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GAO

Report to Congressional Requesters

May 2006

MEDICARE

Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved

GAO-06-654

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Highlights

Highlights of GAO-06-654, a report to congressional requesters

MEDICARE

Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved

Why GAO Did This Study

On January 1, 2006, Medicare began providing coverage for outpatient prescription drugs through its new Part D benefit. Beneficiaries who enroll in Part D may choose a drug plan from those offered by private plan sponsors under contract to the Centers for Medicare & Medicaid Services (CMS), which administers the Part D benefit. Beneficiaries have until May 15, 2006, to enroll in the Part D benefit and select a plan without the risk of penalties.

GAO was asked to review the quality of CMS's communications on the Part D benefit. GAO examined 70 CMS publications to select 6 documents for review and contracted with the American Institutes for Research to evaluate the clarity of these texts; made 500 calls to the 1-800-MEDICARE help line; and contracted with the Nielsen Norman Group to evaluate the usability of the Medicare Web site.

What GAO Recommends

GAO is recommending that the CMS Administrator enhance the quality of its communications by taking actions to improve written materials, its 1-800-MEDICARE help line, and the Medicare Web site. CMS said that GAO's findings did not present a complete and accurate picture of its activities. However, CMS said that it supports the goals of GAO's recommendations and is already taking steps to implement them.

www.gao.gov/cgi-bin/getrpt?GAO-06-654.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at aronovitzl@gao.gov or (312) 220-7600.

What GAO Found

The information given in the six sample documents that GAO reviewed describing the Part D benefit was largely complete and accurate, although this information lacked clarity. The documents were unclear in two ways. First, although about 40 percent of seniors read at or below the fifth-grade level, the reading levels of these documents ranged from seventh grade to postcollege. Second, on average, the six documents did not comply with about half of 60 common guidelines for good communication. For example, the documents used too much technical jargon and often did not define difficult terms, such as formulary. Moreover, 16 beneficiaries and advisers that GAO tested reported frustration with the documents' lack of clarity and had difficulty completing the tasks assigned to them. Although the documents lacked clarity, they informed readers of enrollment steps and factors affecting coverage decisions and were consistent with laws, regulations, and agency guidance.

Customer service representatives (CSR) responded to the 500 calls GAO placed to CMS's 1-800-MEDICARE help line accurately and completely about two-thirds of the time. Of the remainder, 18 percent of the calls received inaccurate responses, 8 percent of the responses were inappropriate given the question asked, and about 3 percent received incomplete responses. In addition, about 5 percent of GAO's calls were not answered, primarily because of disconnections. Accuracy and completeness rates of CSRs' responses varied significantly across the five questions GAO asked. For example, while CSRs provided accurate and complete responses to calls about beneficiaries' eligibility for extra help 90 percent of the time, the accuracy rate for calls concerning the drug plan that would cost the least for a specified beneficiary was 41 percent. For this question, the CSRs responded inappropriately for 35 percent of the calls by explaining that they could not identify the least costly plan without the beneficiary's personal information—even though CSRs had the information needed to answer the question. The time GAO callers waited to speak with CSRs also varied, ranging from no wait time to over 55 minutes. For 75 percent of the calls—374 of the 500—the wait was less than 5 minutes.

The Part D benefit portion of the Medicare Web site can be difficult to use. GAO's test of the site's overall usability—the ease of finding needed information and performing various tasks—resulted in scores of 47 percent for seniors and 53 percent for younger adults, out of a possible 100 percent. While there is no widely accepted benchmark for usability, these scores indicate that using the site can be difficult. For example, the prescription drug plan finder was complicated to use and some of its key functions, such as "continue" and "choose a drug plan," were often not visible on the page without scrolling down.

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Abbreviations

AIR	American Institutes for Research
CMS	Centers for Medicare & Medicaid Services
CSR	customer service representative
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
NN/g	Nielsen Norman Group
SHIP	State Health Insurance Assistance Program
SMOG	Simplified Measure of Gobbledygook

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United States Government Accountability Office
Washington, DC 20548

May 3, 2006

Congressional Requesters

In the most significant change to the Medicare program since its inception, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)[1] established an outpatient prescription drug benefit in Medicare, known as the Part D benefit. Coverage for this new benefit began on January 1, 2006. Until this time, Medicare, the federal program that finances health care benefits for about 42 million elderly and disabled beneficiaries, had not generally provided coverage for outpatient prescription drugs. Beneficiaries may choose a Part D plan[2] from multiple plans offered by private sponsors[3] under contract to the Centers for Medicare & Medicaid Services (CMS),[4] the agency that is responsible for administering the Medicare program, including the Part D benefit. These plans differ in the drugs they cover and the pharmacies they use. In addition, the costs to the enrollee for the monthly premium, the annual deductible, and co-payments for covered drugs vary by plan. As of April 20, 2006, more than 30 million of Medicare's 42 million beneficiaries were enrolled in a Part D plan or had other outpatient prescription drug coverage. Beneficiaries have until May 15, 2006, to select a plan without the risk of penalties in the form of higher premiums.

Given the newness and complexity of the Part D benefit, it is critical that beneficiaries and their advisers, including members of their families, understand the available options so that beneficiaries can make informed decisions on whether to enroll in Part D, and if so, which drug plan to choose. Beneficiaries need to compare drug plans in light of their anticipated prescription drug needs and existing arrangements for paying

[1]Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-2152 (to be codified at 42 U.S.C. §§ 1395w-101—1395w-152). MMA redesignated the previous part D of title XVIII of the Social Security Act as part E and inserted a new part D after part C.

[2]For Part D standard coverage, Medicare pays on average 75 percent of prescription drug costs up to $2,250, after a $250 deductible. Beneficiaries then pay their next $2,850 in drug costs. If their drug costs exceed this amount, Medicare will pay about 95 percent of their additional costs for the rest of the calendar year.

[3]Drug plan sponsors include insurance companies and other private organizations.

[4]CMS is an agency in the Department of Health and Human Services.

for these drugs. In addition to comparing costs and drug coverage, beneficiaries need to consider whether the plans they are comparing have contracted with a local or mail-order pharmacy that will provide a convenient means of filling their prescriptions.

As part of its responsibilities, CMS has undertaken outreach and education efforts to provide beneficiaries and their advisers with the information they need about Part D through various media, including written documents, the 1-800-MEDICARE help line,[5] and the Medicare Web site.[6] As of December 2005, CMS has produced more than 70 written documents to explain Part D to beneficiaries. *Medicare & You*—the beneficiary handbook—is the most widely available of these documents and was sent directly to beneficiaries in October 2005. Other CMS documents are targeted to specific groups of beneficiaries, such as dual-eligible beneficiaries[7] and beneficiaries with Medicare Advantage or Medigap policies.[8] Since March 1999, CMS has administered its nationwide 1-800-MEDICARE help line to answer beneficiaries' questions about the Medicare program. As of December 2005, about 7,500 customer service representatives (CSR) were handling calls on the help line, which operates 24 hours a day, 7 days a week, and is run by two CMS contractors. Calls are answered by an automated system and are routed to a CSR for specific questions, including those about Part D. CMS provides CSRs with detailed scripts to use in answering the questions. CSRs type in related keywords to generate a list of suggested scripts for a given question, select the script they consider best suited to the question, and read excerpts or the entire script. Call center contractors write the scripts, and CMS checks them for accuracy and completeness. CSRs can also consult other information sources, such as the Medicare Web site. CMS does not allow CSRs to offer individualized guidance to callers, including advice in choosing a drug

[5]In December 2004, we reported on the information being provided to beneficiaries through the Medicare help line on eligibility, enrollment, and benefits. (See GAO, *Medicare: Accuracy of Responses from the 1-800-MEDICARE Help Line Should Be Improved*, GAO-05-130 (Washington, D.C.: Dec. 8, 2004).)

[6]The Medicare Web site is *www.medicare.gov*.

[7]Dual-eligible beneficiaries are Medicare beneficiaries who are also eligible for Medicaid—the federal-state health program for low-income individuals—and receive full Medicaid benefits for services not covered by Medicare.

[8]Medicare Advantage replaced the Medicare+Choice managed care program and expanded the availability of private health plan options to Medicare beneficiaries. Medigap policies provide supplemental health coverage sold by private insurers to help pay for Medicare cost-sharing requirements, as well as for some services not provided by Medicare.

plan. CMS's Medicare Web site provides information about all aspects of the Medicare program. The Web site contains basic information about the Part D benefit; suggests factors for beneficiaries to consider when choosing a plan; describes situations common to beneficiaries with guidance on next steps to take in deciding whether to enroll and what plan to choose; lists frequently asked questions; and allows users to view, print, or order publications. In addition, the site contains information on cost, coverage, and convenience of individual plans. There is also a tool that allows beneficiaries to enroll directly in the plan they have chosen.

CMS has also arranged for State Health Insurance Assistance Programs (SHIP) to provide Part D information on request to Medicare beneficiaries and their advisers. Currently, CMS provides grants to the 54 SHIPs—one in each state, the District of Columbia, the Virgin Islands, Puerto Rico, and Guam. State SHIPs provide subgrants to over 1,300 local organizations to assist SHIPs in their efforts. In total, SHIPs rely on over 12,000 trained counselors, most of whom are volunteers, to provide free counseling and assistance via telephone and face-to-face sessions, public education presentations and programs, and media activities.

Widespread confusion among beneficiaries about the costs and coverage under the new benefit has been reported by the media and others. For example, according to an October 2005 survey by a research organization, some beneficiaries are unaware of the penalties for late enrollment and others did not realize that beneficiaries had to sign up for the benefit.[9] In light of your interest in ensuring that Medicare beneficiaries receive the information they need to make informed decisions, you asked us to examine the quality of the information being provided on the Part D benefit. In this report, we examined

- the extent to which CMS's written documents describe the Part D benefit in a clear, complete, and accurate manner;
- the effectiveness of CMS's 1-800-MEDICARE help line in providing accurate, complete, and prompt responses to callers inquiring about the Part D benefit;
- whether CMS's Medicare Web site presents information on the Part D benefit in a usable manner; and

[9]The Henry J. Kaiser Family Foundation, *The Medicare Drug Benefit: Beneficiaries Perspectives Just Before Implementation*, http://kff.org/kaiserpolls/med111005nr.cfm (downloaded Apr. 26, 2006).

- how CMS has used SHIPs to respond to the needs of Medicare beneficiaries for information on the Part D benefit.

We briefed your staff regarding the results of our review on April 19, 2006. Appendix I contains information we provided during our briefing to your staff.

To evaluate CMS's written documents describing the Part D benefit, we examined 70 relevant CMS publications and selected a sample of six documents for in-depth review. These documents represent a variety of document types, content, and target audiences and include Section 6 of the *Medicare & You* beneficiary handbook, which discusses Part D. To assess the clarity of the sample documents, we contracted with the American Institutes for Research (AIR), a firm with experience in evaluating written documents. AIR evaluated the texts by using three standard readability tests;[10] 60 commonly recognized good communications practices; and user testing with 11 Medicare beneficiaries and 5 advisers to beneficiaries, all of whom were asked to perform 18 specified tasks related to enrollment, coverage, costs, penalty, and informational resources and provide feedback about their experiences. To evaluate completeness, we reviewed the sample documents to determine if they included sufficient information for the beneficiaries to identify (1) their next steps in deciding whether to enroll and what plan to choose and (2) important factors, such as penalty provisions, that could affect their coverage decisions. To evaluate accuracy, we reviewed the sample documents for consistency with MMA, regulations, and CMS guidance.

