor. MS SMP Counselor again noticed that Ms. Turner did not join the first call until after all the personal info and plan info was provided by the agent. From the second recording, MS SMP Counselor believed that the first call was dropped and was aware that the agent was not present when the Today's Options rep phoned Ms. Turner to continue the conversation.

Update 09/05/08: MS SMP Counselor and Ms. Turner attempted to contact the Pyramid investigator.

Update 09/08/08: The investigator phoned MS SMP Counselor. Counselor outlined her following concerns.

- The agent gave all personal and plan info prior to Ms. Turner joining the call.
- Although the investigator, MS SMP Counselor, and other experienced listeners would quickly recognize the call as a telephonic enrollment, most Medicare beneficiaries were not likely to know that the call was an enrollment conversation.
- Ms. Turner steadfastly denied her enrollment, and MS SMP Counselor believed Ms. Turner was very truthful.

Pyramid's investigator told MS SMP Counselor that the telephonic recordings were apparently done on 04/27/07.

The Pyramid investigator said that there had been a new development. During the investigation, a plan VP spoke at length with the insurance agent. The insurance agent admitted to the VP that Ms. Turner had not signed the application. Based upon the plan's investigation, Today's Options is in the process of notifying CMS that Ms. Turner's enrollment should be voided.

MS SMP Counselor suggested that the investigator give the news directly to Ms. Turner so MS SMP Counselor placed a three-way call to Ms. Turner. Ms. Turner was very relieved to know that the truth had finally surfaced. Ms. Turner expressed her desire that insurance agent not be allowed to do this same thing to anyone else.

Neither Ms. Turner nor MS SMP Counselor was ever contacted by anyone associated with any of the four 1-800-MEDICARE complaints filed against the agent and/or the plan. The resolution of Ms. Turner's retroactive disenrollment and the agent discipline were directly linked to MS SMP Counselor's prior contact within the Special Investigations Unit for Today's Options.

MS SMP Counselor is concerned that Ms. Turner's case may never have been successfully resolved via 1-800-MEDICARE alone. MS SMP Counselor believes the resolution depended upon the following events which had no link to 1-800-MEDICARE.

- *Ms. Turner's medical provider knew retroactive disenrollments were possible and referred Ms. Turner to Mississippi Senior Medicare Patrol.*
- *Ms. Turner's medical provider knew the MS SMP Counselor's track record for successful retroactive disenrollments over the past several years.*
- *Ms. Turner told the truth and was strong enough to stand firm under pressure.*
- *MS SMP Counselor and the investigator from Universal American's Special Investigations Unit had worked together on prior complaints which were successfully resolved.*

TESTIMONY OF COLTER MCLELLAN

MEDICARE BENEFICIARY
PICAYUNE, MISSISSIPPI

CLIENT
MISSISSIPPI SENIOR MEDICARE PATROL

1-800-MEDICARE: IT'S TIME FOR A CHECK-UP

SEPTEMBER 11, 2008

I am Colter McLellan of Picayune, Mississippi. I am a Medicare Beneficiary who has been the victim of agent misrepresentation.

I want to divide my testimony into three parts.

- The first section is an outline of what I experienced when my wife and I unsuccessfully attempted to resolve our Medicare problems.
- The second section covers the events after the Mississippi Insurance Department referred me to the Mississippi Senior Medicare Patrol.
- The third section contains my personal observations.

My Experience:

A little background is necessary for you to understand the problems that I experienced with 1-800-MEDICARE. My wife Doris and I attended a presentation on Today's Options, a Medicare Advantage plan offered by Pyramid. The host insurance agent gave a glowing, "prepared" performance on the benefits of this new Medicare Advantage plan. My wife and I thought Today's Options would be less expensive and a good replacement for our existing Medicare Supplements. We both enrolled into what we believed to be another type of Medicare Supplement. We did not understand that the private plan Today's Options would replace our original Medicare coverage instead of replacing our Medicare Supplements.

We continued to believe the untruths until reality came knocking on our door. To make a long story short, the agent misled us in some critical areas. Our new Pyramid Today's Options plan failed to duplicate our previous coverage with original Medicare and Medicare Supplement.

