

**INFORMATION DISSEMINATION ACTIVITIES IN
IMPLEMENTING THE NATIONAL MEDICARE & YOU
EDUCATION PROGRAM (NMEP): Fall 1998 – Fall 2001**

Centers for Medicare & Medicaid Services (CMS)

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Executive Summary

This report summarizes the information dissemination activities undertaken by the Centers for Medicare & Medicaid Services (CMS) in implementing and conducting an assessment of the National Medicare & You Education Program (NMEP). The report summarizes each of the NMEP information channels, and includes information regarding the assessment and cost of the NMEP. A description of the National Media Campaign is also included.

The Balanced Budget Act of 1997 mandated the most significant changes to Medicare since its inception. One of these changes was the expansion of health insurance options by the creation of Medicare + Choice. To support the new program and to help people with Medicare make more informed health care decisions, CMS initiated the NMEP. The NMEP employs numerous specific information channels to educate people with Medicare and help them make more informed decisions concerning: Medicare program benefits; health plan choices; supplemental health insurance; beneficiary rights, responsibilities, and protections; and health behaviors.

A pilot program of specific NMEP activities afforded us an opportunity to study and monitor the way these specific information channels function. Two key NMEP components implemented and tested in five pilot states (Oregon, Washington, Arizona, Florida and Ohio) prior to the planned nationwide implementation in Fall 1999, were the new *Medicare & You* Handbook and 1-800-MEDICARE toll-free line. This phased implementation allowed CMS to improve new NMEP activities through performance monitoring and assessment prior to the nationwide implementation.

CMS is taking a multifaceted approach to testing our overall strategy in educating beneficiaries about Medicare. We have developed a performance assessment system for all elements of NMEP to use for continuous quality improvement. The channel-specific assessments cover the following: print materials; toll-free telephone services (1-800-MEDICARE); the Internet (www.medicare.gov); Regional Education About Choices in Health (REACH); National Alliance Network; national training and support for information givers; and enhanced beneficiary counseling from the State Health Insurance Assistance Programs (SHIPs). These assessment activities identify what is working well and what needs to be improved for each of the activities for communicating information about Medicare and Medicare + Choice.

Additionally, we are conducting case studies in five communities in the original five pilot states (Dayton, OH; Eugene, OR; Olympia, WA; Sarasota, FL and Tucson, AZ) and in one community (Springfield, MA) which was outside the original five pilot states. We are

studying these in order to describe the evolution of the NMEP in these six communities and identify “best practices” that could be used in other areas. The case studies add to our other assessment activities by providing information about how all of the activities related to the NMEP work together at the local level. We are continuing to monitor the case study sites over time.

To evaluate the impact of the NMEP at the national level, we added a supplement to the winter round of the 1999 Medicare Current Beneficiary Survey (MCBS). This supplement gathered information about the ability of people with Medicare to obtain Medicare information when they need it, and about their awareness and understanding of Medicare and Medicare + Choice messages. We have repeated this supplement annually.

CMS’ monitoring activities have provided the Agency with feedback on the progress of the NMEP efforts and on potential areas for improvement. Over the three years, the activities have provided a deeper understanding of the complexities of information and educating people with Medicare.

CHAPTER I

BACKGROUND

In 1994, CMS developed a strategic plan that identified improving service to beneficiaries as the Agency's primary mission. This newly articulated focus included the HCFA Online project that provided Medicare beneficiaries with additional information about the program. In 1997, CMS underwent a major reorganization, one of the purposes of which was to give a prominent organizational home to beneficiary information activities. This created a new component, the Center for Beneficiary Services (CBS) -- charged with improving customer service to people with Medicare. Along with the creation of a dedicated Center, CBS developed the Medicare Beneficiary Customer Service Program, a strategy and framework for coordinating its customer service initiatives.

CMS Consumer Information Dissemination in the Pre-Balanced Budget Act (BBA) Period

Prior to passage of the BBA, CMS produced a number of publications. Included among these was the Medicare Handbook. Because there were insufficient funds available to mail the Handbook to every person with Medicare every year, generally, people with Medicare received the Handbook only when they enrolled in the program. In 1996, CMS mailed the Handbook to every person with Medicare; we received criticism from some members of Congress for doing so in an election year.

Regarding information about managed care plans, people with Medicare learned about the availability of local managed care plans primarily through the plans' marketing campaigns. Managed care plans provided marketing materials directly to beneficiaries and handled enrollment activities. CMS did not provide beneficiaries with specific information on local plans. The Medicare Handbooks in the years prior to BBA contained

a single page on beneficiary choice of fee-for-service or managed care for Medicare benefits. One additional brochure was available on managed care (Medicare and Managed Care), and one on Medicare Supplemental Insurance (The Guide to Health Insurance for People with Medicare).

CHAPTER II
STATUTORY MANDATE

Medicare beneficiary communication was given added prominence in August of 1997, when the Balanced Budget Act (BBA) was enacted into law. The law included some of the most significant changes to Medicare since the program was enacted in 1965. Among these changes was a new Medicare Part C, which provided beneficiaries with additional choices in how they could receive health care services.

The law added new types of health plans such as private fee-for-service plans, provider-sponsored organizations, preferred provider organizations, and Medical Savings Accounts to the existing options of managed care organizations and to the Original Medicare plan.

To inform the Medicare beneficiary population about these choices, the law provided for specific dissemination activities that CMS implemented with a new education campaign called the National Medicare & You Education Program (NMEP). The NMEP is the largest and most comprehensive educational campaign in the history of the Medicare program. Specifically, the law included:

A. Content of the Communication

CMS was directed to provide information on many topics, including: general Medicare program information on covered benefits; health plan election and enrollment procedures; beneficiary rights and protections; Medicare supplemental insurance (also known as Medigap); comparative information to facilitate beneficiary comparison of Medicare health plan choices; and the potential for Medicare health plan contract terminations.

B. Communication Channels

CMS was directed to mail printed information annually to people with Medicare, and others as they become eligible for Medicare. CMS was to maintain a toll-free telephone service, an Internet site, an annual nationally coordinated educational and publicity campaign - all of which were to provide information to beneficiaries.

C. Form of Communication

CMS was directed to use plain language and to format information to be easily understood by Medicare beneficiaries.

D. Timing of Communication

As part of the goal of moving Medicare more in the direction of privately sponsored insurance coverage, BBA required Medicare to conduct an annual open enrollment period at which time people with Medicare would make an annual choice of health plans. This is analogous to what many private companies do, as well as the Federal Employee Health Benefit Program. The BBA included a new annual open enrollment period for the month of November, starting in 1999.

The law specified dates by which CMS was to provide information to beneficiaries about their local choices so that beneficiaries may elect to enroll in a Medicare health plan during certain periods of the year. The law required the Secretary to mail such information to each eligible person with Medicare at least 15 days prior to the start of the annual open enrollment period. The nationally coordinated educational and publicity campaign to inform beneficiaries about their Medicare + Choice options was to occur in November of each year.

E. Funding

BBA authorized the Department of Health and Human Services (DHHS) to collect user fees from Medicare + Choice health plans to support the education campaign in the amounts of \$200 million in FY1998, \$150 million in FY1999, and \$100 million in

FY 2000. (See Attachment A for funding history of the NMEP).

CHAPTER III

INTRODUCTION TO NATIONAL MEDICARE & YOU EDUCATION PROGRAM (NMEP)

In the Fall of 1997, with the new CMS organization, the newly enacted BBA, and new funds for the beneficiary education campaign, the National Medicare & You Education Program (NMEP) began to take shape. With the NMEP, CMS entered into a fundamentally new relationship with beneficiaries, their families, and a myriad of beneficiary-related organizations. CMS's new role as an educator in a nationwide education campaign included several new goals for the agency:

- creating *awareness* among the beneficiary community of the new choices that were available to them;
- developing an *understanding* of those new choices and their ramifications; and
- helping beneficiaries *use new information* to make informed health care choices.