To assess the accuracy, completeness, and promptness of the help line responses, we made 500 calls to 1-800-MEDICARE, posing one of five questions about Part D in each call so that each question was asked 100 times. To develop the questions, we considered topics listed on the Medicare Web site and topics addressed in scripts frequently accessed by CSRs. To develop our criteria for evaluating the accuracy and completeness of CSRs' responses, we used three resources: (1) the prescription drug finder tool on the Medicare Web site, (2) the 1-800-MEDICARE scripts, and (3) input from CMS officials. We also recorded

[10]The three tests were the Flesch-Kincaid Grade Level, the SMOG (Simplified Measure of Gobbledygook) Reading Grade Level, and the Fry Readability Estimate. These tests use such measures as sentence length and the number of syllables in a selection of text to arrive at a reading level, which is expressed in terms of school grade level.

the length of each call, including wait times, and the time it took to be connected to a CSR.

To assess whether the Medicare Web site presents information on the Part D benefit in a usable manner, we contracted with the Nielsen Norman Group (NN/g), a firm with expertise in Web design. NN/g conducted three evaluations: (1) it calculated an overall usability score for the site—considering factors such as site navigation, customer support, and presentation of online forms—to reflect the ease of finding necessary information and performing various tasks; (2) it determined the usability of 137 detailed aspects of the Web site, including aspects of Web design, online tools, and writing style; and (3) it tested the ability of seven participants (five beneficiaries and two advisers to beneficiaries) to complete a total of 34 user tests to determine the ease of performing a variety of Web-related tasks, such as browsing the site and determining how to join a plan. We also reviewed the results of CMS's analysis of its Web site's compliance with requirements that federal government Web sites be accessible to people with disabilities.

Finally, to examine how CMS has used SHIPs to meet the information needs of beneficiaries regarding Part D, we obtained information about SHIPs, their funding, changes made in response to the new benefit, and the impact of Part D on the demand for SHIP services. In addition, we interviewed CMS officials who monitor SHIP activities as well as SHIP coordinators in the five states with the largest populations of Medicare beneficiaries—California, Florida, New York, Pennsylvania, and Texas.

We performed our work from November 2005 through May 2006 in accordance with generally accepted government auditing standards. For more information on our methodology, see appendix II.

Results in Brief

The sample of CMS's written documents we reviewed describing the Part D benefit to Medicare beneficiaries and their advisers were largely complete and accurate, but the information these documents presented lacked clarity. The documents were unclear in two ways. First, about 40 percent of seniors read at or below the fifth-grade level, but the reading levels of the documents ranged from seventh grade to postcollege. As a result, documents at these levels are not completely clear and understandable for many seniors. Second, on average, the six documents did not comply with about half of the 60 commonly recognized guidelines for good communications. For example, although the documents included concise and descriptive headings, they used too much technical jargon and

often did not define difficult terms, such as formulary.[11] The 11 beneficiaries and 5 advisers we tested reported frustration with the documents' lack of clarity as they encountered difficulties in understanding and attempting to complete 18 specified tasks. For example, none of these beneficiaries and only 2 of the advisers were able to complete the task of computing their projected total out-of-pocket costs for a plan that provided Part D's standard coverage. Only 1 of the 18 tasks was completed by all beneficiaries and advisers. Even those who were able to complete a given task expressed confusion and frustration as they worked to comprehend the relevant text. Although the sample documents lacked clarity, the information presented in them was generally complete. The documents informed readers of next steps in determining whether to enroll and what plan to choose, and of important factors that could affect their coverage decisions. The information in the sample documents was also generally accurate when evaluated for consistency with MMA, implementing regulations, and agency guidance.

Responses to the 500 calls we placed to CMS's 1-800-MEDICARE help line regarding the Part D benefit were frequently accurate and complete. However, we nonetheless received a substantial number of responses that were inaccurate, incomplete, or inappropriate and that sometimes involved an extensive wait before we could speak to a CSR. CSRs answered 67 percent of the calls accurately and completely. Of the remainder, 18 percent of the calls received inaccurate responses, 8 percent of the responses were inappropriate given the question asked, and about 3 percent received incomplete responses. In addition, about 5 percent of our calls were not answered, primarily because of disconnections.[12] Accuracy and completeness rates of CSRs' responses varied significantly for the five questions we asked. For example, for the question on whether a beneficiary qualifies for extra help, CSRs provided an accurate and complete response 90 percent of the time. However, for a question concerning which drug plan would cost the least for a beneficiary with certain specified prescription drug needs, the accuracy rate was 41 percent. CSRs inappropriately responded 35 percent of the time that this question could not be answered without personal identifying information—such as the beneficiary's Medicare number or date of birth—even though the CSRs could have answered our question using CMS's

[11]A formulary is a list of prescription drugs covered by a health plan.

[12]The percentages related to the responses we received to our 500 calls exceed 100 percent because of rounding.

Web-based prescription drug plan finder tool. The amount of time we waited to speak with a CSR also varied, ranging from no wait time to over 55 minutes. For 75 percent of the calls—374 of the 500—we waited less than 5 minutes. For the remainder of the calls, 62 were answered in less than 15 minutes, 39 calls were answered in from 15 minutes to less than 25 minutes, and 25 led to a wait of 25 minutes or more.

We found that the Part D benefit portion of the Medicare Web site can be difficult to use. In our evaluation of overall usability—the ease of finding needed information and performing various tasks—we found usability scores of 47 percent for seniors and 53 percent for younger adults, out of a possible 100 percent. While there is no widely accepted benchmark for usability, these scores indicate that using the site can be difficult. For example, tools such as the drug plan finder were complicated to use, and forms that collect information online from users were difficult to correct if the user made an error. In our evaluation of the usability of 137 detailed aspects of the Part D portion of the site, including features of Web design and online tools, we found that 70 percent of these aspects could be expected to cause users confusion. For example, key functions of the prescription drug plan finder tool, such as the "continue" and "choose a drug plan" buttons, were often not visible on the page without scrolling down. In our evaluation of the ability of seven participants to collectively complete 34 user tests, we found that on average, participants were able to proceed slightly more than halfway through each test. In addition, CMS evaluated whether its Web site complied with pertinent federal requirements regarding accessibility for people with disabilities in March 2006. Although CMS has established features to make information on its Web site accessible to disabled users, it found that two requirements were not met, making it difficult for the visually impaired to use. A CMS official told us that the agency made the appropriate corrections on April 20, 2006. Because of time constraints, we did not verify that these corrections were made.

CMS relies on SHIPs to play a significant role in providing counseling and education on the Part D benefit to Medicare beneficiaries. CMS increased SHIP funding from $12 million for the 2003 SHIP grant year[13] to $31.7 million for the 2005 grant year. CMS kept funding relatively high for the 2006 grant year—$30 million—to ensure that SHIPs continued to play an important role in educating beneficiaries about Part D. The number of

[13]A SHIP grant year begins on April 1 of the year the funds become available.

beneficiaries served by SHIPs has also increased. During the 2004 SHIP grant year, SHIPs served approximately 2.52 million people. During the first 9 months of the 2005 SHIP grant year—when CMS was gearing up its outreach and education on Part D—SHIPs served approximately 3.3 million individuals, an increase of nearly 770,000 from the prior full grant year. CMS attributes the increase in demand for SHIP services—as reflected in increases in the number of calls, face-to-face assistance, and referrals from the 1-800-MEDICARE help line—to beneficiaries' need for assistance on Part D. The average number of calls per month referred from the help line to SHIPs, for example, increased from about 16,000 referrals for May through September 2005 to an average of about 43,000 for October and November 2005, about the time Part D enrollment began. According to CMS officials, this increased demand can be attributed to callers seeking advice on choosing a drug plan. Unlike CSRs on the help line, SHIP counselors can offer individualized guidance to callers on enrollment and plan selection. SHIP coordinators in the five states we contacted confirmed that there was a substantial increase in the demand for their services because of the new Part D benefit. For example, the California SHIP served over 120,000 people in January 2006, compared to about 35,000 served in all of 2005.

Conclusions

Within the past 6 months, millions of Medicare beneficiaries have been making important decisions about their prescription drug coverage and have needed access to information about the new Part D benefit to make appropriate choices. CMS faced a tremendous challenge in responding to this need and, within short time frames, developed a range of outreach and educational materials to inform beneficiaries and their advisers about Part D. To disseminate these materials, CMS largely added information to existing resources, including written documents, such as *Medicare & You*; the 1-800-MEDICARE help line; the Medicare Web site; and support for SHIPs. However, CMS has not ensured that its communications to beneficiaries and their advisers are provided in a manner that is consistently clear, complete, accurate, and usable. Six months have passed since these materials were first made available to beneficiaries, and their limitations could result in confusion among those seeking to make coverage decisions. Although the initial enrollment period for Part D will end on May 15, 2006, CMS will continue to play a pivotal role in providing beneficiaries with information about the drug benefit during the year and in subsequent enrollment periods. CMS has an opportunity to enhance its communications on the Part D benefit. This would allow beneficiaries and their advisers to be better prepared when deciding whether to enroll in the benefit, and if enrolling, which drug plan to choose.

Recommendations for Executive Action

In order to improve the Part D benefit education and outreach materials that CMS provides to Medicare beneficiaries, we are recommending that the CMS Administrator take the following four actions:

- Ensure that CMS's written documents describe the Part D benefit in a manner that is consistent with commonly recognized communications guidelines and that is responsive to the intended audience's needs.
- Determine why CSRs frequently do not search for available drug plans if the caller does not provide personal identifying information.
- Monitor the accuracy and completeness of CSRs' responses to callers' inquiries and identify tools targeted to improve their performance in responding to questions concerning the Part D benefit, such as additional scripts and training.
- Improve the usability of the Part D portion of the Medicare Web site by refining Web-based tools, providing workable site navigation features and links, and making Web-based forms easier to use and correct.

Agency Comments and Our Evaluation

We received written comments on a draft of this report from CMS (see app. III). CMS said that it did not believe our findings presented a complete and accurate picture of its Part D communications activities. CMS discussed several concerns regarding our findings on its written documents and the 1-800-MEDICARE help line. However, CMS Did Not Disagree With Our Findings Regarding The Medicare Web Site Or The Role Of Ships. CMS Also Said That It Supports The Goals Of Our Recommendations And Is Already Taking Steps To Implement Them, Such As Continually Enhancing And Refining Its Web-Based Tools.

CMS discussed concerns regarding the completeness and accuracy of our findings in terms of activities we did not examine, as well as those we did. CMS stated that our findings were not complete because our report did not examine all of the agency's efforts to educate Medicare beneficiaries and specifically mentioned that we did not examine the broad array of communication tools it has made available, including the development of its network of grassroots partners throughout the country. We recognize that CMS has taken advantage of many vehicles to communicate with beneficiaries and their advisers. However, we focused our work on the four specific mechanisms that we believed would have the greatest impact on beneficiaries—written materials, the 1-800-MEDICARE help line, the Medicare Web site, and the SHIPs. In addition, CMS stated that our report is based on information from January and February 2006, and that it has undertaken a number of activities since then to address the problems we identified. Although we appreciate CMS's efforts to improve its Part D

communications to beneficiaries on an ongoing basis, we believe it is unlikely that the problems we identified in this report could have been corrected yet given their nature and scope.

CMS raised two concerns with our examination of a sample of written materials. First, it criticized our use of readability tests to assess the clarity of the six sample documents we reviewed. For example, CMS said that common multisyllabic words would inappropriately inflate the reading level. However, we found that reading levels remained high after adjusting for 26 multisyllabic words a Medicare beneficiary would encounter, such as Social Security Administration. CMS also pointed out that some experts find such assessments to be misleading. Because we recognize that there is some controversy surrounding the use of reading levels, we included two additional assessments to supplement this readability analysis—the assessment of design and organization of the sample documents based on 60 commonly recognized communications guidelines and an examination of the usability of six sample documents, involving 11 beneficiaries and 5 advisers.