Less than four months of Today's Options left my wife and me begging our original Medicare Supplement company to allow us to return so we could again have superior coverage and wonderful customer service. Since we had been on Today's Options for less than a year, we thought it would be easy to return to traditional Medicare and our Medicare Supplement.

Here is an outline of my 1-800-MEDICARE contacts along with selected Today's Options contacts that are necessary for you to follow the chain of events.

- On April 13, 2007, my wife and I wrote Today's Options a letter which requested the plan to terminate both of our enrollments. I faxed those cancellation requests to Pyramid. This was our first attempt to disenroll from Today's Options.

- On April 16, 2007, I made the following calls:
    - I contacted 1-800-MEDICARE. The New York representative told me not to worry because Today's Options would take care of the problem.
    - I phoned 1-800-MEDICARE for the second time and spoke with a representative in South Carolina. I asked that person to call Today's Options to confirm that Today's Options had received our faxes and was indeed working on our terminations from the Today's Options plan.
    - I made a third call to 1-800-MEDICARE and spoke with a representative in Philadelphia. That representative committed to conduct research and contact me with the results.

- On April 18, 2007, I phoned 1-800-MEDICARE and first spoke with a Medicare representative in Iowa. That person transferred me to a second Medicare representative in South Carolina. The South Carolina representative told me that so far Medicare had not received any information from Pyramid concerning the disenrollments from the Today's Options plan.

- On April 18, 2007, I also phoned Today's Options. Pyramid's Filipino customer service representative told me not to worry because the disenrollment information would be automatically sent to Medicare.

- On April 26, 2007, I phoned Today's Options. The plan customer service representative told me that my wife and I had used an incorrect term "terminate" instead of the correct term "disenroll." The Today's Options representative then told me that my wife and I would have to ***reapply for disenrollment and use the correct terminology.*** I did not understand why the plan representative did not just correct our first letter. I did not understand why my wife and I had to write a totally new disenrollment letter. However, my wife and I made the mandated correction and faxed our second disenroll request to the plan the same day I was instructed to reapply for disenrollment.

- May 3, 2007, I called 1-800-MEDICARE and explained the actions to date. The Medicare representative said the Medicare Regional Office would speak with me after someone at the Regional Office had spoken with Pyramid.

- On May 8, 2007, I phoned 1-800-MEDICARE. A Virginia Medicare representative took my call but then transferred my call to a representative in South Carolina. The South Carolina representative said that my complaint would be sent to higher level at Medicare and that someone at the "higher level of Medicare" would get in touch with Today's Options to resolve the issue and that "higher level" Medicare representative would call me back within twenty-four hours.

- On July 26, 2007, I asked the 1-800-MEDICARE representative in South Carolina about my May 8th call. The representative was unable to give me any information. Apparently no action had been taken on my issue.

- On August 1, 2007, I spoke with a 1-800-MEDICARE representative in Iowa, who transferred me to Kentucky, who transferred me to South Carolina. Supposedly, the South Carolina representative filed a second complaint against Today's Options, a Pyramid plan.

- On August 3, 2007, I spoke with a Virginia representative of 1-800-MEDICARE This representative was a disenrollment specialist. During the call, I became so frustrated that I could not deal with all the problems.

Mississippi Insurance Department and Mississippi Senior Medicare Patrol:
On August 3, 2007, I followed a friend's advice and contacted the Mississippi Insurance Department. I was referred to Betty Green, Mississippi Department of Human Services, Division of Aging. Ms. Green, the Grant Coordinator for Mississippi Senior Medicare Patrol (MS SMP), assigned me to Dawn Crouse, Mississippi SMP Volunteer Counselor, who became my advocate. Ms. Crouse immediately set an appointment to do my intake.

At this point, I wish to refer you to selected portions of my attached Mississippi Senior Medicare Patrol intake form. Ms. Crouse has done a wonderful job of documenting all her efforts, including calls to 1-800-MEDICARE. Only because Ms. Crouse became our advocate, my wife and I were finally given retroactive disenrollments from Today's Options, a Medicare Advantage plan offered by Pyramid.

