Last Chance for Patient Choice

August 13, 2013

Background and Explanation of Hogan-Hansen Study on Medicare's ability to accept beneficiary calls

Background
CMS (Medicare) implemented their competitive bidding scheme in nine MSAs effective January 1, 2011. Implementation of this bidding scheme resulted in a dramatic alteration to the home health care infrastructure – an 80% reduction in healthcare suppliers of oxygen, wheelchairs and hospital beds; reductions in levels of service provided, change in quality of equipment and assistive devices; dramatic reductions in access to home healthcare equipment and services among beneficiaries; and, changing of suppliers for thousands of people; among other impacts. The frail elderly and the disabled populations in these nine markets were the population which suffered the impacts of CMS's implementation of this bidding scheme.

On April 17, CMS issued a report titled, "Competitive Bidding Update—One Year Implementation Update" in which it reported on the results of the program and specifically made the following claims about impact on beneficiaries and beneficiary complaints:

> *"The results of CMS's real-time claims monitoring is supported by the low number of beneficiary complaints the agency has received. Since implementation, CMS has been carefully monitoring complaints coming into its regional offices, its toll-free number 1-800-Medicare, and to the Medicare Competitive Acquisition Ombudsman's office. CMS received 127,466 beneficiary inquiries regarding the competitive bidding program during 2011. This represented less than 1 percent of total call volume at the 1-800-Medicare call center. The vast majority of inquiries were about routine matters, such as questions about the program or finding a contract supplier. The number of overall beneficiary complaints, defined as inquiries that express dissatisfaction with the program and cannot be resolved by a call center operator, continues to be minimal. All complaints were assigned to program experts for prompt resolution. In the fourth quarter of calendar year 2011,CMS received six beneficiary complaints. This is a minute fraction of the 2.3 million Fee-for-Service beneficiaries residing in the nine competitively bid MSAs for 2011."*

Table 3: Beneficiary Complaints by Quarter, 2011	*Quarter 1*	*Quarter 2*	*Quarter 3*	*Quarter 4*	*Total*
Beneficiary Complaints	*43*	*73*	*29*	*6*	*151*

Concern over CMS's inability or unwillingness to engage beneficiary feedback
Patient advocate groups and medical equipment industry groups adamantly disagreed with CMS's finding and report. The CMS findings were not in any way consistent with the stories

and observations of these groups. Multiple beneficiary and industry groups have brought forward multitudes of complaints and concerns from beneficiaries. It is our belief that there have been and continue to be large numbers of beneficiaries negatively impacted by the CMS bidding scheme. We believe there are numerous problems with CMS's alleged monitoring of complaints. One of these problems is that it is exceedingly difficult for beneficiaries to access CMS offices to ask a question, to seek assistance, to wage a complaint or resolve a problem.

Independent Study

We engaged an independent accounting firm to perform a survey of accessibility and effectiveness of the CMS 1-800-Medicare question and complaint system. The survey results demonstrated a shocking lack of accessibility to CMS and explain, in part, why CMS alleges to have not received many complaints. Among the findings:

- On average, its takes a caller to CMS over 5 minutes before they reach a live person with whom to speak.
- This 5 minute timeframe contrasts with an average of less than 20 seconds it takes to reach a live person at any of 100 random DME providers, day and night.
- Further, in calls to DME providers, 90% of the callers reached a live person in less than one minute. In attempting to reach CMS, 0% of callers reached a live person in under one minute.
- In calls to DME providers, 100% of the callers reached a live person in less than two minute. In attempting to reach CMS, only 28% of callers reached a live person in under two minute.
- It is inconceivable that any organization, especially one serving an elderly population, would establish a user/customer/beneficiary support system where callers must wait more than 45 seconds to reach a live person. CMS's level of disregard for its beneficiary callers either constitutes gross incompetence or deliberate avoidance of beneficiary input and questions.
- The independent accounting firm also asked the CMS phone team whether or not the new competitive bidding rules would apply in their zip code and whether or not those rules would change anything about DME providers they could access or DME equipment they would use. In all 100 calls, the caller used a round 2 bid MSA as their home, but 96% of the time CMS told them that zip code was not in round 2 of competitive bidding. In all 100 calls, the caller indicated needing either oxygen, a wheelchair or a hospital bed. In 98% of the calls, CMS indicated that the DME product was not covered by competitive bidding now or in the future.