Second, CMS expressed concern about our examination of the usability of the six sample documents. The participating beneficiaries and advisers were called on to perform 18 specified tasks, after reading the selected materials, including a section of the *Medicare & You* handbook. CMS suggested that the task asking beneficiaries and advisers to calculate their out-of-pocket drug costs was inappropriate because there are many other tools that can be used to more effectively compare costs. We do not disagree with CMS that there are a number of ways beneficiaries may complete this calculation; however, we nonetheless believe that it is important that beneficiaries be able to complete this task on the basis of reading *Medicare & You*, which, as CMS points out, is widely disseminated to beneficiaries, reaching all beneficiary households each year. In addition, CMS noted that it was not able to examine our detailed methodology regarding the clarity of written materials—including assessments performed by one of our contractors concerning readability and document design and organization. We plan to share this information with CMS, once our report has become public.

Finally, CMS took issue with one aspect of our evaluation of the 1-800-MEDICARE help line. Specifically, CMS said the 41 percent accuracy rate associated with one of the five questions we asked was misleading, because, according to CMS, we failed to analyze 35 of the 100 responses. However, we disagree. This question addressed which drug plan would cost the least for a beneficiary with certain specified prescription drug

needs. We analyzed these 35 responses to this question and found the responses to be inappropriate. The CSRs would not provide us with the information we were seeking because we did not supply personal identifying information, such as the beneficiary's Medicare number or date of birth. We considered such responses inappropriate because the CSRs could have answered this question without personal identifying information by using CMS's Web-based prescription drug plan finder tool. Although CMS said that it has emphasized to CSRs, through training and broadcast messages, that it is permissible to provide the information we requested without requiring information that would personally identify a beneficiary, in these 35 instances, the CSR simply told us that our question could not be answered. CMS also said that the bulk of these inappropriate responses were related to our request that the CSR use only brand-name drugs. This is incorrect—none of these 35 responses were considered incorrect or inappropriate because of a request that the CSR use only brand-name drugs—as that was not part of our question.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days after its date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. We will also make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (312) 220-7600 or aronovitzl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.

Leslie G. Aronovitz
Director, Health Care

List of Requesters

The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
House of Representatives

The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Appendix I: Briefing on Medicare Part D

Medicare Part D: CMS Communications to Beneficiaries Could Be Improved

Briefing for Congressional Staff
Updated

1

Contents

- Purpose and Objectives
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- Objective 2: 1-800-MEDICARE Help Line
- Objective 3: Medicare Web Site
- Objective 4: State Health Insurance Assistance Programs

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Purpose and Objectives

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established the new Part D outpatient prescription drug benefit.
- The Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing this new benefit. CMS has taken steps to inform beneficiaries and their advisers about Part D using written documents, a toll-free help line, and an Internet Web site. CMS also gives State Health Insurance Assistance Programs (SHIP) funds to provide information about the Medicare program, including Part D.

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Purpose and Objectives (continued)

- We assessed information that CMS provides to Medicare beneficiaries to educate them about Part D. Specifically, we assessed:
  1. The extent to which CMS's written documents describe the Part D benefit in a clear, complete, and accurate manner.
  2. The effectiveness of CMS's 1-800-MEDICARE help line in providing accurate, complete, and prompt responses to callers inquiring about the Part D benefit.
  3. Whether the Medicare Web site presents information on the Part D benefit in a usable manner.
  4. How CMS has used SHIPs to respond to the needs of Medicare beneficiaries for information on the Part D benefit.

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Objective 1: Written Documents Methodology

- We performed in-depth review of a sample of six CMS documents describing the Part D benefit. The sample was selected to represent a variety of document types, content, and target audiences.
- We contracted with the American Institutes for Research (AIR) to assess the clarity of sample documents.

[a]Dual-eligible beneficiaries are Medicare beneficiaries who receive full Medicaid benefits for services not covered by Medicare.

[b]Medicare Advantage replaces the Medicare+Choice managed care program and expands the availability of private health plan options to Medicare beneficiaries.

[c]Medigap policies provide supplemental health coverage sold by private insurers to help pay for Medicare cost-sharing requirements, as well as for some services not provided by Medicare.

Six sample documents	Target audience
Medicare & You (Section 6: Medicare Prescription Drug Coverage)	All beneficiaries
Things to Think about When You Compare Plans	All beneficiaries
Frequently Asked Questions about: Retiree Prescription Drug Coverage & the New Medicare Prescription Drug Coverage	Beneficiaries with employer or union coverage
The Auto-Enrollment Notice	Dual-eligible beneficiaries[a]
Quick Facts about Medicare's New Coverage for Prescription Drugs for People with a Medicare Health Plan with Prescription Drug Coverage	Beneficiaries with Medicare Advantage[b]
Do You Have a Medigap Policy[c] with Prescription Drug Coverage?	Beneficiaries with Medigap

Source: GAO.

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Objective 1: Written Documents Methodology (continued)

- To determine the clarity of the sample of Part D written documents describing the Part D benefit, AIR
  - evaluated text by sentence length and the number of syllables using three standard readability tests—Flesch-Kincaid, SMOG, and Fry;
  - assessed the design and organization of the documents based on 60 commonly recognized written communications guidelines, including those to aid senior readers; and

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Objective 1: Written Documents Methodology (continued)

- tested the usability of sample documents with 16 participants—11 Medicare beneficiaries, including 1 disabled beneficiary who was under 65, and 5 advisers to beneficiaries.
  - Everyone was asked to perform 18 specified tasks related to enrollment, coverage, costs, penalty, and informational resources. They were also asked to provide feedback about their experiences.
  - Although the size of the group was small, research shows that as few as 5 individuals can provide meaningful insights into common problems.

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Objective 1: Written Documents Methodology (continued)

- To evaluate completeness, we reviewed the sample documents to determine if they included sufficient information to identify (1) next steps in determining whether to enroll and what plan to choose and (2) important factors, such as penalty provisions, that could affect coverage decisions.
- To evaluate accuracy, we reviewed the sample documents for consistency with laws, regulations, and CMS guidance.

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Objective 1: Written Documents—Documents Lack Clarity

- Readability assessment: Sample documents explaining the Part D benefit are written at a reading level that is difficult for many seniors.
  - Reading levels for the sample documents were challenging for at least the 40 percent of seniors, who read at or below the 5th grade level.
    - Reading level estimates for the sample texts[1] ranged from 7th grade to postcollege level.
  - Reading levels remain challenging for at least 40 percent of seniors even after adjusting for 26 multisyllabic words, such as Medicare, Medicare Advantage, and Social Security Administration. After the adjustment, the estimated reading level ranged from 8th to 12th grade.

[1]Estimates have a likely margin of error of ± two grades.

9

Objective 1: Written Documents—Clarity (continued)

- Document design and organization assessment: The sample documents demonstrated adherence to about half of the 60 commonly recognized written communications guidelines, on average.
  - **Desirable features:** The documents
    - were written with a respectful and polite tone,
    - were free of clichés and slang,
    - contained useful contact information,
    - included concise and descriptive headings, and
    - generally followed graphic and formatting guidelines.

10

Objective 1: Written Documents—Clarity (continued)

- **Undesirable features**: The documents
  - used too much technical jargon,
  - often did not define difficult terms,
  - included sentences and some paragraphs that were too long, and
  - did not use sufficient summaries to assist the reader in identifying key points.

11

Objective 1: Written Documents—Clarity (continued)

- Usability assessment: Beneficiaries and advisers to beneficiaries were frustrated by the documents' lack of clarity and often could not complete the 18 assigned tasks.
  - One of the 18 assigned tasks was completed by all beneficiaries and advisers.
  - Eleven of the 18 assigned tasks were completed by at least half of the beneficiaries and advisers.
  - Four of the 18 assigned tasks were completed by 2 or fewer of the 11 beneficiaries.
  - Nine of the 18 assigned tasks, were completed by 2 or fewer of the 5 advisers.

12

Objective 1: Written Documents—Clarity (continued)

- Some of the tasks that proved difficult included
  - computing projected total out-of-pocket costs for a plan that provided Part D's standard coverage (successfully completed by none of the 11 beneficiaries and 2 of the 5 advisers),
  - evaluating whether it was possible to enroll in Medicare Part D and keep drug coverage from a retiree health plan (successfully completed by 2 beneficiaries and 2 advisers), and
  - determining the course of action for dual-eligibles who are automatically enrolled in a plan that does not cover all drugs used (successfully completed by 4 beneficiaries and 1 adviser).

13

Objective 1: Written Documents—Clarity (continued)

- Participants described documents as too wordy, confusing, and hard to follow.
- Participants struggled with technical terms, such as “classes of commonly prescribed drugs” and “formulary,” which is a list of drugs covered by a plan.
- Even when most participants were able to complete the tasks, they expressed confusion and frustration.

14

Objective 1: Written Documents—Documents Are Generally Complete

- Our analysis showed that the sample documents were generally complete and informed readers of next steps in determining whether to enroll and what plan to choose as well as important factors that could affect their coverage decisions. For example:
  - All documents reviewed provided sources of assistance and relevant contact information, which could aid in identifying next steps for coverage decisions.
  - All documents reviewed provided the dates of the start of initial program enrollment and coverage.

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Objective 1: Written Documents—Completeness (continued)

- However, our analysis also identified a few exceptions where the documents did not mention some important issues. For example:
  - *Medicare & You* noted that drug plan information may change, but made no mention of possible changes on the pages beneficiaries would use to compare coverage and select a plan. Such information is needed because drug plans can change their covered drugs and prices.
  - The documents did not provide sufficient information about the cumulative effect of the penalty for missing the initial enrollment deadline.

16

Objective 1: Written Documents—Documents Are Generally Accurate

- Our analysis showed that the sample documents were generally accurate and that the text was consistent with MMA, implementing regulations, and agency guidance.
- However, we noted a few misleading statements in *Medicare & You.* For example:
  - The document implied that if a beneficiary's doctor applied for an exception it would be granted, whereas exceptions to the formulary are granted at each plan sponsor's discretion.
  - The document outlined the minimum requirements for standard coverage by Part D plans. However, it did not indicate that few plans offer this exact coverage and that beneficiaries should be prepared to compare plans with varying premiums, co-payments, and covered drugs to choose plans that best suit them.

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Objective 2: 1-800-MEDICARE Help Line Methodology

- We placed 500 calls to 1-800-MEDICARE, posing one of five questions in each call, so that each question was asked 100 times. To develop the questions, we considered topics listed on the Medicare Web site and obtained help line reports that listed the scripts that customer service representatives (CSR) frequently accessed to respond to callers' questions.
- Calls were randomly placed at different times of the day and on different days of the week from January 17 to February 7, 2006, to match the daily and hourly pattern of calls reported by 1-800-MEDICARE in October 2005.

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Objective 2: 1-800-MEDICARE Help Line Methodology (continued)

- To evaluate the accuracy and completeness of CSRs' responses to our five questions, we used three resources:
  - the prescription drug finder tool on the Medicare Web site,
  - the 1-800-MEDICARE scripts prepared by CMS and contractors for CSRs to use in responding to callers' questions, and
  - input from CMS officials on the criteria we used to evaluate responses.
- To evaluate the promptness of the help line in answering calls, we recorded the length of time it took to connect to a CSR for each call.