CMS contracted with the consulting firm of Arthur Andersen to help develop the NMEP. Arthur Andersen provided assistance with framing the key messages of the education campaign, developing specifics behind the information channels, providing print expert consultation, zip code cluster analysis, project management support, and pre-press production services.

Moreover, the agency convened a Federal Advisory Committee Act (FACA) committee, the Citizens Advisory Panel on Medicare Education in 1999, to increase public input into the NMEP. Members on the committee represent a range of expertise including senior citizen advocates, health researchers, health insurers, providers, clinicians, and employers.

The first focus of the NMEP was on presenting information on the Medicare + Choice program. The agency was committed to:

- *educating* beneficiaries in order for them to make informed health plan decisions;
- *protecting* beneficiaries from making decisions based on inaccurate or misleading information; and
- *ensuring* that information was accurate and easily understood.

Medicare beneficiaries and their families were provided information through seven key mediums, also known as information channels: Beneficiary print materials; Toll-free telephone services; Internet activities; Regional Education About Choices in Health (REACH) campaign; National Alliance Network; National training and support; and Enhanced State Health Insurance Assistance Program (SHIP) counseling.

One of the challenges of providing information to people with Medicare is that this population is diverse in terms of education and literacy. Additionally, research has revealed that a large part of the Medicare population knows very little about Medicare-related topics.

- Thirty-three percent of the Medicare population has less than 12 years of education; about 16 percent has less than 9 years of schooling.
- Approximately 44 percent of adults 65 and over are considered to have limited reading skills (Kirsch, Jungebult, Jenkins and Kolstad, 1993).
- Almost 57 percent of people with Medicare report that they know only a little or almost none of what they need to know about the availability and benefits of Medicare health maintenance organizations (HMOs) (Centers for Medicare & Medicaid Services, 1999).
- Other studies found that 1 in 3 Medicare beneficiaries enrolled in a managed care plan were unfamiliar with managed care concepts. A similar percentage of beneficiaries in original fee-for-service Medicare were also uninformed about managed care (Hibbard, 1998).
- The Office of Inspector General (OIG) found that many beneficiaries who were denied services by their managed care plan and subsequently disenrolled did not know they could appeal the plan's decision to deny services (OIG, 1998).

Survey data regarding information seeking behaviors indicated that, when asked how they would like to obtain Medicare information: 41 percent would prefer to talk to someone; 25 percent would prefer to read a brochure or pamphlet; but a few prefer TV or radio (4 percent), newspapers or magazines (4 percent), or the internet (3 percent). Among those seeking information about Medicare + Choice plans, about 40 percent would contact the Medicare program (including the 1-800-MEDICARE line); about 24 percent would contact the health plan directly.

CMS began the NMEP with the expectation that an enterprise as large, new and challenging as the NMEP would require evaluation in order to make ongoing refinements. As such, we conducted an assessment of each of the information channels, as well as a cross-cutting and comprehensive assessment of the education efforts, and consumer testing of all publications and materials. Since the Fall 1998, CMS has been conducting case studies in Dayton, OH; Eugene, OR; Olympia, WA; Sarasota, FL; Tucson, AZ; and Springfield, MA to see how various NMEP components work together at the local level. The case studies include a survey of people with Medicare called the NMEP Community Monitoring Survey, media monitoring, site visits to case study communities, and telephone interviews with selected informants in the CMS Regional Offices and in the communities. Attachment B includes a description of each of our data sources for the assessment of the NMEP.

In order to ensure information was easily understood by various cultural groups, in 1999 CMS launched the HORIZONS (Health Outreach Initiative Zeroing In On Needs) project to improve health education communication to Medicare beneficiaries from diverse populations and with barriers to access due to language, location and low literacy. Team members developed critical communication strategies targeted at four specific groups of beneficiaries: African Americans, Hispanics, Asian Americans and Pacific Islanders, and American Indians and Native Alaskans.

CHAPTER IV

BENEFICIARY PRINT MATERIALS

CMS' primary beneficiary print material is the Medicare & You Handbook. To meet the needs of our diverse beneficiary population, the Handbook is available in English, Spanish, Braille, audio-tape (English and Spanish) and large print (English and Spanish). The Handbook reflects content largely prescribed by BBA and has been revised annually, incorporating improvements based on beneficiary feedback and testing, consultation with low literacy experts, and feedback from lessons learned. The Handbook is mailed monthly to new Medicare enrollees, as well as on an annual basis to all current Medicare beneficiary households each fall. Medicare & You consists of a national version (English and Spanish), as well as 26 area-specific versions.

In addition to the Handbook, CMS publishes almost 40 topic-specific publications, including material on: services Medicare covers (e.g., mental health, home health care), health care choices (e.g., choosing a doctor; choosing a hospital), Medicare health plan choices and supplemental coverage (e.g., the Guide to Health Insurance; private fee-for-service plans), rights and protections, costs and payments (e.g., assignment; secondary payer). Many of these publications are available in English, Spanish, Large Print, Braille, and audio-tape. Some are available in Chinese. Current publications are listed in Attachment C.

Medicare & You Handbook - Background:

- In the Fall of 1998, CMS created and distributed the new *Medicare & You Handbook* in 5 states (AZ, OH, FL, OR, and WA) in a pilot effort. CMS chose a phased-in approach to understand how best to design/produce/mail print materials, and reach the beneficiary population about Medicare. Those beneficiaries who did not receive a Handbook received a bulletin to provide basic information on Medicare changes and phone number referrals for answers to questions. Customized Handbooks were updated quarterly and mailed to new enrollees each month. New enrollees residing in non-pilot states received a national version of *Medicare & You*, with national phone numbers, and a referral to the website for plan comparison information. To reduce cost, only one

beneficiary residing in a household with two to four beneficiaries is mailed a handbook. The remaining beneficiaries receive a postcard instructing them how to receive their own copy of *Medicare & You*, if desired.

Language and media preferences for Handbooks other than English print were captured by the Call Center to allow subsequent mailings for preferred versions such as Spanish print, audio-tape (English and Spanish), Braille, and large print (English and Spanish).

- ***Medicare & You 2000:*** As a result of the pilot experience, a number of process and product improvements were made to *Medicare & You 2000*, including changes to the design of the Handbook to accommodate both fixed and variable information. As a result of the cluster/zip code analysis and cost considerations, a total of 26 unique, area-specific, Handbooks were created along Regional Office and state lines, with 5 states requiring more than one Handbook (TX, OH, FL, NY and CA). Again, multi-beneficiary households with matching addresses received one Handbook, with the remaining beneficiaries receiving postcards. Feedback postcards were added to 17 million copies of the Handbook for the Fall mailing (10 area-specific versions), to solicit information about the ease of use and ability to find needed information. Preferences for alternative formats and language were captured by the Call Center for subsequent *Medicare & You* mailings. National Handbook versions were shipped to partners, the CMS warehouse and Call Center. In addition to the annual Fall mailing, area-specific Handbooks were updated each quarter and mailed to approximately 2.4 million new Medicare enrollees on a monthly basis (approximately 200,000 per month).
- ***Medicare & You 2001:*** Specifications for *Medicare & You 2001*, multi-beneficiary household and feedback postcards remained virtually unchanged, following cluster analysis and lessons learned. Separate mail files were created for beneficiaries with preferences for alternative language and/or format, and

these were mailed rather than a conventional English print version. In addition, due to our inability to correct non-matching (but otherwise valid) addresses through the Social Security Administration, we created specifications for an additional “suppression” file, consisting of beneficiaries who did not wish to receive a future copy of *Medicare & You*, and who were mailed a postcard instructing them how to receive their own copy of the Handbook, if desired. The Call Center continued to collect preference and suppression requests for subsequent mailings.