Intake from Mississippi Senior Medicare Patrol:
Here are pertinent selections from my official intake at Mississippi Senior Medicare Patrol.

Date: 08/03/07

MS SMP Counselor: Volunteer Dawn V. Crouse

Caller/Reporter: Colter McLellan (Referral to MS SMP by MS Insurance Dept.)

First Beneficiary Name: Colter McLellan
Age at time of intake: 70

Second Beneficiary Name Doris N. (Jean) McLellan
Age at time of intake: 69

Beneficiary Info:
Colter and Doris McLellan attended an insurance agent's group presentation on Today's Options by Pyramid. Mr. and Mrs. McLellan both enrolled into Pyramid Today's Options, with coverage to begin on 01/01/07.

The McLellans believe the agent misled them into believing that Today's Options was a good replacement for their Medicare Supplements, for several reasons.

- The agent did not disclose that Pyramid would be getting monthly Part B premiums plus additional monthly amounts.
- The McLellans thought/understood the premiums would only be $35.00/mo.
- In addition to the agent's misrepresentations, Pyramid has not covered the same charges that Medicare/Medigap had previously paid.

The McLellans began having serious doubts about Today's Options. Since 04/13/07, Mr. McLellan has been attempting to disenroll himself and his wife from their Today's Options plans. Mr. McLellan faxed the disenrollment requests to Pyramid.

On 04/26/07, Mr. McLellan initiated a call to Today's Options to confirm their disenrollments. The Today's Options representative told Mr. McLellan that he would have to ***reapply for disenrollment and use the correct terminology*** – i.e., "disenroll" vs. Mr. McLellan's original "terminate." Mr. McLellan made the requested change and faxed the ***second requests*** on 04/26/07.

Mr. McLellan phoned Today's Options on 05/07/07. The Today's Options representative verbally confirmed the 04/30/07 disenrollments and the 05/01/07 returns to original Medicare.

In the 05/17/07 letter from Today's Options, both McLellans were supposedly given 04/30/07 disenrollments and returned to original Medicare on 05/01/07.

Because of on-going claim problems, Mr. McLellan phoned Today's Options on 07/25/07. The Today's Options representative verbally confirmed that Medicare had been notified of the disenrollments on 05/08/07 (Batch # 071280, Contract # H5421).

In spite of the Mr. McLellan's numerous phone calls to Today's Options and to 1-800-MEDICARE, Medicare records never reflected the 04/30/07 disenrollments.

During Mr. McLellan's calls to 1-800-MEDICARE, retroactive disenrollments were never offered by the 1-800-MEDICARE representatives in spite of the McLellans' complaints that Today's Options did not offer the exact same coverage as original Medicare and that the insurance agent had misrepresented the plan - Today's Options.

Mr. McLellan eventually contacted the Mississippi Insurance Department who referred the McLellans to Mississippi Senior Medicare Patrol for resolution.

MS SMP Plan:
MS SMP Counselor and Mr. McLellan phoned 1-800-MEDICARE to request retroactive disenrollments during the first 08/03/07 phone call. MS SMP Counselor and Mr. McLellan suffered through long wait times and less than ideal customer service. The 1-800-MEDICARE personnel were not very responsive; some were belligerent and argumentative. One female representative asked questions and then did not allow MS SMP Counselor to completely answer before the representative constantly interrupted. It became obvious that MS SMP Counselor was not making any progress. MS SMP Counselor (Certified Purchasing Manager with 20+ years in corporate America as professional employee and manager) refused to subject her client to further abuse so MS SMP Counselor severed the connection.

Because MS SMP Counselor knew that the McLellans were desperate for closure, MS SMP Counselor asked Mr. McLellan if he could endure another round of long wait times. MS SMP Counselor and Mr. McLellan again phoned 1-800-MEDICARE. Eventually, MS SMP Counselor was able to reach a Medicare supervisor and point out that Mr. McLellan had tried to secure disenrollments since April 2007. The helpful supervisor processed 07/31/07 disenrollments and requested 01/01/07 retroactive disenrollments for both McLellans.