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Objective 2: 1-800-MEDICARE Help Line Methodology (continued)

- CSRs' responses were scored in one of five categories based on specific criteria we developed:
  - Accurate and Complete – responses met our defined criteria
  - Inappropriate – responses reflected the need for personal beneficiary information, which was not actually required to answer the question
  - Inaccurate – responses did not meet our defined criteria
  - Incomplete – responses partially met our defined criteria
  - Unanswered – calls did not receive responses from CSRs

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Objective 2: 1-800-MEDICARE Help Line Methodology (continued)

Question	Criteria
1. What drug plan can a beneficiary get that will cover all of his/her [specified] drugs at a [specified] pharmacy; have a mail-order option; and cost the least amount annually with [or without] a deductible?	An accurate and complete response would identify the prescription drug plan that has the lowest estimated annual cost for the drugs the beneficiary uses.
2. Can a beneficiary who is in a nursing home and not on Medicaid sign up for a prescription drug plan?	An accurate and complete response would indicate that such a beneficiary can choose whether to enroll in a Medicare prescription drug plan.

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Objective 2: 1-800-MEDICARE Help Line Methodology (continued)

Question	Criteria
3. Can a beneficiary enroll in the Medicare prescription drug program and keep his/her current Medigap policy?	An accurate and complete response would inform the caller that enrolling for the prescription drug benefit would depend on whether the beneficiary's Medigap plan was creditable—that is, whether the coverage it provided was at least as good as Medicare's standard prescription drug coverage—or noncreditable. The CSR response would also mention that the beneficiary's Medigap plan should have sent him/her information that outlines options.

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Objective 2: 1-800-MEDICARE Help Line Methodology (continued)

Question	Criteria
4. What options does a beneficiary, who has retiree health insurance with prescription drug coverage that is not as good as the Medicare prescription drug coverage, have as it relates to the Medicare benefit?	An accurate and complete response would indicate that a beneficiary has two options: (1) keep current health plan and join the prescription drug plan later with a penalty; or (2) drop current coverage and join a Medicare drug plan.
5. How do I know if a beneficiary qualifies for extra help?	An accurate and complete response would refer the beneficiary to the Social Security Administration.

Source: GAO.

23

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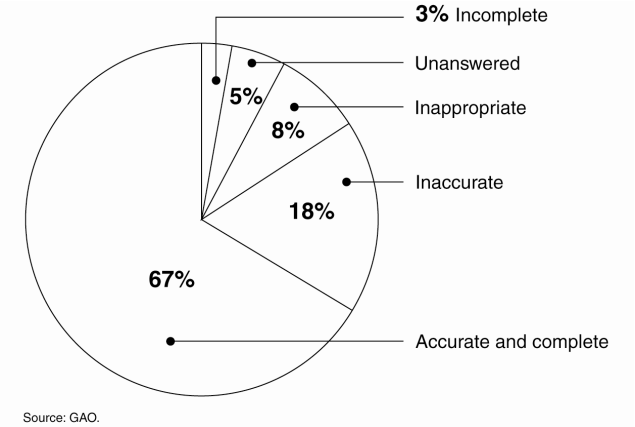
Objective 2: 1-800-MEDICARE Responses Often Accurate and Complete, but Some Not

- We found that the 1-800-MEDICARE help line provided accurate and complete answers to 334 of our 500 calls, a rate of about 67 percent. In addition, it provided accurate—but incomplete—answers for about 3 percent of our calls.

Distribution of Unanswered Calls and Accurate and Complete, Inaccurate, Incomplete, and Inappropriate Responses[a]



[a]Percentages exceed 100 because of rounding.

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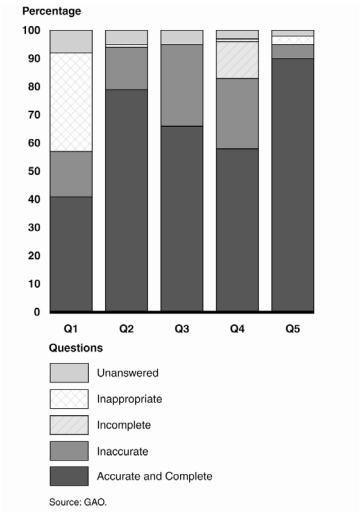
Objective 2: 1-800-MEDICARE—Variation in Results for Individual Questions

- The accuracy and completeness of responses to our five questions varied significantly, from 41 percent to 90 percent.
  - Q1 – 41 percent
  - Q2 – 79 percent
  - Q3 – 66 percent
  - Q4 – 58 percent
  - Q5 – 90 percent
  - Average for all questions—67 percent

Distribution of Unanswered Calls and Accurate and Complete, Inaccurate, Incomplete, and Inappropriate Responses by Question



25

Objective 2: 1-800-MEDICARE—Variation (continued)

- CSRs answered some questions better than others. For example:
  - CSRs accurately and completely answered question 5 (whether a beneficiary qualifies for extra help), which had a specific script, 90 percent of the time.
  - CSRs accurately and completely answered question 2 (whether a beneficiary in a nursing home, who was not on Medicaid, could sign up for the drug benefit) 79 percent of the time—even though there was no specific script for the question.

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Objective 2: 1-800-MEDICARE—Variation (continued)

- CSRs' responses for question 3 (whether a beneficiary with a Medigap policy could enroll in the drug benefit) were accurate and complete 66 percent of the time. Many of the responses were inaccurate because they did not provide adequate information about creditable and noncreditable coverage.
- The accuracy and completeness rate for question 4 (about retiree health insurance) was 58 percent. Many of the responses were inaccurate because the CSRs did not follow the available script or provide sufficient information about the implications of the beneficiary's decision.

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Objective 2: 1-800-MEDICARE—Variation (continued)

- CSRs' responses to question 1 (which requires CSRs to use the prescription drug plan finder Web tool) were accurate and complete less than 50 percent of the time. The rate is largely caused by CSRs' inappropriate responses—35 out of 100 times—that they were unable to answer the question without personal identifying information, such as the beneficiary's Medicare number or date of birth.

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Objective 2: 1-800-MEDICARE—Variation (continued)

- We did not obtain answers for 23 of the calls we placed because of unintentional disconnections, intentional disconnections, or an inoperative Web tool.
  - Unintentional disconnections occurred when the system inadvertently disconnected the call (19 calls).
  - Intentional disconnections were programmed by the telephone company when wait times were projected to exceed 20 minutes (3 calls).
  - The prescription drug plan finder Web tool used by CSRs was not operative at the time of our call (1 call).

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Objective 2: 1-800-MEDICARE—Variation in Wait Times

- The amount of time we had to wait to speak with a CSR varied significantly, ranging from no wait to more than 55 minutes.
  - About 75 percent of calls were connected in less than 5 minutes.
  - For calls where we waited more than 5 minutes to speak to a CSR, the wait time ranged from 5 minutes to over 55 minutes.
    - Sixty-two calls were on hold from 5 to 14 minutes, 59 seconds.
    - Thirty-nine calls were on hold from 15 to 24 minutes, 59 seconds.
    - Twenty-five calls were on hold 25 minutes or more.
  - For both intentional and unintentional disconnections, we often waited more than 5 minutes before the disconnection occurred. In one case, we were placed on hold for 54 minutes before being disconnected.

30

Objective 3: Medicare Web Site Methodology

- To evaluate the usability of the Part D benefit portion of the Medicare Web site, we contracted with Nielsen Norman Group (NN/g), a firm with expertise in Web design.

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Objective 3: Medicare Web Site Methodology (continued)

- In addition, we reviewed CMS's efforts to comply with section 508 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794d).
  - Section 508 requires that all federal Web sites be designed to make information and services fully available to individuals with disabilities.
  - Our review included an examination of CMS's March 2006 report assessing the compliance of its Medicare Web site with this federal requirement and discussions with CMS officials.

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Objective 3: Medicare Web Site Methodology (continued)

- NN/g performed the following three separate evaluations:
  - Evaluation one: NN/g calculated an overall score of the site's usability, to reflect the ease of finding necessary information and performing various tasks. For this calculation, NN/g considered various factors, such as site navigation, customer support, and presentation of online forms.

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Objective 3: Medicare Web Site Methodology (continued)

- Evaluation two: NN/g evaluated in detail the usability of 137 detailed aspects of the Part D benefit portion of the Web site. Topics included
  - Web design (e.g., home page, navigation, search function, graphics, and organization);
  - tools (e.g., plan finder);
  - writing style (e.g., tone, content, legibility, and readability);
  - accessibility (e.g., availability of site version for the blind); and
  - languages (e.g., links for users who have difficulty reading English).

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Objective 3: Medicare Web Site Methodology (continued)

- Evaluation three: NN/g conducted a total of 34 user tests to determine the ease of performing a variety of Web-related tasks, such as browsing the site, making a change in address, finding plan information under certain scenarios, comparing Medigap and Part D drug coverage, and determining how to join a plan.
  - NN/g asked five Medicare beneficiaries—who were not disabled—and two advisers to beneficiaries to perform one or more user tests each using the Web site.
  - At the end of the user tests, the seven participants were asked to provide feedback about their experiences.

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Objective 3: Medicare Web Site Difficult to Use

- Based on NN/g evaluations, we concluded that the Part D benefit portion of the Medicare Web site can be challenging to use.
  - For evaluation one, the calculated usability scores indicate a need for improvement. The usability score was 47 percent for seniors and 53 percent for younger adults. While there is no widely accepted benchmark for usability, these scores indicate that using the site can be difficult. For example, tools such as the drug plan finder were complicated to use, and forms that collect information online from users were difficult to correct if the user made an error.

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Objective 3: Medicare Web Site Difficult to Use (continued)

- Evaluation two showed that the Part D benefit portion of the Web site was difficult to use. About 70 percent of the 137 detailed aspects of the site were presented in a manner that could be expected to cause a medium or high level of confusion. For example,
  - important functions in the plan finder tool—the “continue” and “choose a drug plan” buttons—are often not visible on the page;
  - plan finder tool defaults to generic drugs, complicating users’ search for drug plans covering brand-name drugs;

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Objective 3: Medicare Web Site Difficult to Use (continued)

- information to assist navigation was often not helpful—for example, text labels associated with links were not always functioning; and
- the writing style presented some challenges—for example, material was written at the 11th grade level.

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Objective 3: Medicare Web Site Difficult to Use (continued)

- For evaluation three, the 34 user tests showed that the site was a challenge for the seven participants to use. For example:
  - For 12 of the 34 tests, participants' initial reactions were that they would not be able to complete the tests and wanted to quit trying.
  - On average, participants were able to proceed slightly more than halfway through each of the 34 tests.
  - When asked for feedback on their experience with using the site, the seven participants, on average, indicated high frustration levels and low satisfaction.

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Objective 3: Medicare Web Site Difficult to Use (continued)

- To comply with section 508 of the Rehabilitation Act, CMS has established features to make information on its Medicare Web site accessible to disabled users. For example, CMS provides a “screen reader” version of the site for the visually impaired. This technology translates text and data into spoken words.

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Objective 3: Medicare Web Site Difficult to Use (continued)

- CMS's March 2006 review of its site's compliance with section 508 showed that two requirements were not met:
  - The plan finder did not provide alternative text for all images—that is, there was no text for the screen reader to read. Therefore, images could not be translated into spoken words for the visually impaired.
  - The plan finder did not allow screen readers to recognize form fields and translate forms into spoken words. As a result, visually impaired users would not have been able to complete Web-based forms.
- A CMS official told us that the agency made the necessary corrections on April 20, 2006, but we did not verify that these corrections were made.

41

Objective 4: SHIP Methodology

- We interviewed CMS officials and reviewed documentation they provided about SHIPs' role in educating beneficiaries about the Part D benefit.
- We contacted the SHIP coordinators in California, Florida, New York, Texas, and Pennsylvania—the five states with the most Medicare beneficiaries. Together, these states accounted for about 35 percent of the country's total Medicare population in 2004.