- ***Medicare & You 2002***: In 2002, specifications for 26 unique, area-specific Handbooks, feedback postcards, and multi-beneficiary postcards were virtually unchanged. However, the DHHS Secretary delayed the deadline for health plans to submit their plan benefit packages to CMS. Because of this delay, CMS was not able to include plan comparison information in the *Medicare & You* Handbooks that were sent in the annual Fall mailing. The Gray Panthers filed a lawsuit against CMS in the summer of 2001, claiming that the omission of this information violated our requirements under the Balanced Budget Act. In the preliminary injunction hearing of this lawsuit, CMS was ordered to comply with the statute and provide plan comparison information to beneficiaries by October 15, 2001. CMS developed a second mailing of 26 unique, area-specific, supplementary booklets containing Medicare + Choice plan comparison information. These booklets were mailed by the deadline to 27.5 million Medicare beneficiaries with health plan options in their areas.
- ***Medicare & You 2003***: *The Medicare & You 2003* Handbook deleted the 28-page section titled: Phone Numbers for Your Local Area, and discontinued inclusion of the feedback postcards. A new feature of the 2003 Handbook will be the addition of the New Notice of Medicare Privacy Practices. This mandated information describes how Medicare can use and disclose personal medical information. These privacy practices will become effective April 14, 2003. People with Medicare will have the right to see and copy the medical information on file and

to correct the information if it is incorrect or incomplete. After April 14, 2003, people with Medicare can also obtain a list of who received their medical information. The “5 Steps to Safer Health Care” and information about assignment are two other new topics included in the 2003 Handbook. Specifications for unique, area-specific Handbooks were virtually unchanged. For the first time, due to an increase in preference requests, CMS will also produce 5 area-specific Spanish Handbooks for Puerto Rico, Southern Florida, Southern California, Texas, and the New York City vicinity.

Assessment Strategy

The evaluation of *Medicare & You* has consisted of: 1) four different types of surveys; 2) consumer testing, including numerous focus groups and cognitive interviews; 3) expert review (including reviews by low literacy experts); and 4) responses to feedback postcards inserted into a sample of Handbooks.

Findings/Improvements Made

Significant findings from the assessment of *Medicare & You* include the following:

- The percentage of people with Medicare who remember receiving the Handbook has increased from 70 percent (1999 Handbook) to 76 percent (2001 Handbook), according to the NMEP Community Monitoring Survey which is conducted in English and Spanish. This change is a statistically significant increase. Of those who remember receiving the Handbook, approximately 76 percent have glanced through it, read parts of it, or read it thoroughly.
- Survey results from February 2001 suggest that most people with Medicare realize that the Handbook is a government publication. Forty-eight percent think that the document is sent by the Medicare program, 6 percent from Social Security Administration, 17 percent from another government agency, and 4 percent from an insurance company or a managed care plan.
- Approximately 40 percent of survey respondents affected by plans terminating from the Medicare program said that they had used the *Medicare & You*

Handbook to find out about their insurance options. These respondents were surveyed through the NMEP case study sites and through surveys conducted in four additional sites¹ to assess the NMEP and the information needs of involuntary disenrollees.

- About 13 percent of the people affected by plans terminating from the Medicare program report using the quality and cost comparison information in the Handbook.
- CMS has funded the Research Triangle Institute to study, through a pre-post experimental design, the effect of the *Medicare & You* Handbook on knowledge of people with Medicare. The Medicare population shows modest but statistically significant gains in knowledge after receiving the Handbook. For example, people with Medicare receiving the Handbook had 8.5 percent higher scores on a 15 item knowledge index.
- Most people with Medicare find the Handbook “fairly easy” to understand, as shown in Table 1.

Table 1: “How easy was the Handbook to understand?”

	1999	2001
Very Easy	19%	21%
Fairly Easy	59%	60%
Fairly Difficult	13%	11%
Very Difficult	2%	3%
Refused/Don’t Know	7%	6%

Source: NMEP Community Monitoring Survey, 1999 and 2001.

¹The additional sites include Centre County, PA; Houston, TX; Minneapolis, MN; and Nassau County, NY. All of these sites were impacted by managed care plans leaving the Medicare program as of January 1, 2001. A total of 5,706 people with Medicare were interviewed across the case study sites and the four additional sites impacted by managed care terminations. Out of the total sample, approximately 40 percent had been disenrolled from managed care plans as a result of Medicare plan terminations as of January 1, 2001.

- The 2001 Handbook is easier for less-educated people with Medicare to read compared to the 1999 Handbook and earlier editions. Of those who did not graduate from high school, 27 percent found the 1999 Handbook “fairly or very difficult” to read, compared with only 22 percent who found the 2001 Handbook “fairly or very difficult” to read.
- The NMEP Community Monitoring Survey indicates that most people with Medicare are satisfied with the Handbook. The February 2001 NMEP Community Monitoring survey data indicate that 66 percent of people with Medicare are satisfied or very satisfied with the Handbook; 17 percent are neither satisfied/nor dissatisfied, 4 percent are dissatisfied or very dissatisfied and the remaining 13 percent don’t know or refused to answer this question.
- We received over 42,000 postcards that were included in the sample of *Medicare & You* 2001 Handbooks. Close to 73 percent of people with Medicare said the handbook was easy to use; 18 percent said neither easy/nor hard; 7 percent hard; and the remaining 2 percent were missing. Approximately 72 percent said they found the information they wanted; 11 percent said they did not find the information they wanted; 13 percent did not need information; and the remaining 4 percent were missing.

All of the testing and assessment activities have consistently shown that most people with Medicare use the Handbook as a reference document; *Medicare & You 2000* was revised to reflect this. Other changes to *Medicare & You* have been made as a result of the assessment activities. *Medicare & You* received the 2001 Vice President's Award for Plain Language.

Improvements to Medicare & You 2000

- Use of 14 point font, and scholar columns for easy reading
- Addition of section of definitions for important terms
- Added cover message for identifying contents of booklet in easy to read bullets
- Added State identification to the back cover

- Three-page easy to read summary was added to provide a basic overview of Medicare and highlight key changes in program

Improvements to Medicare & You 2001

- Improved design for easier reading, such as removing lines on scholar columns, and removing reverse text headers
- Addition of graphics per low literacy review suggestion
- Use of improved navigational aids to facilitate readers being able to find information they need easily.

Improvements to Medicare & You 2002

- Included a side-by-side comparison of Original Medicare Plan and Medicare+Choice Plans on costs, doctor choice, extra benefits and convenience.
- Added section on “Other Insurance and Ways to Pay Health Care Costs”

CHAPTER V

TOLL-FREE TELEPHONE SERVICES

CMS established a toll-free line to provide people with answers to their Medicare questions, as well as to provide targeted educational pamphlets, flyers, and Medicare + Choice health plan comparison information upon request. The toll-free telephone services operators are now available 24 hours a day, 7 days a week to assist callers with questions and provide referral services. The phone number is 1-800-MEDICARE (TTY/TDD 1-877-486-2048). The operators and automated response line can respond to English and Spanish language inquiries.

Because the telephone service is one of the more expensive components of NMEP, CMS devised a strategy to optimize funds by working to direct inquiries to different tiers of customer service representatives depending on the complexity of the callers' questions.