Update 08/08/07: An employee at CMS Atlanta phoned to confirm the retroactive disenrollments. MS SMP Counselor notified the McLellans.

Update 08/21/07: During recent out of state travel, Mr. McLellan called Medicare and learned that both McLellans have now been returned to Medicare. Mr. McLellan had some questions about retroactive disenrollments vs. the McLellans' old medical bills.

Update 11/12/07: In a 08/17/07 letter, Today's Options confirmed the McLellans' retroactive returns to original Medicare. Mr. McLellan notified MS SMP Counselor that Ms. McLellan's providers have indicated that her return to original Medicare was still incomplete and claims cannot be correctly paid.

MS SMP Counselor and Mr. McLellan phoned 1-800-MEDICARE. Supposedly, both McLellans have been retroactively returned to original Medicare.

MS SMP Counselor and the McLellans phoned Medicare COB (800.999.1118 8:00 AM – 8:00 PM ET M-F). Both McLellans now have original Medicare since the beginning of their Medicare eligibilities.

MS SMP Counselor and Mr. McLellan phoned a hospital and left a message for someone in insurance billing. That person returned the call and said the Medicare Common Working File still has no end date for Today's Options. MS SMP Counselor needs to call CMS.

Update 11-15-07: 1-800-MEDICARE confirmed that the McLellans are back on original Medicare and the Common Working File is correct for both spouses.

Update 11/16/07: Mr. McLellan phoned MS SMP Counselor to ask several questions about the retroactive disenrollments vs. medical bills.

Important Points Based upon Intake from Mississippi Senior Medicare Patrol:

As you see in the attached selection from the Mississippi Senior Medicare patrol intake, Ms. Crouse and I made our first joint call to 1-800-MEDICARE on August 3, 2007. That call was unbelievable. We waited for a long time before we were able to speak to the first Medicare representative. From there forward, we were placed on hold for very long stretches of time. When Ms. Crouse and I finally were able to talk with representatives beyond that first level, I was shocked at the rude and obnoxious behavior of those Medicare representatives. Ms. Crouse was evidently not intimidated because she terminated that call. Ms. Crouse again dialed 1-800-MEDICARE so we could continue to pursue retroactive disenrollments for my wife and me.

About fifteen months passed ***between*** the time I first tried to disenroll and **when** I received a written disenrollment confirmation from Today's Options. On July 18, **2008**, a letter from Today's Options confirmed my wife's and my January 1, **2007** return back into original Medicare. **This was the first written acknowledgement from Today's Options** concerning retroactive disenrollment. Around the same time that the Today's Options letter arrived, I received a call from someone at Today's Options who verbally confirmed the retroactive disenrollment but who apparently was attempting to get me to ***re-enroll*** into Today's Options. Of course, my wife and I had no intentions of enrolling into a Medicare Advantage plan ever again.

Personal Observations:

Without Mississippi Senior Medicare Patrol and without Ms. Crouse's advocacy and helpful guidance, I am afraid that my wife and I would still be stuck in Today's Options.

I believe that the 1-800-MEDICARE representatives should have been more responsive. That very first representative, on April 16, 2007, should have informed me that retroactive disenrollment was possible if there had been agent misrepresentation.

Why is it so hard for Medicare Beneficiaries to obtain understandable information? Why does 1-800-MEDICARE fail to educate Medicare Beneficiaries on their options such as disenrollment and retroactive disenrollment? Why can 1-800-MEDICARE not use simple, understandable explanations that are geared toward the general public's education level?

TESTIMONY OF DAWN V. CROUSE

FULL-TIME VOLUNTEER SMP COUNSELOR
MISSISSIPPI SENIOR MEDICARE PATROL
COLUMBUS, MISSISSIPPI

1-800-MEDICARE: IT'S TIME FOR A CHECK-UP

SEPTEMBER 11, 2008

My name is Dawn V. Crouse. I am a volunteer for Mississippi Senior Medical Patrol (MS SMP). Since March of 2006, I have worked as a full-time Volunteer SMP Counselor. I have the same training as paid SMP Counselors. My specialties are Medicare Part C and Part D errors, fraud, and abuse.