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Objective 4: SHIPs' Responses to Beneficiaries' Needs Concerning Part D

- According to CMS, it relies on SHIPs to play a significant role in beneficiary counseling and education on the Part D benefit.
- In anticipation of the increased demand for SHIP services regarding the Part D benefit, CMS increased SHIP funding in recent years. Funding for the 2003 SHIP grant year[2] was $12 million, and it reached $31.7 million for the 2005 grant year. CMS kept funding relatively high for the 2006 grant year—$30 million—to ensure that SHIPs continue to play an important role in educating beneficiaries about the Part D benefit.

[2]A SHIP grant year begins on April 1 of the year the funds become available.

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Objective 4: SHIPs' Responses to Part D (continued)

- During the 2004 SHIP grant year, SHIPs served approximately 2.52 million people. According to preliminary data for the first 9 months of the 2005 SHIP grant year—when CMS was gearing up its outreach and education on Part D—SHIPs served approximately 3.3 million individuals, an increase of nearly 770,000 from the prior full grant year. CMS attributes this increase in demand for services to beneficiaries' need for assistance on the Part D benefit.

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Objective 4: SHIPs' Responses to Part D (continued)

- The average number of calls referred from the 1-800-MEDICARE help line to SHIPs has increased significantly.
  - The monthly average of number of calls referred to SHIPs increased from 16,000 referrals for May through September 2005 to approximately 43,000 for October and November 2005, the months around the time when enrollment in the Part D benefit began.
  - According to CMS officials, this increased demand was influenced by callers seeking advice on choosing a drug plan. Unlike CSRs on the help line, SHIP counselors can offer individualized guidance to callers.

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Objective 4: SHIPs' Responses to Part D (continued)

- Specifically, the five SHIPs we contacted experienced a large increase in demand for their services because of the Part D benefit.
  - California served over 120,000 people in January 2006, compared to about 35,000 served in all of 2005.
  - Florida, mostly during November and December of 2005, held at least six "phone bank" events—where SHIP counselors were available to take calls on the Part D benefit during live newscasts. Florida plans to hold two additional phone banks as the May 15 enrollment deadline approaches.

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Objective 4: SHIPs' Responses to Part D (continued)

- New York reported nearly doubling its formal training sessions for SHIP counselors in 2005, to prepare them for the demand for services related to the Part D benefit.
- Texas counseled 45,719 clients and conducted 523 outreach events from November 15, 2005—the official start of the enrollment period—to March 22, 2006.
- Pennsylvania held over 3,000 enrollment events, which were attended by more than 130,000 people, from May 2005 to February 28, 2006.

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Objective 4: SHIPs' Responses to Part D (continued)

- The SHIP officials in four of the five states we contacted indicated that the demand for their services related to the Part D benefit has declined since the benefit began in January 2006. However, each SHIP contacted expects a surge in demand as the May 15 enrollment deadline approaches.
- Since December 2005, CMS has been conducting biweekly meetings with its regional offices, which interact directly with SHIP offices, to gauge SHIPs' ability to meet the demands of beneficiaries.

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Appendix II: Objectives, Scope, and Methodology

In this report, we assessed (1) the extent to which the Centers for Medicare & Medicaid Services' (CMS) written documents describe the Medicare Part D prescription drug benefit in a clear, complete, and accurate manner; (2) the effectiveness of CMS's 1-800-MEDICARE help line in providing accurate, complete, and prompt responses to callers inquiring about the Part D benefit; (3) whether CMS's Medicare Web site presents information on the Part D benefit in a usable manner; and (4) how CMS has used State Health Insurance Assistance Programs (SHIP) to respond to the needs of Medicare beneficiaries for information on the Part D benefit. To obtain information on CMS's efforts to educate beneficiaries about Part D, we interviewed agency officials responsible for Part D written documents, the 1-800-MEDICARE help line, the Medicare Web site, and SHIPs. Following our briefing of congressional staff on April 19, 2006, the briefing slides were updated to reflect CMS's reported correction to the Medicare Web site to comply with section 508 of the Rehabilitation Act of 1973.[1] We determined that the data used were sufficiently reliable for the purposes of this report.

Written Documents

To assess the clarity, completeness, and accuracy of written documents, we compiled a list of all available CMS-issued Part D benefit publications intended to inform beneficiaries and their advisers and selected a sample of 6 from the 70 CMS documents available, as of December 7, 2005, for in-depth review, as shown in table 1. The sample Part D documents were chosen to represent a variety of publication types, such as frequently asked questions and fact sheets available to beneficiaries about the Part D drug benefit. We selected documents that targeted all beneficiaries or those with unique drug coverage concerns, such as dual-eligibles and beneficiaries with Medigap.[2]

[1] 29 U.S.C. § 794d (2000).

[2] Medigap policies provide supplemental health coverage sold by private insurers to help pay for Medicare cost-sharing requirements, as well as for some services not provided by Medicare.

Table 1: Sample of Six Selected Documents

Document	Target audience
Medicare & You, Section 6: Medicare Prescription Drug Coverage	All beneficiaries
Things to Think about When You Compare Plans	All beneficiaries
Frequently Asked Questions about: Retiree Prescription Drug Coverage & the New Medicare Prescription Drug Coverage	Beneficiaries with employer or union coverage
Introduction to the Auto-Enrollment Notice	Dual-eligible beneficiaries[a]
Quick Facts about Medicare's New Coverage for Prescription Drugs for People with a Medicare Health Plan with Prescription Drug Coverage	Beneficiaries with Medicare Advantage[b]
Do You Have a Medigap Policy with Prescription Drug Coverage?	Beneficiaries with Medigap

Source: GAO.

[a]Dual-eligible beneficiaries are Medicare beneficiaries who receive full Medicaid benefits for services not covered by Medicare.

[b]Medicare Advantage replaced the Medicare+ Choice managed care program and expanded the availability of private health plan options to Medicare beneficiaries.

To evaluate clarity, we contracted with the American Institutes for Research (AIR)—a firm with experience in evaluating written material. AIR evaluated the texts of the six sample documents using three methodologies:

1. three standard readability tests;[3]
2. 60 commonly recognized written communications guidelines, including practices to aid senior readers; and
3. user testing with 11 Medicare beneficiaries and 5 advisers to beneficiaries, who performed 18 specified tasks related to enrollment, coverage, cost, penalty, and information resources and provided feedback about their experiences.

[3]The three tests were the Flesch-Kincaid Grade Level, the SMOG (Simplified Measure of Gobbledygook) Reading Grade Level, and the Fry Readability Estimate. The tests use such measures as sentence length and the number of syllables in a selection of text to arrive at a reading level, which is expressed in terms of school grade level.

We reviewed the sample documents for completeness to determine whether they contained sufficient information to allow the beneficiaries to identify (1) their next steps in determining whether to enroll and what plan to choose and (2) important factors, such as penalty provisions, that could affect their coverage decisions. To identify those important factors associated with the Part D benefit, we reviewed relevant laws, regulations, and 1-800-MEDICARE scripts prepared for customer service representatives (CSR) to read to callers and obtained information from advocacy groups. To evaluate the accuracy of information, we reviewed the sample materials for compliance with laws, regulations, and CMS guidance.

The 1-800-MEDICARE Help Line

To determine the accuracy and completeness of information provided regarding the Part D benefit, we placed a total of 500 calls to the 1-800-MEDICARE help line. We posed one of five questions about Part D in each call, so that each question was asked 100 times. Each question was pretested before we finalized its wording. We randomly placed calls at different times of the day and different days of the week from January 17 to February 7, 2006. Our calling times were chosen to match the daily and hourly pattern of calls reported by 1-800-MEDICARE in October 2005. We informed CMS officials that we would be placing calls; however, we did not tell them the questions we would ask or the specific dates and times that we would be placing our calls.

To select the five questions, we considered topics identified in the Medicare Web site's frequently asked questions. In addition, we considered topics most frequently addressed by 1-800-MEDICARE CSRs based on help line reports. To evaluate the accuracy of CSRs' responses to our five questions, we used three resources: (1) the prescription drug plan finder tool on the Medicare Web site, (2) 1-800-MEDICARE scripts, and (3) input obtained from CMS officials on the criteria we used for evaluating CSR responses. Table 2 lists the questions we asked and the criteria we used to evaluate the accuracy of responses.

Table 2: Questions and Criteria Used to Evaluate Accuracy

Question	Criteria
1. What drug plan can a beneficiary get that will cover all of his/her [specified] drugs at a [specified] pharmacy; have a mail-order option; and cost the least amount annually with [or without] a deductible?	An accurate and complete response would identify the prescription drug plan that has the lowest estimated annual cost for the drugs the beneficiary uses.
2. Can a beneficiary who is in a nursing home and not on Medicaid sign up for a prescription drug plan?	An accurate and complete response would indicate that a beneficiary can choose whether to enroll in a Medicare prescription drug plan.
3. Can a beneficiary enroll in the Medicare prescription drug program and keep his/her current Medigap policy?	An accurate and complete response would inform the caller that enrolling for the prescription drug benefit would depend on whether the beneficiary's Medigap plan was creditable—that is, whether the coverage it provided was at least as good as Medicare's standard prescription drug coverage—or noncreditable. The CSR response would also mention that the beneficiary's Medigap plan should have sent him/her information that outlined options.
4. What options does a beneficiary, who has retiree health insurance with prescription drug coverage that is not as good as the Medicare prescription drug coverage, have as it relates to the Medicare benefit?	An accurate and complete response would indicate that a beneficiary has two options: (1) keep current health plan and join the prescription drug plan later with a penalty or (2) drop current coverage and join a Medicare drug plan.
5. How do I know if a beneficiary qualifies for extra help?	An accurate and complete response would refer the beneficiary to the Social Security Administration.

Source: GAO.

When placing our calls, we identified ourselves as a beneficiary's relative, but did not provide CSRs with specific identifying information, such as a Medicare beneficiary number or date of birth. During our calls, CSRs were not aware that their responses would be included in a research study. We recorded the length of each call, including wait times, and the time it took before being connected to a CSR. We evaluated the accuracy and completeness of the responses by CSRs to the 500 calls by determining whether key information was provided.

The results from our 500 calls are limited to those calls and are not generalizable to the universe of calls made to the help line. The questions we asked were limited to matters concerning the Part D benefit and do not encompass all of the questions callers might ask.

Medicare Web Site

We contracted with the Nielsen Norman Group (NN/g)—a firm with expertise in Web design—to assess the usability of the Part D information available on the Medicare Web site. This study consisted of three separate evaluations. First, NN/g compared the site's compliance with established usability guidelines to determine a usability score to reflect the ease of finding necessary information and performing various tasks. Specifically, to determine the usability scores, NN/g evaluated various aspects of the Web site using industry-recognized "good" Web design practices, as indicated by the contractor, and the collective body of knowledge from NN/g internal reports and experts, or NN/g usability guidelines.[4]

Second, NN/g determined the degree of difficulty associated with 137 detailed aspects of Web site design for the Part D portion of the site. The 137 aspects fall into the following general categories:

- overall Web design (e.g., home page, navigation, search function, graphics, and overall organization);
- tools (e.g., plan finder);
- writing style (e.g., content, tone, legibility, and readability);
- accessibility (e.g., availability of a version of the Web site for the blind); and
- languages (e.g., availability of languages other than English).