Background

The toll-free call center number (1-800-MEDICARE or 1-800-633-4227) was introduced in October 1998 in the 5 pilot states with callers having 24 hour access to the automated information and the ability to reach customer service representatives during regular business hours. The pre-recorded information helps callers request Medicare publications, phone numbers and other general Medicare information. The service accommodates both English and Spanish-speaking callers and offers a TTY line (telecommunications device for the deaf and hearing impaired): 1-877-486-2048. This phased implementation allowed CMS to obtain feedback from callers to improve operations before national implementation. By March 1999, all people with Medicare had access to 1-800-MEDICARE. During 1999, calls were not as frequent as had been estimated, with 1.9 million calls being received.

In response to caller requests, customer service representatives could order "print-on-demand" publications in 2000 from Medicare Health Plan Compare (with health plan information specific to the caller's residence) and mail them to callers. Approximately 3.7 million calls were received in 2000.

In 2001, 1-800-MEDICARE expanded its operations. Customer service representatives are now available 24 hours a day / 7 days a week. In 2001, 4.9 million calls were received. In addition, the new personal plan finder capability was added to the customer service representatives (CSR) portfolio to assist callers looking for help in making health plan choices. A series of commercials in English and Spanish were developed to increase beneficiary knowledge about 1-800-MEDICARE and their options in Medicare.

The National Media Campaign generated increased call volume to 1-800-MEDICARE. By February 2002, call volume had leveled off after an initial spike with the National Media Campaign. (See Chapter XIV for a more complete description of the National Media Campaign). Six call center sites were operational: Davenport and Waterloo, Iowa; Indianapolis, Indiana; Suffolk, Virginia; Columbia, South Carolina; and Peoria, Illinois. There were also 621 customer service representatives available. From January 2002 through April 2002, 1,760,000 calls were received. Generally, the first quarter yields the lowest number of calls, so it is anticipated that the number of calls in 2002 will far exceed 2001 call volumes, especially if new initiatives such as a Medicare Prescription Card Program are implemented.

Assessment Strategy

In addition to examining data collected through the calls, including performance on 25 different indicators, such as length of call and service level, CMS contracted with Abt Associates Inc. from 1998 to Spring 2001² to conduct a customer satisfaction survey and mystery shopping:

- In the customer satisfaction survey, 1-800 toll-free line callers are recontacted. This survey provides information about the topic of the call, the satisfaction with the information/service provided, and the demographics of the caller.
- “Mystery Shopping” is a technique by which anonymous assessment calls are placed by individuals pretending to be a friend or a relative of a beneficiary.

² Currently, KPMG Consulting is continuing the assessment of 1-800-MEDICARE.

Mystery shoppers ask a series of questions for which specific answer comments are pre-identified, and record information about the accuracy and consistency of answers, the appropriateness of referrals, and the courteousness of the customer service representatives (CSRs). The purpose of mystery shopping with 1-800-MEDICARE is to determine whether the customer service representatives (CSRs) can use the desktop scripts that CSRs access to answer questions or assist in interpreting a script to fit the question being posed. The assessment is not a test of the 1-800-line desktop; rather, it is a test of the CSR's ability to appropriately use the scripts to give complete and accurate answers to the caller's questions. By virtue of asking the same question hundreds of times, the accuracy and the consistency of answers can be assessed. CMS and Abt Associates Inc. have jointly selected topics and answer components to all questions asked by mystery shopping callers to 1-800-MEDICARE. Over time, the emphasis has switched to focus on the content of the answer, rather than on the CSR qualities (e.g., courtesy, opening and closing, etc.). This is because the CSR courtesy evaluations has improved consistently over time and now show very good results. There are also some additional assessment tools that assess CSR courtesy and interaction skills.

Findings/Improvements Made

The NMEP Community Monitoring survey includes questions regarding the usage of 1-800-MEDICARE.

- The 2001 NMEP Community Monitoring survey indicates that 14 percent of people with Medicare call a toll-free number to obtain information about Medicare, with 6 percent calling 1-800-MEDICARE. This is an increase of almost 2 percentage points from the 2000 survey.
- Survey data also indicate that factors associated with lower 1-800-MEDICARE usage among people with Medicare include: being older; having less education; and not having noticed publicity about Medicare changes.

Over 3,719 caller satisfaction surveys have been conducted from start-up (November 1998), through January 2001. In general, callers are satisfied with the service provided by the Medicare representatives.

- Of all callers: 61 percent are very satisfied; 24 percent are satisfied; 3 percent are neither satisfied nor dissatisfied; 5 percent are dissatisfied; 5 percent are very dissatisfied; and 2 percent refused to answer this question.³
- Overall, the majority of callers who spoke to Medicare customer service representatives report that their calls are handled well: about 47 percent of the callers rate the overall performance as excellent; 34 percent as very good; 13 percent as good; 4 percent as fair; and 1 percent as poor.
- Regarding specific characteristics, the majority of callers rate all characteristics as either excellent or very good. Callers are the least satisfied with the thoroughness of knowledge of Medicare program information (27 percent rated this as fair or poor). During the review period, the scope of questions 1-800-MEDICARE was equipped to answer was limited to basic Medicare information and managed health care plan information.
- Overall, 57 percent of the 1-800-MEDICARE callers find the automated system easy to use, 23 percent find it confusing, 4 percent find it neither easy nor hard, and the remaining 10 percent had no comment. The reasons callers gave for confusion with the automated system include: no option matched their concern, they wanted to speak to a live person, there were too many options, the recording went too fast, and they did not understand how to use the system or what was being said.

³To provide some comparison in terms of the satisfaction levels, we looked at two questions on the Medicare managed care Consumer Assessment of Health Plans (CAHPS) Survey. On the CAHPS survey there is a question about whether the person with Medicare called the health plan's 1-800 number and whether there was a problem getting help. Close to 31 percent of the respondents called their plan's 800 number and 66 percent of those using the number said that it was not a problem to get help.

- The callers' assessments of how well their questions were answered were overall positive: 73 percent of the callers felt that all their questions had been answered; 19 percent felt they had some of their questions answered; and 6 percent felt that none of their questions had been answered.
- When asked to indicate how much trouble they had to go through to get all the information and answers they wanted, including if they were referred to another number, 41 percent said they went through no trouble at all, 24 percent went through a little trouble, 21 percent went through some trouble, and 13 percent went through a great deal of trouble.

Approximately 2,500 mystery shopping calls were conducted from the start-up of the pilot (November 1998) through mid-March 2001. Mystery callers complete worksheets, which are checked for completeness. Since December 1999, mystery shopping of 1-800 MEDICARE has indicated that customer service is consistently high, and that inaccuracies in the answers are rare (only when the CSR didn't read from a script). During the period from December 1999 to March 2001, 91 percent of the calls were rated as understandable by the mystery shoppers. Eighty-five percent of all callers receiving a referral also received some information from 1-800-MEDICARE. The overall courteousness of the CSRs was rated very high with 94 percent of calls opening and closing courteously.

Almost all of the answers to calls included correct information. Although over time the completeness of answers to questions has improved, there has been some variation across customer service representatives in terms of how they have answered specific questions. As an example, one question that has been asked 582 times is "My parents are considering joining an HMO, but lately I've been reading about HMOs changing their benefits or dropping out of the Medicare program altogether. If my parents join a plan and later it reduces benefits or leaves the Medicare program, what will happen to them?" Each time the question is asked it is phrased slightly differently. The following are some

of the key answer components provided, with the frequency that the particular component was mentioned by the CSR during a call:

- If an HMO discontinues Medicare, you can return to original Medicare or enroll in another Medicare HMO. (86%)
- If an HMO discontinues Medicare, you are still covered by Medicare; there are options for the types of Medicare coverage available to you. (67%)
- If an HMO discontinues Medicare and you return to original Medicare you can purchase a Medigap policy A, B, C or F within 63 days after your HMO coverage ends. (20%)

The assessment of 1-800-MEDICARE suggests that customer service is very high and that CSRs do an excellent job answering the more straightforward questions. The majority of the calls to 1-800-MEDICARE are fairly simple, straightforward questions. As illustrated in the above example, the assessment of data from the 1-800-MEDICARE mystery shopping indicated that there is room for improvement in providing more complete answers to complex questions – few calls include all of the information that could be conveyed – and in providing more consistent answers. Also, the assessment of 1-800-MEDICARE mystery shopping data indicated that referrals given for the same question were inconsistent, although most were appropriate.