To round out my total experience, I have a very active eighty-seven year old mother and a disabled husband. Both family members are enrolled in Medicare.

My testimony is split into two parts. The first part contains highlights from my actual experience as a Volunteer SMP Counselor. The second part discusses some of my observations and/or suggestions.

Actual Experiences:

#1 One of my dual eligible clients had had several strokes and was seriously impaired. His primary care physician asked my client's neighbor/pastor to contact me for assistance with a retroactive disenrollment. During our call to 1-800-MEDICARE, the neighbor/pastor sat beside my client and read his Medicare number, character by character, to him. Even with this type of help, my client was only able to correctly repeat two characters without two to three attempts for each character. I explained to the 1-800-MEDCIARE representatives the enrollment problems for Mississippi dual eligibles. When I requested retroactive disenrollment from the plan, both the Benefit Specialist and the Help Queue refused to process my request. They both said that my client must be able to provide specific examples of agent misrepresentation before my client would be eligible for a disenrollment and retroactive disenrollment. Even when I pointed out that my client had severe mental impairment, the disenrollment and retroactive disenrollments were denied by the 1-800-MEDICARE representatives. I ended the call.

I immediately redialed 1-800-MEDICARE for a second round. This time both the Benefit Specialist and the Help Queue were appalled at the previous refusals and promptly processed a disenrollment for the end of the month and a request for a retroactive disenrollment which would allow my client to return to original Medicare. Original Medicare plus Mississippi Medicaid would to cover virtually all my client's medical charges.

#2 While I was assisting clients Colter and Doris McLellan, Mr. McLellan and I phoned 1-800-MEDICARE to request retroactive disenrollments. Both call center employees were exceptionally rude. While I was attempting to answer one question, one call center employee abruptly interrupted and asked another question. While I was attempting to answer the new question, the same woman abruptly interrupted and asked yet another question. After multiple interruptions from the 1-800-MEDICARE, I attempted to address the interruptions, but I could not even point out the difficulties of continuous interruptions before being interrupted again. I finally determined that this call was a lost cause and that my client had been subjected to enough abuse. I severed the connection.

Mr. McLellan and I immediately made a second call to 1-800-MEDICARE. The second call went very smooth. The requests for retroactive disenrollments occurred without incident.

#3 I became a Certified Purchasing Manager (C.P.M.) in 1984 so I understand the negotiation process and the basics of contact law. I am well aware that misrepresentation can be actual statements, serious omissions, or a combination of the two.

During multiple conversations with personnel assigned to the South Carolina Call Center, I was told that misrepresentation could only occur if the plan or the insurance agent actually made incorrect or misleading statements. Every time I attempted to politely provide a correct definition of misrepresentation, I was emphatically told that misrepresentation had to be actual statements. I was often told to call the plans to complain about the agents.

Interestingly, I did not experience the incorrect information during many other calls to other 1-800-MEDICARE call centers.

#4 During two separate Saturday calls to the South Carolina Call Center, I requested retroactive disenrollments. In response to several probing questions, both representatives told me that no supervisors were present. I was told that no supervisors were available and to call again on Monday.

I knew South Carolina calls could be routed to the next available Benefit Specialist or Help Queue in any other location so I again dialed 1-800-MEDICARE.
During my third call, I was fortunate to be connected to the Kansas Call Center. The personnel there were shocked to hear that South Carolina representatives failed to transfer my call to their center which always has coverage for Benefit Specialist or Help Queue needs. My client and I were given apologies and the retroactive process went smoothly.

#5 I know exactly what to request when calling 1-800-MEDICARE. Too many times the first representatives at 1-800-MEDICARE attempt to refer me to the plans. If the plans had responded to previous attempts to resolve issues, the issues would have been resolved without calls to 1-800-MEDICARE. I often wonder how many beneficiaries just give up rather than insisting that the various call centers assist them.

#6 During a call, the same beneficiary information has to be repeated over and over. This wastes everyone's time.