NN/g determined the difficulty level in using each of the 137 aspects. NN/g noted aspects that had good design and would not be expected to cause confusion. For those aspects with a design that would be expected to cause confusion, NN/g ranked the associated difficulty level as high, medium, or low.[5]

Third, NN/g performed a qualitative evaluation on January 20 and 23, 2006, to test the ability of five Medicare beneficiaries and two beneficiary advisers to perform specified tasks related to Medicare beneficiaries using the Web site and to obtain feedback about participants' experiences. While the results are not statistically valid, these users provided important

[4]These guidelines are presented in an NN/g report called *Web Usability for Senior Citizens: 46 Design Guidelines Based on Usability Studies with People Age 65 and Older*. For this study, NN/g conducted usability tests of 17 Web sites with 44 seniors. Based on the test findings, NN/g developed 46 design guidelines that would make Web sites more attractive to seniors.

[5]In addition, NN/g indicated cases where an aspect was not functioning correctly from a Web site development standpoint by giving it a "bug" mark.

insights into the usability of the Medicare Web site. Participants were asked to "think out loud" as they worked through their tasks, while an NN/g facilitator observed their behavior and took notes. NN/g gave each task a score. At the end of their sessions, NN/g asked participants for input regarding their confidence in the answers they obtained from the Web site, and their overall satisfaction and frustration levels associated with using the site.

Finally, we obtained the results of CMS's March 2006 review of its Web site's compliance with section 508 of the Rehabilitation Act of 1973, as amended. This law requires federal agencies to make the information on their Web sites accessible to people with disabilities. We also discussed the results of this review with agency officials and followed up with them to determine the status of CMS's corrective actions.

State Health Insurance Assistance Programs

To determine the role of SHIPs in helping Medicare beneficiaries understand Part D, we interviewed CMS officials who monitor SHIPs' activities. We also reviewed information that we obtained from CMS officials and other sources on the program, its funding, changes made in response to the introduction of Part D, and the impact of Part D on the demand for SHIP services. In addition, we interviewed SHIP officials in California, Florida, New York, Texas, and Pennsylvania—the five states with the largest Medicare populations—to obtain information on the experience of their SHIPs with Part D.

We conducted our work from November 2005 through May 2006 in accordance with generally accepted government auditing standards.

Appendix III: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DATE: MAY 1 2006

200 Independence Avenue SW
Washington, DC 20201

TO: Leslie G. Aronovitz
Director, Health Care

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Government Accountability Office's (GAO) Draft report, *"MEDICARE: Communications to the Beneficiaries on the Prescription Drug Benefit Could Be Improved" (GAO-06-654)*

The Centers for Medicare & Medicaid Services has reviewed the findings in the GAO report entitled *MEDICARE: Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved (GAO-06-654)* regarding CMS communications on the Part D benefit. Having clear and effective communication about Medicare's new prescription drug coverage is one of the Agency's critical priorities. We have worked very hard to ensure that Medicare beneficiaries have the information they need to make decisions about enrolling in a drug plan that works for them. We are pleased that the millions of beneficiaries who have enrolled in Part D are experiencing very high rates of satisfaction with their coverage. Each week, tens of thousands of beneficiaries are enrolling in Part D, which gives them real savings and protections for the future.

While we greatly appreciate the feedback from your report and have already worked to implement your recommendations, we do not believe that your findings present a complete or accurate picture of the Part D communication activities. We understand that the report is based on studies of particular aspects of some of our communications tools at one point in time three months ago, in January and early February 2006. In addition to the many "continuous improvement" activities we have undertaken to address startup issues in the drug benefit since that time, there are much more extensive internal and external evaluations of our communications activities completed before, during, and after that time which have different conclusions, as we note below. These evaluations have used well-established methods which have been clearly documented and reviewed; in contrast, you have not yet responded to our requests for information on the methods you have applied. Additionally, your report does not address the unique breadth and depth of CMS activities to educate and to reach out to people with Medicare and the community that supports them in their health care decisions. From the outset, it was clear that no single source of information would be adequate or preferred by all of our beneficiaries. Consequently, we have expanded the range of tools available and vastly expanded our local partnerships to help beneficiaries use them, partnering with more than ten thousand diverse public and private organizations around the country in this effort.

Importantly, the report does not look at this broad array of communication tools to help Medicare beneficiaries consider their drug plan options. For example, the report dismisses all of the tools used by our customer service representatives and our website for

beneficiaries that provide personalized identifying information to enable us to provide them with personally customized service. The vast majority of our callers provide such personal identification, yet these tools were not evaluated. In fact, the report misleadingly states that we provided the right information on a lower share of cases because some customer service representatives sought to get this personal information to serve the beneficiary more quickly and effectively. Where GAO did actually get information on drug costs, as thousands of callers get every day, customer service representatives provided accurate information at a much higher rate. As another example, GAO evaluated whether beneficiaries could calculate their out-of-pocket drug costs in the standard Medicare benefit by hand, using only the *Medicare and You* handbook, but very few beneficiaries have opted to use the handbook in this way because: (1) there are far better tools available for quickly and automatically calculating drug costs on the web, on the phone, and through our partner organizations, and (2) over 90 percent of our beneficiaries are choosing plans with benefits other than the standard plan, because they prefer features like zero deductibles, flat copays, and coverage in the "donut hole." Beneficiaries are overwhelmingly using other tools to make effective cost comparisons.

In fact, the drug plan finder element of the website has received 164.6 million page views between November 15, 2005 and April 26, 2006. The Frequently Asked Questions (FAQ) section of www.medicare.gov has been accessed more than one million times since January 1, 2006. CMS has also responded to more than 19,000 emails received through the FAQ section, with 93% of them being resolved satisfactorily in the first response.

Finally, there is no attention in the report at all to major aspects of our communications activities and expenditures, such as the expansion of our community based education and outreach efforts through an extensive network of grassroots partners across the country. This significant emphasis on reaching people where they live, work, play and pray is a key component of our success in reaching millions of people with Medicare and those who work on their behalf. No mention is made of the specialized campaigns targeting African American, Hispanic, American Indians, Asian American and Pacific Islander and in low income communities. These campaigns utilize new partnerships, employ materials in other languages and specialized paid media campaigns. These targeted campaigns within the broader campaign allow us to reach all segments of the Medicare population, including those who might benefit from the low income subsidy and those with language and other cultural barriers to accessing information.

We believe that there have been a number of key elements to our successful education campaign. First, we recognized early on that we would need to supplement our proven traditional communications tools, including the Medicare & You Handbook, the 1-800-MEDICARE line, and the State Health Insurance Assistance Programs (SHIPs) with additional advanced technology and grassroots resources, as well as use earned and paid media opportunities. Second, we determined that the provision of personalized assistance and one-on-one counseling was the key ingredient to success. This necessitated our building a grassroots network of traditional and non-traditional partners who were willing to be trained to provide the one-on-one counseling. We strongly believe this is important for beneficiaries to make confident decisions about their Part D plan. We knew we

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would have to develop a grassroots capacity and local networks to supplement the CMS regional structure to provide the necessary education and enrollment assistance at the community level. This would involve reaching out, not just to our traditional partners such as the SHIPs, but to all the groups and organizations that have contact with our beneficiaries on a daily basis "where they work, where they play, and where they pray."

We appreciate any and all ideas for improving our communications efforts, and we take very seriously the four tasks that GAO recommends to improve CMS' education efforts. We support the goal of these tasks and have already taken many steps to meet them.

Ensure that CMS's written documents describe the Part D benefit in a manner that is consistent with commonly recognized communications guidelines and that is responsive to the intended audience needs. – CMS employs a wide variety of consumer research techniques, simple language best practices, and independent evaluations in both English and in Spanish documents to ensure the readability and usefulness of our educational materials including those describing Part D. These tests have demonstrated that CMS written documents follow best practice guidelines for written communications with the intended audiences. These techniques and practices are summarized in Attachment A. Because of the importance of this topic, we are always interested in improving our written products. We look forward to an opportunity to review what GAO used in its review and will compare them to the evaluation methods we are already using, as soon as GAO is willing to provide the methodological details.

Determine why CSRs frequently do not search for available drug plans if the caller does not provide personal identifying information. —As discussed with the GAO reviewers, CMS has instructed CSRs, in cases where that information is unavailable, to perform a search that provides general information on the plan options available to the beneficiary. Our web tools have always been set up to support such "unauthenticated" searches as well.

1-800 MEDICARE CSRs do have the ability to conduct a general search for callers who do not have their Medicare number. If the person provides personal information, the authenticated search, other information that may influence their decision is pulled into the search, e.g., low income subsidy status or coverage through a retiree drug subsidy. Because this path provides more robust and specific results, CMS has encouraged CSRs to stress the importance of an authenticated Prescription Drug Plan Finder search to callers. The importance of authenticated searches is stressed in the CSR training materials and scripts. We have placed warnings throughout the training materials about the downside of proceeding without the personalized information and CSRs do suggest that the person call back when they have it.

Even so, we know that there are occasions in which someone may not want to provide this information, or another caller may be inquiring on behalf of a beneficiary and not have the information, or a reporter or analyst may be calling for information. It has been emphasized to CSRs that non-authenticated general information is to be shared if the caller is unable to provide specific information that would enable a more detailed search. An

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example of relevant CSR instructions follows. "If a caller indicates they are calling for someone else and just wants general information on plans available in their area, you do not need to personalize the search if the caller does not want to. You can provide general plan information and send a personalized booklet if requested." CMS has a comprehensive quality review process on calls and we will continue to monitor calls to ensure that CSRs are pursuing the general search when appropriate.

At the same time, we believe that GAO presents this finding in a way that is incorrect and misleading. We believe that the 41% accuracy rate unfairly portrayed how accurately CMS answers questions on drug plan options without beneficiary personal identification information, when the GAO failed to analyze 35 out of the 41 responses. In actuality, when the responses are analyzed, correct answers are actually being provided a majority of the time. Further, the bulk of the responses characterized as "inaccurate" were related to the test caller's request that the CSR use only brand name drugs (i.e., no generic drug substitution). This request is highly unusual in our call experience as generic versions of a drug are identical in their clinical effects. However, we have subsequently modified the web tool used by our CSRs to make it easier to override the generic drug substitution logic in the tool.

Monitor the accuracy and completeness of CSRs responses to callers' inquiries and identify tools targeted to improve their performance in responding to questions concerning the Part D benefit, such as additional scripts and training.—We have worked hard to ensure beneficiaries have access to accurate and clear information when they call 1-800-Medicare. Our ongoing monitoring program, which evaluates a random sample of hundreds of actual calls received each month, has found that calls to 1-800-MEDICARE in 2006 have been answered accurately 93 percent of the time. The high accuracy rate is reflected in high rates of overall satisfaction from 1-800-MEDICARE callers, which averaged 84 to 85 percent in February and March.

Improve the usability of the Part D portion of the Medicare website by refining web-based tools, providing workable navigation features and links, and making web-based forms easier to use and correct. -- CMS is continually enhancing and refining their web-based tools to provide Medicare beneficiaries and their caregivers the information needed to compare, choose and enroll in a prescription drug plan that best meet their needs. We summarize some of our recent enhancements below. Online enrollment has been highly successful, as evidenced by the 3 million beneficiaries who have enrolled in the prescription drug plans using CMS' web-based drug plan finder. Our partner organizations have used the web tools to assist millions more with their enrollment-related needs. The high level of online enrollment and use by partners indicates that many people have found that this resource is useful and effective for undertaking the most important step of enrolling in a drug plan, and we are pleased that thousands more are using it every day.

We cannot emphasize enough CMS' commitment to continuously improve the communications with beneficiaries and other constituents. We want our websites to continue to be recognized as benchmarks for excellence. Attachment A outlines

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improvements that we have made to the website since the GAO review and we believe demonstrate our continued commitment to excellence.