Based upon feedback received, a number of improvements have been made to the 1-800 number. These improvements include: streamlining the desktop scripts that CSRs access to answer questions; enhancing training for the customer service representatives; simplifying the automated response unit and including instructions about how to use the voice prompts in *Medicare & You 2000* and subsequent Handbooks; and increasing the publicity about 1-800-MEDICARE. Inquiries that CSRs receive have been evaluated to increase the number handled by the automated response unit. The effort doubled the percentage, from 20 to 40, that are handled by the automated response unit, for a savings of about \$5.00 per call.

Several new initiatives began in October 2001. The first initiative expanded the availability of the 1-800-MEDICARE with CSRs answering the phones 24 hours a day, 7 days a week. The second initiative involved a two-tier system to address callers' needs. Routine questions are answered by a CSR at the tier 1 level. If the questions are more complicated, they are referred to a tier 2 level CSR to answer. The tier 2 level CSRs are more highly trained than the tier 1 level CSRs. The CSRs are able to give information to people with Medicare on plan choices using a new Medicare Personal Plan Finder -- a way for people with Medicare to increase their options in finding a Medicare health plan.

Another feature of the 1-800-MEDICARE is the Print-on-Demand. This allows the text that the CSR is reading from and referring to during the call to be printed and sent to the caller.

CMS is continuing to assess the 1-800-MEDICARE to make future improvements in its operations. Since January 2002 we have been making 75 calls per week through mystery shopping. In 2002, mystery shopping analysis has focused upon CSR comprehension and accuracy more than the procedures or the mechanics of a call. Recent data (March 2002 calls) indicates that for Tier 1 CSRs, superior ratings were given for active listening (86%), ability to paraphrase issues (70%), ability to ask probing questions (66%), and comprehension of caller's concerns (46%). During this period for Tier 2 CSRs, superior ratings were given for active listening (84%), ability to paraphrase issues (70%), ability to ask probing questions (65%), and comprehension of caller's concerns (62%).

CHAPTER VI

INTERNET ACTIVITIES

CMS' website, www.medicare.gov, includes information about eligibility, enrollment, benefits and services, Medicare + Choice health plan comparisons, telephone numbers of Medicare related agencies, nursing home comparison information, ESRD comparison information, and general and comparative information on Medigap and Supplemental insurance.

Background

In March 1998, CMS launched its beneficiary oriented Internet site, www.medicare.gov. In 1999, the website was enhanced by the addition of Nursing Home Compare. In 2000, a number of new products were added to the website, including: (1) "Medigap Compare," which allows beneficiaries to find private health insurance plans that supplement Medicare; (2) "Participating Physician Directory," which includes the name, specialty and location of physicians who agree to accept assignment for all Medicare beneficiaries; (3) the "Prescription Drug Assistance Program," which includes a number of programs that assist beneficiaries with drug expenses (e.g., Medigap plans, Medicare + Choice plans that offer drug coverage, State pharmacy assistance programs, drug company assistance programs, programs offered by organizations for specific diseases, and community-based programs); and (4) a Spanish version of Medicare Health Plan Compare.

In 2001 the website was enhanced by the addition of "Dialysis Facility Compare," and the Medicare Personal Plan Finder - a new decision-making tool which helps people choose the health plan that best matches their needs. Other enhancements include:

- Users can now order publications online.
- A listserv was developed to allow people to subscribe to and receive routine email updates and information about site changes.

- A customer service tool was added which allows users to search for answers to their questions. If the site does not contain the information the user is seeking, there is a direct online “Ask a question” feature which CMS staff monitor and respond to user questions on a daily basis.

Assessment Strategy

Continuous assessment activities for the Internet site include automated tracking of utilization, on-line users “bounceback” surveys⁴, computer lab sessions followed by focus groups, and an expert review of the site by website designers and reviewers familiar with healthcare issues⁵. The methodology behind the bounceback form is to allow visitors who access the website the option to complete an online survey. A limitation to this online survey is that the site does not prohibit a visitor to the site from completing the survey multiple times, because users visit websites multiple times for different reasons. Additionally, the bounceback survey is optional so it does not represent all visitors to the site.

Findings/Improvements Made

The use of the Internet by people with Medicare is increasing. The percentage of people with Medicare with access to the Internet has increased from 6.8 percent in 1997, to 21.3 percent in 1999, to 28.5 percent in 2000 (Centers for Medicare & Medicaid Services 1997, 1999, 2000). According to the NMEP Community Monitoring Survey, the percentage of people age 65 or older with Medicare using the Internet to seek Medicare information has increased from 1.4 percent in October 1998, to 3.0 percent in February 2000 - and remained essentially the same in February 2001. Among this group, Internet

⁴ A bounceback form for the website was initiated in April 1999. The purpose of the bounceback form was to elicit systematic response from Internet users who have “visited” the website and to collect a demographic profile of the users.

⁵ CMS has been funding Westat through a subcontract with KPMG Consulting to conduct the bounceback forms and the computer lab sessions/focus groups.

usage for Medicare information is negatively associated with being older, being female, having less education, and having poor knowledge of the Medicare program.

During the first quarter of 2002, the www.medicare.gov site received 24,004,095 page views (37,394,378 hits), a significant increase over the previous year. The www.medicare.gov site received 7,726,364 page views⁶ (20,269,022 hits) for the first quarter of calendar year 2001. In comparing the www.medicare.gov website to other DHHS websites for the same time period, www.4woman.gov, the official website for the National Women's Health Center which is part of DHHS' Office of Women's Health, received 3,123,003 page views (13,865,618 hits). The Office of Public Health Service's Office of Disease Prevention and Health Promotion website, www.healthfinder.gov, received 4,390,537 page views (18,225,233 hits) for the same time period. Total page views received for 1999 totaled 10.6 million, for 2000, 21.9 million page views and for 2001, 39.7 page views were received.

Since the inception of bounceback forms in April 1999, through mid-March 2001, 16,693 bounceback forms were filled out.

- The largest group of respondents to the bounceback survey are current or soon-to-be people with Medicare (38 percent), followed by relatives or friends of people with Medicare (27 percent), and health professionals such as social workers or nurses (25 percent).
- Most users find www.medicare.gov user-friendly.
- Approximately 85 percent of users filling out the bounceback form indicate that the site contains useful information, and approximately 88 percent of users indicate that the site is easy to use.
- Visually impaired focus group participants thought www.medicare.gov was well designed for use with assistive technology.

⁶ A page view counts a page as a whole regardless of the number of images or other files that page contains.

- Overall, the expert reviewers judged the content of the site favorably; still, recommendations were made to modify the presentation of the information in a more “consumer-oriented” manner.

There are a number of improvements that have been made based on feedback received from users of the site and the expert review. Participants in the computer lab sessions and focus groups did not notice the search engine and had problems finding some of the information available on the site, for example, telephone numbers. Participants made recommendations about keeping the use of graphics to a minimum for faster loading. Expert reviewers of the content area suggested less use of jargon, bureaucratic language and acronyms, and more description about specific links such as “Wellness” and “Medicare Compare.” Some of the improvements that have been made based on feedback received include: simplifying language; enhancing searching capacity; and making the publication section more user friendly for novice Internet users or those using assistive technology. Additionally, recent changes have been made to change the look, navigation and feel of the site to make it more user-friendly. Changes include shrinking the image sizes to enable faster response times to pages; making it even more user-friendly for the visually impaired; and making printing from the site easier.