#7 Advocates, Medicare beneficiaries, and family members are at the mercy of the call centers. Many times I get follow up calls from plans and/or CMS Regional Offices that concern information that I had clearly provided during my original calls to 1-800-MEDICARE. Unfortunately, not all my information was included in the original complaints by 1-800-MEDICARE.

#8 I realize that call centers are organized according to the levels of required training. The first representative has less training than a Benefit Specialist, and the Help Queue has more expertise than the Benefit Specialist. I help many clients who just simply cannot handle what they perceive as a confusing maze of people and questions when they attempt to call 1-800-MEDICARE for help.

#9 My experience has been that all levels at the call centers in Kansas and Kentucky consistently provide polite, caring, patient customer service. Even if I encounter a very new representative at those two call centers, there are sincere apologies if the call has to be placed on hold while the representative researches issues.

#10 Beneficiaries who clearly communicate reasons for one or more SEP's are not always offered retroactive disenrollments during calls to 1-800-MEDICARE. It appears that the beneficiaries and their family members must already know about the availability of SEP's/disenrollments/retroactive disenrollments and then request the appropriate actions for themselves.

#11 A dropped call can be a nightmare, especially during extended wait times. Too often I have finally gotten to a Benefit Specialist or Help Queue when the line goes dead. Sometimes the dropped call is associated with one or more hours of combined hold and work times.

#12 There are noticeable customer service differences between call centers. In my experience, Kentucky and Kansas consistently provide more complete, accurate service.

Suggestions for Improvement:

#1 Fully trained advocates from Senior Medicare Patrol or SHIP should have special contact numbers to directly access either a Benefits Specialist or Help Queue. The advocate could be required to have **all the answers** to a national template of questions prior to contacting the special numbers. The call centers could have the option of ending the call if the advocates are not prepared and fail to immediately supply the predetermined information.

#2 The first 1-800-MEDICARE representative should have capabilities of inputting all information, including authorizations for advocates, gathered during the call. This would cut down on the same information being requested over and over during a single call as the caller is transferred to a Benefit Specialist and/or Help Queue.

#3 For dropped calls, the call center's Benefit Specialist or Help Queue needs the ability to try to re-establish contact with the caller. (Some Part D and Part D plans are already doing this.)

#4 When a beneficiary gives verbal permission for an advocate to conduct the call, the contact phone number and name should be the advocate's. Many clients are unable to deal with the issue(s). That is why they are working with the advocate instead of calling 1-800-MEDICARE themselves.

Overall Observations/Suggestions:
Many representatives at 1-800-MEDICARE are caring and responsive. Most of these people are sincerely doing their best to provide good service to beneficiaries. A number of the problems that beneficiaries and advocates experience are inherent in the very complicated design of 1-800-MEDICARE.

I have twenty-plus years in manufacturing in various professional and managerial positions. I spent over ten years in new product introduction. I went through five corporate-wide software system implementations; I was on the core implementation team for four of those projects. My corporate background required me to be in a "continuous improvement" mode. I would like to suggest that those of us "in the trenches" could provide valuable feedback to those who are attempting to streamline and/or improve 1-800-MEDICARE.

Thank for your time and interest.

TESTIMONY OF FRANKIE F. FERGUSON

MEDICARE BENEFICIARY
OXFORD, MISSISSIPPI

CLIENT
MISSISSIPPI SENIOR MEDICARE PATROL

1-800-MEDICARE: IT'S TIME FOR A CHECK-UP

SEPTEMBER 11, 2008

I am Frankie F. Ferguson of Oxford, Mississippi. I am a Medicare Beneficiary who has tried since December 2007 to disenroll from a Medicare Advantage plan. My disenrollment attempts include a written disenrollment request sent to Today's Options, multiple calls to 1-800-MEDICARE, and recent assistance from Mississippi Senior Medicare Patrol.

I decided to try a Medicare Advantage plan for the first time. I enrolled into Today's Options on 2/1/07.

By the Fall of 2007 which was less than a year after my Today's Options enrollment, I was not happy with the plan so I decided to go back to traditional Medicare and purchase a Medicare Supplement.