All of our communications methods, in conjunction with our far-reaching grassroots efforts, have helped provide the important information about Part D needed by beneficiaries, providers and partners to ensure the Medicare drug program is a success. In fact, the vast majority of beneficiaries are using their coverage to save money and get protection for the future: actual premiums and drug costs are much lower than had been expected because of strong competition, and because beneficiaries are using the enrollment tools to choose plans that save them more (over 73 percent of beneficiaries are enrolling in plans stand-alone prescription drug plans with premiums below the average); the drug plans are successfully filling over three million prescriptions a day; and each week hundreds of thousands of beneficiaries are enrolling in the new program.

Tab A attached provides additional details about our communications materials and approaches. Also attached are technical comments for your consideration in Tab B. We will use the findings of the GAO report going forward as we continue our commitment to ensure that Medicare beneficiaries have the information they need to make informed health care decisions.

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Tab A

DETAILED INFORMATION ABOUT PART D EDUCATION AND OUTREACH

Over the past two years, we have dedicated significant resources to the development and implementation of an extensive education and outreach campaign surrounding Medicare prescription drug coverage, including a variety of beneficiary publications and materials, the 1-800-MEDICARE helpline, the Medicare Prescription Drug Plan Finder web tool on www.medicare.gov, personalized assistance via the State Health Insurance Assistance Program (SHIP) counseling program, and local enrollment events. All of these initiatives are rooted in a foundation of continuous quality improvement that involves identifying the information that needs to be conveyed, using consumer research to determine the most effective messages and vehicles, preparing materials accordingly, and measuring material effectiveness. This thorough, comprehensive and careful process ensures that all of our educational materials are as accurate, clear and informative as possible.

Handbook and other written materials

CMS has produced and disseminated an unprecedented number of written communication products on Medicare prescription drug coverage. These materials meet their intended goal of quickly and easily providing action-oriented information on a variety of topics related to Part D. Written materials exist in the form of booklets, brochures, fact sheets and letters. Some key communication products are available in Braille and audiotape, and many have been translated into alternate languages to increase accessibility to information.

Medicare & You Handbook

- The Handbook is an important information source for all Medicare beneficiaries on the Medicare program and their medical and drug coverage. Each year, all beneficiary households receive a copy and we know from our consumer research that beneficiaries keep it to use as a reference source. Our customer surveys of beneficiaries who read the *Medicare & You 2006 Handbook*, conducted in January-February 2006, showed that 72 percent were "very" or "somewhat satisfied" with the Handbook.

- For 2006, we updated the *Medicare & You Handbook* to reflect information on the new Medicare prescription drug coverage by including a summary of the new coverage and information on how it can help Medicare beneficiaries in different situations. In addition, we reorganized the *Handbook* to help Medicare beneficiaries decide whether and how to choose among alternative plans. For example, a prominently highlighted box on the inside cover of the *Handbook* serves to remind beneficiaries that they need to make a choice about prescription

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drug coverage for 2006. Beneficiaries are directed to the specific *Handbook* section that provides more details on how to select a prescription drug plan.

- The *Medicare & You Handbook* has been designed to assist beneficiaries in deciding how to choose a plan based on cost, coverage, convenience and peace of mind both now and in the future. In addition to general information, the *Handbook* includes information for beneficiaries based upon their current prescription drug coverage status.

- CMS uses a series of steps before, during, and after printing *the Medicare & You Handbook* to ensure accuracy. Some steps may be combined or omitted as appropriate for other targeted publications and deadlines for publication.

- Before printing the *Handbook*, CMS conducts multiple rounds of internal review by program staff experts in components throughout CMS. CMS also subjects the Handbook to expert review by external organizations. CMS solicits comments from an extensive list of advocacy groups, academic partners, industry trade organizations, Congressional staff, and other interested stakeholders. CMS writers/editors do the final proofing. Finally, the CMS Office of External Affairs/Graphics reviews the *Handbook*. CMS provides a final desktop publishing troubleshooting check to ensure that materials include only the files (such as logos, photos, and fonts) that CMS has legal rights to use.

- During the printing process, CMS reviews printer "blueline" copies. CMS reviews first proofs from the printer to ensure the publication layout is accurate. CMS has an opportunity to correct printer errors (generally something that was altered in the transfer from electronic file to print plate) or make author's alterations (errors previously missed) before printing begins. Specially trained CMS and/or GPO staff go on-site to the print contractor to conduct quality assurance inspections of the publication, checking for errors as the *Handbook* is being printed.

- After printing, CMS carefully monitors and investigates reports of errors in publications, including tracking related feedback from representatives at 1-800-MEDICARE. CMS corrects publications, as needed, and issues updated electronic files and/or errata sheets to accompany printed publications.

- CMS is very concerned about the readability of our publications. We have to balance the often competing goals of explaining technical information about Medicare coverage in clear and simple language while ensuring its accuracy. We go to great lengths to explain terms that beneficiaries need to understand to address readability concerns. For example, all publications include phone numbers and web sites, in case people need more information. CMS has found that this contact information is nearly universally identified and understood by beneficiaries.

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- GAO noted readability test score findings as evidence that our written documents lacked clarity. CMS doesn't routinely perform readability tests like the Fry, SMOG, FOG or Flesch-Kincaid on completed publications. Our writers may use these tests as tools during the drafting process to provide a rough estimate of the readability level and identify elements such as passive sentences, which can be readily improved. These kinds of tests rely largely on counting syllables per word, words per sentence, and sentences per paragraph to determine a "grade level" readability score which we do not find to be a useful parameter in gauging "readability" of Medicare materials because there are terms that may be unfamiliar to the Medicare population. As such, we go to great lengths to explain concepts that may be readily understood. For example, "Medicare," "deductible," "formulary" and "prescription" are all multi-syllabic words that would inflate scores in these types of reading tests. However, they are terms for which there are few or no simpler substitutes. People with Medicare (and in health insurance generally), commonly recognize most of these terms. Where they don't, as with "formulary," we use them with careful explanation in context, which also inflates the readability test scores by adding words to the sentence. Such tests would not account for this phenomenon and it is not usually accounted for by omitting certain words in the scoring process given how many terms for which we provide detailed explanations.

- These readability test scores are somewhat misleading and incomplete as a measure of the ease or difficulty of materials.
    - Plain language and literary experts like Roger Shuy and the Georgetown University Round Table on Language and Linguistics, the Social Security Administration, the Maine AHEC Health Literacy Center, the Delegates Assembly of the International Reading Association, and the U.S. Securities and Exchange Commission state that individual's tested literacy level and their ability to read and understand materials written at the corresponding grade level rarely match.
    - Test scores don't take into account other criteria that improve clarity of message, like navigational cues and graphic elements.
    - It's challenging to account for multi-syllabic terms like "Medicare" or "prescription" that are widely-understood and/or for which there are no simpler alternatives.
    - When appropriate, our publications provide a glossary to help beneficiaries understand words that may be new to them. The Medicare & You handbook contains such a glossary, as do our other large booklets. However, glossaries would mitigate the goals of brief fact sheets and letters, and therefore, for these types of materials, every effort is made to define difficult terms in context, which can inflate standard readability test scores.

- As an additional measure of clarity, GAO states they used 60 "commonly recognized guidelines" to evaluate our publications. It is difficult to sufficiently comment on the findings without knowing these 60 criteria, beyond the handful of

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examples in the report. However, it is important to note that to the best of our knowledge, these guidelines were compiled from multiple sources for the purposes of this evaluation and are not commonly recognized as a set. We look forward to the opportunity to review these guidelines and their relationship to our publications in the future, to assess where improvements might be made.

- To evaluate and improve the usability of Medicare publications, CMS hires contractors to conduct research with beneficiaries, caregivers, and other people who help beneficiaries. CMS uses focus groups to help us understand what information is important to beneficiaries. We also conduct cognitive interviews to test how well beneficiaries understand the content in our draft publications. Our drafts are revised based on the feedback that we receive.

- Consumer testing for the *Handbook* dates back to 1998. Over the years, we have qualitatively tested the *Handbook* with over 1000 aged and disabled beneficiaries, caregivers, and Medicare counselors. Each year, the basic testing is conducted in two rounds to allow for iterative improvements. Lessons learned from year to year are applied to each new version of the book.

- Multiple methods are used to test the book. The most heavily relied on method is cognitive interviews where participants are given tasks "cold," that is without prior preparation. We've also relied on triads and focus groups which allow participants to generate ideas on how to improve the book.

- We also conduct "diary groups" where beneficiaries are asked to make comments on the book as they read through it at home and are then brought in for focus groups. Tested content developed for particular publications is also used in other publications as appropriate. This overlap ensures consistency across CMS publications.

- Information collected from beneficiaries earlier this year indicated that 61 percent of respondents said the *Medicare & You Handbook* was "very easy" or "somewhat easy" to understand.

- CMS elicited feedback from more than 300 beneficiaries on Part D materials. The Medicare & You handbook language was tested by a testing contractor, BearingPoint, with over 150 beneficiaries. This testing helped us simplify our language and explain concepts more clearly.

- GAO used similar testing methods on a smaller scale to evaluate the clarity of our written materials. We are interested in reviewing the details of the 18 tasks that were used the interviews conducted with beneficiaries and beneficiary advisors, and understanding which tasks correlated to which tested products. GAO's report provides no details on the tasks that respondents completed successfully, and describes only three tasks that were difficult. These three indicate that the purpose and expectations of these publications may have been overlooked. The

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primary goal of our written communications in this phase was awareness - to make beneficiaries aware of the new coverage, aware that they needed to take some action, and aware of the resources available to help them make decisions. None of these publications were intended to independently lead a reader through such complex activities as computing projected out-of-pocket costs. Other feedback on our publications shows they are successful in meeting their intended goals.

- The National Association of Government Communicators critiqued the *Medicare & You 2005 Handbook* for the 2004 Blue Pencil Competition. The handbook received positive feedback in the judges' ratings. The judges rated the handbook in categories such as writing, editing, purpose, design, printing, cost effectiveness, and dissemination.
    - The judges strongly agreed that the writing was clear, concise, and appropriate for its intended audience.
    - One judge wrote, "Given the complexity of this subject, the writing is extremely clear and easy to understand. Technical terms are well explained, and needed information is easy to locate."
    - In the area of design, another judge commented that, "Choice of font, typeface, and size; leading; and margins made the book attractive, while ensuring accessibility for users (especially seniors). Use of blue headings and other design elements contributed to ease of use, as well."
    - In the category of purpose, the judges strongly agreed that the purpose of the handbook is clear and that the handbook gets its message across with well-supported topics. As an overall final comment, a judge wrote, "This entry is very well suited to its purpose and audience."
- CMS began preparations for the 2007 *Medicare & You Handbook* in late December 2005. To date, staff and leadership have held input meetings with key advocates and stakeholders, tested early draft revisions with beneficiaries, established a firm project plan, and instituted additional quality assurance and proofing processes. The *Handbook* is currently on schedule for its required mailing in the fall of this year, with a comprehensive external review process ending this week and extensive consumer testing scheduled in mid-May.

1-800- MEDICARE

It is a top priority at CMS to ensure that beneficiaries have timely access to accurate information and receive satisfactory service when contacting 1-800-MEDICARE.

- Between 2004 and the beginning of the open enrollment period, CMS conducted numerous activities to prepare for the prescription drug benefit, including the development of a comprehensive training curriculum on the prescription drug

benefit and the Plan Finder tool for Customer Service Representatives (CSRs). Since November 15, 2005, CMS has made continuous updates to scripts and reference materials for CSRs to ensure they are able to communicate accurate information to beneficiaries and people calling on behalf of beneficiaries.