Since its inception in the Spring of 1998, www.medicare.gov has received numerous awards for its outstanding service to people with Medicare (Attachment D).

CHAPTER VII

REGIONAL EDUCATION ABOUT CHOICES IN HEALTH CARE (REACH) CAMPAIGN

The REACH Campaign is a national education and publicity campaign implemented at the local level by CMS' Regional Offices and their partners. The purpose of the campaign is to ensure that people with Medicare receive accurate and reliable information tailored to meet community needs. Regional Offices partner with trusted community-based groups to promote awareness of 1-800-MEDICARE, www.medicare.gov and other local support services that can help beneficiaries make good choices. The REACH Campaign is also focused on helping the most vulnerable Medicare beneficiaries; large amounts of Campaign resources are directed toward underserved communities (low-income, ethnic minorities, etc.) and beneficiaries impacted by plan withdrawals. The Campaign includes localized mass media programs and advertisements, face-to-face presentations, health fairs, call-in radio shows, as well as hundreds of other outreach opportunities.

Background

Regional Education About Choices in Health (REACH) is the localized outreach component of the NMEP. Since 1998, each of CMS' 10 Regional Offices, working with numerous state and community level coalitions and partners, has conducted educational and outreach efforts at the regional, state and local levels to inform beneficiaries (and others) about Medicare + Choice (M+C) options and Medicare. The REACH campaign has become increasingly more sophisticated in its approach by leveraging partners and local media to target specific groups such as African-Americans; American Indians; Hispanics; Asian and Pacific Islanders; and rural people with Medicare. The REACH campaign and its partners engage in a multi-faceted approach to educating these groups. Print, radio and television media promote awareness of Medicare choices, and live events such as public presentations and exhibits at local health fairs are used to provide more detailed information and support to those who are particularly vulnerable.

Two-day train-the-trainer workshops were held in 1998 in each Regional Office city in

preparation for the Fall 1998 outreach campaigns and health fairs. These workshops have continued each year with the addition of two new components in 2001: translation of basic materials into Spanish, and training modules translated into web format for access on the Internet.

REACH education activities range from small presentations in senior centers or church-based meetings to large-scale health fairs. REACH education activities include informing beneficiaries and caregivers in crisis situations, such as plan non-renewals or hospital closings. While in the first two years of REACH (1998 and 1999) the focus was on live events (presentations, meetings, health fairs), beginning in 2000, media events have played an increasingly major role in the program. These media activities include paid public service announcements (PSAs), radio talk shows, Q & A columns in newspapers, and other types of radio and TV events. Since 2000, REACH has been nationally coordinated through national and Regional Office business plans, consistent messages, and campaign parameters regarding commonly-agreed upon goals and objectives. However, because implementation of REACH occurs at the local level, the Regional Offices rely upon CMS' invaluable partners to carry out REACH activities, so that as many people as possible may be "reached by REACH." These partners include traditional ones, such as fiscal intermediaries, carriers and SHIPS, as well as the myriad of other types of partners (businesses, national and local non-profit organizations) and coalitions.

Assessment Strategy

In 1999 and 2000, a wealth of data on the REACH campaign was collected through direct observation of activities and interviews of outreach staff and event attendees using structured protocols. These data were used to establish a baseline for performance measurement to analyze activities and identify best practices.

Findings/Improvements Made

Abt Associates Inc., the contractor for the national evaluation of the REACH in both

1999 and 2000, compiled the data received from 2,825 Audience Feedback Forms sent from the Regional Offices for all live event types of activities. The data findings were overwhelmingly positive. For example: 85 percent of those attending a health fair or an exhibit said they would recommend it to a friend or relative; 92 percent of people with Medicare attending a presentation, or an education or training activity said they would recommend it to a friend or a relative. Most of the people with Medicare (79 percent) would definitely attend a similar event in the future.

Abt concluded that conducting live events (such as health fairs and public presentations) was very valuable in addressing the special needs of small populations and in difficult situations, such as plan non-renewals. However, Abt determined that it is not a cost-effective strategy for mass education about Medicare. Abt recommended that social marketing techniques be employed to determine which type of events are most suited to the differing information seeking behavior within segments of the Medicare population.

Abt also recommended that mass media would be the best way to reach a large majority of the people with Medicare who are considered passive and reactive information seekers. CMS agreed with this assessment and concluded that increasing media activities would be substantially more cost effective than health fairs and presentations. The 2001 REACH business plan reflects this shift in emphasis. Despite this general premise, the data also indicated that people with Medicare react very positively to health fairs and presentations in special situations where a live event is an effective approach.

In 2000, the Regional Offices worked diligently to strengthen existing partnerships and to establish new relationships with non-traditional partners. The assessment of the campaign revealed several positive findings about partnering activities. Multi-site secondary partnering activities were used to expand the “reach of REACH.” Many of the Regions were able to partner effectively with large employers, thus mobilizing a large number of human resource professionals to provide information and counseling to current and retired staff, as well as caregivers and pre-beneficiaries. Additionally, there

was an increased coalition building among community-based organizations serving diverse populations. Often these organizations are able to help CMS better understand the information needs of these special populations and the most effective vehicles for reaching them, while providing a viable information conduit in the process. For the 2001 REACH, CMS continued to improve in this area by the expansion of measurable goals for developing new partnerships and by targeting REACH activities according to the information needs of their populations.

In 2001, the REACH campaign took the charge of a “nationally coordinated campaign” to a higher level by further evolving the process of planning and setting strategies. The Regional Offices continued to be held accountable for implementing activities and leveraging partners. The Central Office also worked to provide consistent direction, staff resources, national materials, assessment, and overall campaign coordination.

Quantitative criteria and social marketing research were used to help identify the most efficient campaign activities for investment. The Regional Offices continued to conduct live events, including face-to-face events, presentations, and health fairs in the appropriate “niche” settings identified by the earlier assessment research. There was an increased use of partnerships and coalitions, especially focusing on the vulnerable populations to provide ongoing, reliable sources for basic Medicare information.

For the 2001 program, Barents Groups of KPMG Consulting and Westat, Inc. conducted a partners assessment for CMS. The Barents-Westat teams conducted interviews with REACH staff in all CMS Regional Offices (ROs) and with a sample of 120 REACH partners (12 within each of the 10 ROs). The following are some of the key findings of that partners assessment.

- Most of the ROs have included partnership efforts as a core business process for REACH and related programs. In these cases, all Beneficiary Services Branch staff have a defined set of responsibilities for partnership strategies, or a team is specially designated to use partnerships to achieve the related goals of the REACH Business Plan.

- Effective partnerships benefit REACH because they leverage resources, provide access to new or underserved audiences, and promote outreach that meets local needs. In many areas, partners drive REACH in the sense that their programming (with some adjustments in messaging or materials distribution) is key to helping the RO meet its REACH goals.
- Traditional partners (i.e., State Health Insurance Programs (SHIPS), Quality Improvement Organizations (QIOs), Carriers, and Fiscal Intermediaries (FIs)) generally have long-standing relationships with the ROs and with one another. State-based coalitions of these partners are common in many Regions and the coalitions are instrumental in pooling resources and expertise, offering an opportunity for networking, and avoiding duplication of effort. However, these coalitions have lost ground in some states due to recent changes in Customer Service Plan (CSP) funding to FIs and Carriers and new outreach priorities for QIOs.
- Regions where partnership development and partner relations have been more successful appear to have stronger communication processes. The ROs' state liaisons initiate frequent contact with key partners and respond promptly to all partner calls. In addition, these ROs produce partner newsletters, legislative updates, and Medicare updates for the press and general public. Timely and regular information is a core requirement.