On 11/15/07, I signed an application for a Medicare Supplement from United World Life Insurance Company, a Mutual of Omaha company. My coverage began on 1/1/08. My Supplement is still in effect.

My Mutual of Omaha agent prepared my written request for a 12/31/07 disenrollment date. That 12/15/07 letter to Pyramid was signed by my son Rick Ferguson (POA) and mailed by my Mutual of Omaha insurance agent.

Instead of disenrollment confirmation, Pyramid continued to send me premium notices for Today's Options. Several people advised me to be patient because disenrollments took time.

After what I thought to be a reasonable time for Pyramid to complete my disenrollment, I made several phone inquiries to both Pyramid and to 1-800-MEDICARE. On 3/3/08, I phoned Pyramid without accomplishing anything.

In addition to my own efforts, my son enlisted the aid of the Mutual of Omaha agent. My agent made at least three calls to 1-800-MEDICARE on my behalf. The first two calls were in January or February of 2008, and the last one was in March 2008. Stemming from the March call to 1-800-MEDICARE, a Pyramid representative phoned my agent at his residence even though my agent's residence phone number had not been provided by my agent during his call to 1-800-MEDICARE. Like all the other contacts with Pyramid, nothing was resolved.

On 3/31/08, I phoned 1-800-MEDICARE. I filed a complaint because Today's Options had failed to disenroll me back on 12/31/07 per my 12/15/07 letter. On 4/4/08, the plan took no action and refused this new retroactive disenrollment request because of my supposed "untimely processing of disenrollment request." I did not understand why Today's Options said my disenrollment request was "untimely." The plan ignored my written 12/15/07 disenrollment request and then my 3/31/08 complaint. Both of my actions were taken during the time that Medicare allowed changes to the Medicare Advantage plans.

On 5/5/08, I again phoned 1-800-MEDICARE. I explained the problem and filed another complaint. I thought that Medicare would take care of the problem this time. I did not know that 1-800-MEDICARE again routed my complaint back to Today's Options. I later learned that Today's Options again deemed my disenrollment request to be "untimely," took no action, and simply closed out the complaint on 6/10/08.

Since Today's Options had ignored my 12/15/07 letter and my 3/31/08 complaint via 1-800-MEDICARE, I still do not understand why 1-800-MEDICARE sent my 5/5/08 complaint to Today's Options. It should have been obvious by then that Today's Options was the problem and had no intention of becoming the solution.

By late July, my insurance agent, my son, and I were thoroughly disgusted. We could not understand why Pyramid repeatedly refused to disenroll me. My insurance agent discovered that Mississippi Senior Medicare Patrol was available to assist seniors with Medicare errors, fraud, and abuse.

My insurance agent learned that SMP Counselor Dawn Crouse was very knowledgeable of disenrollment processes and asked her for assistance. Ms. Crouse reviewed the situation and pointed out the following.

- My 12/15/07 disenrollment letter was sent during Open Enrollment so I should have been disenrolled from Today's Options on 12/31/07.
- My first call to 1-800-MEDICARE was done prior to the deadline of 3/31/08 so that was another valid reason for disenrollment.

On 8/4/08, Ms. Crouse and I filed a complaint via 1-800-MEDICARE. During this call, my SMP Counselor stressed the following points during the conversation with the 1-800-MEDICARE Customer Service Representative.

- I enrolled in Today's Options on 2/01/07.
- Late in 2007, I decided that I wanted to leave Today's Options and purchase a Medicare Supplement.
- I was in Today's Options less than 12 months when I decided to disenroll.
- Via a written request to Today's Options, I attempted to disenroll from Today's Options as of 12/31/07 and to return to traditional Medicare as of 01/01/08.
- I purchased a Medicare Supplement that went into effect on 1/1/08.
- I had made multiple attempts to disenroll from Today's Options which continuously refused to allow me to disenroll.

During this 8/4/08 conversation with the 1-800-MEDICARE Customer Service Representative, Ms. Crouse clearly indicated that this complaint should be routed to my Medicare Regional Office in Atlanta because the plan was unresponsive to my valid requests for disenrollment.