- CMS's quality monitoring program has found that in 2006, calls to 1-800-MEDICARE have been accurate 93 percent of the time. This quality monitoring program is conducted by contractors who run the call centers. CMS monitors at least 4 calls per month for each of our thousands of CSRs to identify improvement and training opportunities.

- These are not just mystery shopping calls, which are limited to topics chosen by researchers, but actual calls which are representative of the information Medicare beneficiaries want to know. To ensure reliability and accuracy, all monitors score a sample of calls on a weekly basis and meet to review their approaches. The data is analyzed constantly and is used to take immediate corrective action. This work is overseen by a team within CMS dedicated to the quality of the 1-800-MEDICARE call centers.

- Examples of topics receiving the highest volume of inquiries at our call centers include:
  - How to enroll in a plan to obtain prescription drug coverage
  - Complaints about drug coverage
  - How to apply for the limited-income subsidy

- Since the beginning of the new prescription drug benefit, CMS has taken many steps to help beneficiaries get the information they need to select a drug plan. For example, CMS acquired additional infrastructure including telephone lines and workstations at call center sites.

- CMS increased the number of customer service representatives (CSRs) from 3,000 in June 2004 to as many as 7,800 to handle beneficiary calls with minimal wait times.

- On average, from November 15, 2005 to April 12, 2006, callers have experienced wait times of less than 2 minutes, with longer waits sometimes occurring during peak call periods. Call volume to 1-800-MEDICARE peaked around 400,000 calls per day in mid-November when enrollment began, and again in early to mid-January. Currently, call volume reaches 200,000 calls per day on the highest volume day and levels out around 150,000 per day during the remainder of the week. Call volumes have continued to increase slightly since then.

- CMS recognizes that not all beneficiaries are able to use, or have access to, the internet, which is the platform for the useful Medicare Prescription Drug Plan Finder tool. As part of our outreach and communication efforts, CMS trained additional staff exclusively on the use of the Medicare Prescription Drug Plan

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Finder tool so that they could be dedicated to answering calls only about the prescription drug benefit and available plan options.

- We expanded responsibilities and provided additional training for some CSRs and advanced training for others. We required CSRs to take written exams and test calls for certification before allowing them to take live calls. All CSRs have one week of classroom training followed by two or three additional days of practice calls, simulation, quality monitoring, and follow-up coaching to ensure peak performance. Finally, we monitored newly-trained CSRs and those who would benefit from additional coaching at a higher level.

- This year, CMS implemented a 1-800 MEDICARE caller satisfaction survey conducted by Pacific Consulting Group, an independent contractor. This survey provides 1) satisfaction tracking over time and 2) an early warning system that can point to potential service problems. Improvements can then be implemented relatively quickly to enhance caller satisfaction. These CMS customer satisfaction surveys indicate that the bulk of callers who interact with our CSRs, 87 percent are satisfied with their experience. They are particularly pleased with how courteous and patient the CSRs are (rated at 97 percent). These responses came not only from people with Medicare, but also friends or relatives calling on their behalf, who made up 34 percent of callers during March 2006.

- Currently, 500 surveys are conducted each week with 400 callers who spoke with CSRs and 100 callers who used the Interactive Voice Response System.

The data below depict results from weekly calls for those callers that spoke to a CSR. The results show the percentage of respondents in the weeks January 16th, February 27th and March 6th that strongly or somewhat agree with the statements listed below.

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Survey Metric	Week of	January 16th	February 27th	March 6th
		(% agree - strongly or somewhat to the following statements)		
CSR was helpful		84%	89%	88%
CSR understood issue or concern		83%	86%	88%
CSR explained things to me in way I could understand		83%	86%	84%
I received all the information I needed		67%	72%	73%
The CSR was knowledgeable		81%	86%	85%
I received information specific to my issue		75%	80%	80%
Overall I am satisfied		79%	84%	85%

- Pharmacists are a key partner in the implementation of the Medicare prescription drug benefit. To ensure that pharmacists have access to the information they need to assist beneficiaries at the pharmacy counter, CMS developed a dedicated pharmacist 1-866 telephone line. Incoming calls through the dedicated pharmacist line are routed to the head of the queue at the 1-800 MEDICARE number, wait times are substantially lower than the overall average for beneficiaries and other individuals calling the 1-800-MEDICARE line. This helps to relieve any burden on pharmacists, and also ensures that pharmacists are able to assist beneficiaries immediately at the pharmacy counter.

- CMS is well-prepared to handle increased call-volume that may occur before the May 15th enrollment deadline. We have increased the number of CSRs from 3,000 in June of 2004 to 6,000 CSRs for May enrollments. We have also acquired additional infrastructure including telephone lines and workstations at call center sites. We have refined our CSR scripts by reducing redundant information, indexing scripts for quick access, and including probing questions to help the CSRs better identify callers' concerns.

- Despite our efforts, some beneficiaries will wait until the deadline is near, but our top priority is to encourage people to enroll now and avoid the rush.

Medicare.gov

- To ensure that the new Plan Finder tool was well-designed and easily used by beneficiaries and other individuals, CMS worked with a professional website development contractor, CGI Federal and a subcontractor, Navigation Arts.

- As the Medicare Prescription Drug Plan Finder was being designed, CMS engaged in multiple rounds of consumer testing to ensure its usefulness and

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simplicity. CMS conducted three rounds of in-depth interviews with Medicare beneficiaries to obtain feedback as drafts of the tool were developed throughout 2005. Final interviews that focused on messages tailored specifically for beneficiaries based on their insurance information were conducted in September 2005. CMS conducts ongoing consumer research to continue to improve understandability and usability.

- CMS also conducts thorough and ongoing analyses of possible outliers in data, including the Medicare Prescription Drug Plan Finder plan pricing data, pharmacy network, mismatched formulary identifiers (NDC codes), and other missing formulary data. If problems are found with a plan's data, information on the plan will be suppressed from the website until CMS works with the plan to correct its information and properly display it.

- We are proud to say that CMS has received a number of awards for its website from independent organizations. These awards include the "eHealthcare Leadership Award" at the Ninth Annual Internet Conference, the "2005 Pioneer Award" at the E-Gov Institute and Federal Computer Week, and the "Independent Technology Supporting Service to Our Country" award at the Eighth Annual Technology Gala to benefit Juvenile Diabetes.

- We believe that the website has been extremely successful in providing beneficiaries, their caregivers and CMS partners with clear, accurate and timely information to help them enroll in drug plans. In fact, CSRs at 1-800-MEDICARE have access to the Plan Finder to help beneficiaries find the information they need about choosing a plan, enrolling in a plan, or other issues related to accessing their prescription drug coverage. The Plan Finder also has been a critical tool for SHIPs and other partners, such as the ABC Coalition and Medicare Today, to use when conducting outreach to beneficiaries.

- Results from a web-based customer satisfaction survey conducted by MSInteractive, a subsidiary of Market Strategies that specializes in web-site satisfaction research, were very positive. This research, conducted in December 2005, focused only on the prescription drug plan finder tool.

- The survey indicated that content, interactivity, and navigability have the greatest impact on satisfaction. During development of the tool, CMS contracted with a web design firm to leverage their expertise on these impacts. CMS continues to focus on these areas in future enhancements and updates.

- The site's "appearance" and "privacy" scored highly, but had no impact on overall satisfaction.
  - 66 percent of those who enrolled were either "somewhat" or "strongly satisfied" with the tool.
  - 80 percent of those who enrolled would recommend the tool to a friend.

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- 70 percent of users agreed with this statement, "I know more about the Medicare Prescription Drug Plans now that I've used this site."
- Regular internet users had higher ratings of the site.

- In January and February 2006, Abt conducted a telephone survey of a random sample of beneficiaries and found that:
  - 14 percent of respondents used the www.medicare.gov website to get information about Medicare;
  - 60 percent said it was "very easy" or "somewhat easy" to understand the information from www.medicare.gov;
  - Beneficiaries who rated their satisfaction with the information received from medicare.gov as "very/somewhat" satisfied outnumbered the "dissatisfied" beneficiaries 71 percent to 19 percent. Seven percent of beneficiaries were neither "satisfied nor dissatisfied."

- Overall, the drug plan finder element of the website has received 164.6 million page views between November 15, 2005 and April 26, 2006. We do not have a way to differentiate whether those hits were from beneficiaries or their caregivers.

- To date, 3 million beneficiaries have enrolled in prescription drug plans using the Plan Finder. That indicates that at least that many people were satisfied enough with the information they received to undertake the most important step of enrolling in a drug plan.

- The Frequently Asked Questions (FAQ) section of www.medicare.gov has been accessed more than one million times since January 1, 2006. CMS has also responded to more than 19,000 emails received through the FAQ section, with 93% of them being resolved satisfactorily in the first response.

State Health Insurance Assistance Programs (SHIPs)

- While the SHIPs play a significant role in beneficiary counseling and education on Part D, CMS has also created a national grassroots network of more than 24,000 partners and 140 coalitions that rely on traditional tools to help them provide personalized counseling to Medicare beneficiaries every day.

- The network CMS built is diverse and committed, with members from every sector, including advocacy groups, government agencies, service clubs, faith-based organizations, benefits counselors, trained volunteers and healthcare professionals such as doctors and pharmacists.

- This extensive, grassroots-level partnership is truly unprecedented for the Medicare program. It's reaching out to people with Medicare all over the country …"where they live, work, play, and pray." This approach has helped personalize Medicare in every corner of the country.

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- Preliminary data from the State Health Insurance Assistance Programs (SHIPs) shows that individual in-person and telephone contacts, presentations and meetings reached a total of 4.5 million clients, compared to 2.5 million in the previous grant period.

Other Selected Activities

- The Mobile Office Tour has traveled 500,000 miles since last fall and approximately half of the territory covered and events have been in rural areas, in an attempt to reach out to a variety of beneficiaries and partners at the local level. We knew we would have to develop a grassroots capacity and local networks to supplement the CMS regional structure to provide the necessary education and enrollment assistance at the community level. This would involve reaching out, not just to our traditional partners such as the SHIPs, but to all the groups and organizations that have contact with our beneficiaries on a daily basis "where they work, where they play, and where they pray." We needed to involve individuals and institutions: family members and friends; current and former employers; churches and synagogues; financial advisors and community centers, to name but a few.

- CMS is reaching out directly to beneficiaries through an extensive paid and earned media campaign focusing on press and radio, both of which are highly localized in informing beneficiaries of special events in their neighborhoods.

- As we approach May 15, many members of the Cabinet whose agencies have helped build awareness of the prescription drug benefit through their own programs have joined efforts with CMS, including the United States Department of Agriculture, Department of Commerce, Department of Labor and Housing and Urban Development.

- To minimize a possible last minute rush to enroll, CMS is making a monumental effort to enroll beneficiaries well before the May 15th deadline. In the past month, there have been 1,000 events per week across the country to provide beneficiaries with personalized help so they understand the prescription drug coverage options available to them and they can enroll in a plan. In our enrollment efforts, we are targeting beneficiaries who may qualify for the low-income subsidy and beneficiaries who live in rural areas. Our enrollment events are fully coordinated with the Social Security Administration (SSA) to assist beneficiaries in applying for extra help, as well as to help them enroll in a plan.

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Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Acknowledgments

In addition to the contact named above, Susan T. Anthony and Geraldine Redican-Bigott, Assistant Directors; Ramsey L. Asaly; Enchelle Bolden; Laura Brogan; Shaunessye D. Curry; Chir-Jen Huang; M. Peter Juang; Ba Lin; Michaela M. Monaghan; Roseanne Price; Pauline Seretakis; Margaret J. Weber; and Craig H. Winslow made contributions to this report.

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