The Barents-Westat team found that partnering was an integral practice to the REACH program and they listed recommendations that both the CO and the ROs could use to incorporate in future REACH programs. One rationale for partnering in REACH has been to conduct successful outreach efforts for underserved populations. The assessment contractor found that there are several Regions in which significant progress has been made in a short time to develop programs for underserved populations, underscoring the potential for growth in this area. In cases where population-specific partnerships exist, REACH staffs have usually sought them out to address known deficiencies in outreach to that underserved population. In other cases, traditional partners have helped make

connections. Some grew out of coalitions where both the RO and the partners were members.

Many partnerships and activities with partners extend to issues beyond REACH priorities, such as assistance with referrals for difficult cases. This expansion of partnerships to include other CMS issues is to be expected with the traditional CMS-funded partners. Where it happens with new and/or non-traditional partners, it can be interpreted as an indicator that the partnership program is providing broader benefits to overall beneficiary relations. ROs and many partners indicate that the emphasis on specific goals for new partnerships has had a positive impact on REACH, on outreach in general, and on the image of ROs as wanting to work cooperatively with other organizations. Directing ROs to develop new kinds of partnerships has helped provide focus for Regional staff, opening the door for them to evaluate gaps in their partner network and what they have to offer as a partner in the REACH program. In 2002, the ROs will continue to expand partnership activities.

CHAPTER VIII

NATIONAL ALLIANCE NETWORK

CMS created an alliance with more than 100 national public and private sector partners (including associations, advocacy groups, state and federal government offices, and employers and unions) to work with us to create awareness of Medicare related choices, information resources, and assist in the creation of educational tools. The alliance meets quarterly. The Partners' website features current information on program activities and important program statistics.

Background

To expand its reach to people with Medicare, CMS took the bold step of establishing the National Alliance Network as one of several components developed in 1998 as part of the NMEP. CMS' concept of developing a partnership with external organizations was an original concept for this Agency. Rather than act alone, CMS focused on obtaining commitments from a cross-section of organizations, including advocacy groups, health plan organizations, providers, insurers, employers and unions. To forward the goals of the NMEP and educate people with Medicare, a CMS partners network was designed as a "proactive alliance that helps each member organization improve program outcomes," with the plan that "Partners will join CMS to create a coordinated network to reach from the national level down to each community and home in America." CMS and the member organizations were united in a common bond to bring accurate and timely information about Medicare + Choice to their own members and audiences.

Membership in the National Alliance Network is comprised of a diverse yet coordinated effort of organizations and industries. Organizations became part of the National Alliance Network in different ways. Some organizations had already worked with CMS on a regular basis, or at least with each other. Within 60 days of the initial call to action, approximately 70 national and community-based organizations responded to CMS, showing the importance of the Medicare & You campaign.

The multi-faceted approach to educate people with Medicare using the organizations in the National Alliance Network includes: a website, publications, forums, training sessions, coalition-building, meetings, publicity and promotion, and innovative partnerships on an organization specific basis.

Currently, the almost 140 partners in the National Alliance Network (Attachment E) comprise a collaboration of health plan and provider organizations, governmental agencies, advocacy groups, major employers and employer associations/coalitions, unions, employee health benefits consulting firms, and organizations with direct contact with people with Medicare. Together, these organizations represent over 94 million Americans.

Assessment Strategy

Effectiveness of the National Alliance Network can be demonstrated in various ways, including: the rapid growth in the number of organizations in the Network; improved access to timely Medicare information by the partners and their respective constituencies; the size and diversity of the populations served by member organizations; building long-standing coalitions; and unique partnering opportunities that have evolved at the national, regional, state, and local levels. Additionally, focus groups and interviews have been conducted with Network members to obtain feedback on the partnering relationship with CMS.

Findings/Improvements Made

Membership in the National Alliance Network has nearly doubled since 1998. The member organizations represent over 94 million Americans – a major outlet/conduit for publicity and promotion of the Medicare & You education campaign. Through the partnering organizations, CMS has found new visibility for the NMEP at no cost. For example, AARP's Modern Maturity magazine has a readership of 55 million; there have been newspaper releases on the toll free number and the website to 55

million readers in 27 states. The Social Security Administration has included Medicare + Choice information in over 50 million annual Cost of Living notices.

Access to Medicare information has improved through collaborations with organizations such as the American Library Association, dissemination of brochures and pamphlets offering guidance to the website, and the implementation of the Network, in general. Over 16,000 libraries house special materials, including Library editions of the principal Medicare publications.

CHAPTER IX

NATIONAL TRAINING AND SUPPORT FOR INFORMATION GIVERS

CMS develops training materials and conducts workshops which have been held in each regional office city every summer since 1998. These provide uniform training to trainers of local, front-line beneficiary information and assistance organizations and partners.

Background

For the past three years, more than 700 individuals from CMS partner organizations across the country have received training about Medicare + Choice and other changes to the Medicare program. The goal is to provide uniform training to the trainers of local front-line Medicare population information/assistance organizations and partners, so that they have the information and tools to teach others in their organizations and communities how to help people with Medicare understand their options. Attendees of these training sessions include staff from CMS regional offices, State Offices on Aging, advocacy groups, Medicare carriers, Fiscal Intermediaries, Peer Review Organizations, the Social Security Administration, State Health Insurance Programs (SHIPs), and State Insurance Departments. The training sessions are designed to support information intermediaries in their Medicare population education efforts, primarily by sharing Medicare program updates related to the Balanced Budget Act; using technology to stay current on Medicare information; and employing adult learning theory to work effectively with older adults. In 2001, the curriculum for the training sessions consisted of the following modules: All About Medicare in 2001; Rights and Protections for People with Medicare; Medigap and Other Supplemental Insurance; Medicare Program Updates; Coordination of Benefits; Persons Entitled to Medicare Because of Disability; Persons Entitled to Medicare Because of End-Stage Renal Disease; and Training Methodology.

Assessment Findings and Improvements

As a result of feedback from attendees of the training sessions, the training program has been improving over time. CMS is now into the fourth year of conducting train-the-trainer workshops in the 10 Regional Office (RO) cities, assisting these information intermediaries in their efforts. CMS provides consistent up-to-date materials and presents them in 2-day sessions during the summer months. These training sessions have been extremely well received.

- The registrations for the 2000 summer sessions indicated that 73 percent of the attendees use the training materials in their information campaigns.
- The number of participants increases each year, as does the percentage of new attendees; in 2001, the percentage of new participants reached 52 percent.
- Of the participants who completed the evaluation forms for 1999, 2000, and 2001, 97 percent rate the training modules as “Very Useful” or “Useful.”
- Additionally, the participants who completed the evaluation forms for these years rated all satisfaction categories “4” or “5” on a 1-5 Likert scale, with 5 being the highest rating.

For 2001, CMS expanded this training effort to include a Spanish translation of the basic Medicare program training module. Additionally, CMS began developing a Web-based training component. The Web-based training component is designed to supplement the workshops, meeting the Medicare training needs of information intermediaries and partners who do not attend the workshops in person. In 2002, seven modules were developed: 1) All about Medicare in 2002, 2) Rights and Protections for People with Medicare, 3) Medigap and Other Supplemental Insurance, 4) Current Medicare Topics, 5) Coordination of Benefits, 6) Medicare Entitlement Because of a Disability, and 7) Medicare Coverage for Kidney Dialysis and Transplant Services. The first three modules have been adapted to the web-based training. Modules 1 and 3 have been translated into Spanish. A National Train-the-Trainer workshop held June 5-6, 2002 reviewed the modules.