Along with Ms. Crouse's complaint via 1-800-MEDICARE, Ms. Crouse and I left a message for one of Ms. Crouse's contacts in the Compliance Department for Today's Options. Ms. Crouse also sent an email to her contact.

In response to Ms. Crouse's email, the Compliance Department's 8/7/08 email response included the following.

- Pyramid had no record of my 12/15/07 disenrollment letter.
- My first call to Pyramid was not until 3/3/08.
- Pyramid had paid 9 claims in 2007 and 12 claims in 2008.
- Unless I or my POA could provide proof that the written disenrollment was sent or I was in a trial period, there was nothing Pyramid could do "according to CMS guidelines."

Ms. Crouse obtained a copy of my 12/15/07 written disenrollment request and faxed it to Pyramid's Compliance Department on 9/15/08. Ms. Crouse also sent a 9/15/08 email to Pyramid's Compliance Department. Ms. Crouse stressed that I should be given a retroactive disenrollment back to 12/31/07. Ms. Crouse said that I should not be penalized for problems at Pyramid and/or Medicare. Ms. Crouse noted that a number of her clients had complained about Today's Options failing to timely process their disenrollments due to either "lost" written correspondence or unreasonably long processing times.

In a 9/16/08 email, Pyramid's Compliance Department said "to be honest there is no real proof showing she sent this letter." The Compliance Department committed to forwarding the copy of the 12/15/07 letter to the Enrollment Department.

In the meantime, Ms. Crouse spoke with my Mutual of Omaha agent who told her that he personally wrote the 12/15/07 letter. My agent said that he sent the letter himself after my POA signed it.

In a 9/18/08 email, Pyramid's Compliance Department said the Enrollment Department could not find anything prior to the 2008 phone call. The following was part of Pyramid's message.

> "Resolution: Nothing was found in our system that suggests we ever received a letter or a phone call before 2008 to have this plan canceled. If the attached letter was faxed over to us in 2007 then we need a copy of the fax confirmation sheet that shows time and date. Notes in the member's account shows she has been contacted twice and this situation regarding her disenrollment was explained to her. She can't disenroll from her plan until AEP."

The 9/18/08 communication from Pyramid failed to address the concerns in Ms. Crouse's 9/15/08 message which said, "Ms. Ferguson should not be penalized for problems at Pyramid and/or Medicare. She and her son made numerous futile attempts to resolve her 12/31/07 disenrollment. She came to MS SMP as a last resort. . . . A number of my MS SMP clients have complained about Today's Options not processing their correspondence for disenrollments. The complaints have been both lost correspondence and/or unreasonably long processing times.

Medicare records show that I spoke with 1-800-MEDICARE and filed complaints against Pyramid on 3/31/08, 5/5/08, and 8/4/08. Pyramid refused my request for a 12/31/07 disenrollment. Pyramid's only response was that I was attempting to change my plan "outside of open enrollment." It appeared that Pyramid will not even consider that the plan mishandled the 12/15/07 written disenrollment request or that my first 1-800-MEDICARE complaint arrived in time for the 3/31/08 deadline that allowed me to make a plan change and return to traditional Medicare.

In spite of all the efforts of my son, my insurance agent, and my Senior Medicare Patrol Counselor, I am still enrolled in Today's Options and receiving premium notices from Today's Options.

Ms. Crouse and I phoned the Medicare Regional Office in Atlanta. Ms. Crouse was dismayed to learn that my 8/4/08 complaint was sent to Pyramid and that Pyramid simply closed out my complaint on 8/12/08 with the same notation that my request was made "outside of open enrollment." Ms. Crouse expressed her disappointment that the 1-800-MEDICARE complaint was routed to Pyramid instead of the Regional Office since Pyramid was the real problem. As a follow up to that phone conversation with the Regional Office, Ms. Crouse faxed the Regional Office a written complaint against Pyramid.

My Senior Medicare Patrol Counselor has assured me that she will continue to pursue my 12/31/07 disenrollment until the issue is resolved to my satisfaction and per my legal rights.

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