CHAPTER X

ENHANCED BENEFICIARY COUNSELING FROM STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPS)

SHIPs are organizations that are supported from CMS grants to States. SHIPs provide free personal health insurance counseling and assistance to people with Medicare. Primarily staffed by volunteers, the SHIPs provide local, individual in-person and phone counseling, and group outreach and education about Medicare and other forms of health insurance.

Background

Active SHIP programs exist in all 50 States; Washington, D.C.; Puerto Rico; and the Virgin Islands. Approximately two-thirds of the programs are sponsored through the State Units on Aging, and one-third are administered through the State Insurance Department. SHIP services are facilitated through about 1,000 local sponsoring organizations, primarily Area Agencies on Aging. The number of volunteers trained to counsel people with Medicare has been increasing. There are over 500 paid full or part-time staff at the State and local levels, and more than 12,000 highly trained volunteer counselors. All SHIPs have Internet access and 50 SHIPs have toll-free lines.

Assessment Strategy

Assessment activities include interviews with all state SHIP directors, monitoring of changes in volume and content of counseling sessions, and Medicare population survey questions. The monitoring work to date points to the need to develop standard performance measures to assess and evaluate the activities and effectiveness of the SHIPs. Revised performance measures have been identified and pilot tested, and are in the process of being implemented nationwide.

Nearly 2.6 million people with Medicare are served annually through telephone and face-to-face assistance and outreach activities. The kinds of topics brought to the counselors by this Medicare population have been changing. In past years, the traditional Medicare program created confusion around payment, and people with Medicare commonly arrived

at SHIP offices with “shoeboxes” full of bills, statements, Explanations of Medicare Benefits, and cancelled checks to be sorted out. With improvements in traditional Medicare benefits coordination, fewer people with Medicare need assistance with claims, but counselors’ impressions are that more now need help understanding managed care and choosing supplemental and M+C plans.

Findings/Improvements Made

The SHIP Resource Center data shows that about three-fourths of consumer contacts with SHIPs are by telephone. From Spring 2000 to Fall 2000, reports show that 440,050 contacts by telephone were made to SHIP counselors; from the Fall 2000 to Spring 2001, the data shows that 471,334 contacts were made.

Findings indicate that approximately 85 percent of those who received counseling (SHIP and other sources of counseling combined) are “very satisfied” or “satisfied” with the service.

In addition to the one-on-one counseling provided to people with Medicare directly, monitoring activities in the NMEP case study sites confirm another important impact of the SHIP programs. Interviews with many local organizations, state partners, and CMS/regional officials indicate that the SHIP organizations have consistently made important contributions to the NMEP organizational and implementation efforts at state and local levels. Their experience and awareness of Medicare population needs, as well as their willingness to assume important state and local roles in NMEP activities, had a notably positive impact upon the success of the CMS partnership strategy.

From 1999 to 2001, several issues have emerged as key to the SHIP program. These include: the National Performance Report with new measurement areas of media, outreach activity, client demographics and staffing; increased SHIP services to younger, disabled beneficiaries; implementation of SHIP national standards in counselor training;

increased inter-state partnership development; outreach and public education; and implementation of a SHIP resource center to promote best practices.

In September/October 2001, a SHIP website was developed: www.shiptalk.org. Another new SHIP initiative is the customer service program to provide outreach information to disabled Medicare eligibles.

CHAPTER XI

CROSS-CUTTING AND COMPREHENSIVE ASSESSMENT OF THE EDUCATION EFFORTS

In addition to conducting an assessment of each of the individual NMEP information channels, a key monitoring activity examines six communities⁷ to learn how various NMEP components work together at the local level.

Background

The purpose of the NMEP is to create awareness and understanding of health care choices. To evaluate the NMEP, six markets were selected where M + C choices were available to people with Medicare. Important background information is how these insurance markets have changed during the course of the MMEP. In the six case study sites⁸, there were substantial managed care market changes from 1998 to 2002. These changes included fewer available Medicare managed care plans over this period, reductions in benefits, increases in premiums and other charges, and disruptions in provider networks.

Over the five-year study period, the number of Medicare managed care plans offered in the six sites has dropped from 29 to 13. At the end of 2000, the two plans available in Sarasota withdrew, leaving it “abandoned;” three of the other sites also experienced plan terminations. In these sites, the smallest plan(s) withdrew. Additionally, access to managed care plans became more difficult in two sites. In Tucson, where two plans with lower membership terminated at the end of 2000, a remaining plan closed enrollment into one of its products. In Olympia, where another small plan withdrew, a remaining plan instituted capacity limits, thereby potentially limiting enrollment. All

⁷ Five of the communities were in the pilot states and one community was in a non-pilot state.

⁸ The sites include Dayton, OH; Eugene, OR; Olympia, WA; Sarasota, FL; Springfield, MA; and Tucson, AZ.

plans in the case study sites reduced their benefits and/or increased their charges for 2001. In the Spring 2002, there were still 13 managed care plans available in the six sites.

Plan terminations and major benefit or network changes were the main factors causing people with Medicare to switch plans or to return to the Original Medicare Plan. A cohort of aged people with Medicare who have continuously lived in each site since July 1998, has been tracked. In Olympia and Eugene, the most stable sites in terms of managed care offerings, 86 percent and 88 percent of people with Medicare who were in a managed care plan at the beginning of the study in July 1998 were still in the same plan as of February 2001, respectively. The experiences of many beneficiaries in Tucson, Dayton and Springfield have been quite different. In those sites, 45 percent, 56 percent and 68 percent of beneficiaries, respectively, who were enrolled in a plan at the beginning of the study were still in the same plan in February. As of February 2001, more beneficiaries in the cohort had left managed care for the Original Medicare Plan than had switched from Original Medicare to a managed care plan. From July 1998 to February 2000, 8.4 percent of people with Medicare with managed care experience switched to the Original Medicare Plan, while over the following year 12.2 percent switched to the Original Medicare Plan. On the other hand, from July 1998 to February 2000, 4.2 percent of people with Medicare who were enrolled in the Original Medicare Plan changed to managed care, whereas only 1.0 percent changed to managed care during the following year.

During the 2001-2002 enrollment year, there were far fewer withdrawals of Medicare managed care plans from the six markets than in years past. However, in several sites (notably Springfield and Tucson), the one or two dominant plans remaining continued to make fairly dramatic changes in coverage, co-payments and premiums, which had a noticeable impact on media coverage as well as people with Medicare's experiences, perceptions and information-seeking behavior.

Table 2 contains information about managed care penetration and the number of managed care plans available over this period.

Table 2: Medicare Managed Care Enrollment and Number of Plans by Study Site -- 1998 - 2002

	<i>1998 Managed Care Penetration</i>	<i>2000 Managed Care Penetration</i>	<i>May 2002 Managed Care Penetration</i>	<i>1998 Medicare Plans in Study Site</i>	<i>2000 Medicare Plans in Study Site</i>	<i>May 2002 Medicare Plans in Study Site</i>
Dayton, OH	16.8%	16.5%	15.7%	4	3	2
Eugene, OR	45.9%	45.0%	37.5%	4	3	3
Olympia, WA	37.2%	41.4%	30.5%	4	4	3
Sarasota, FL	12.1%	11.3%	NA	4	2	0
Springfield MA	21.3%	21.6%	19.7%	6	3	3
Tucson, AZ	48.8%	49.1%	35.9%	7	4	2

Source: Centers for Medicare & Medicaid Services, Group Plan Files.

Assessment Strategy:

Abt Associates Inc. was the contractor responsible for conducting the case studies from Fall 1998 through Spring 2001. From Fall 2001 until June 2003, Ketchum, Westat, and Barents Group will conduct the case studies sites assessment. The community case studies include interviews and focus groups with key information providers, as well as

surveys and focus groups with people with Medicare living in these communities, and extracts of the CMS Enrollment Data Base (EDB).

NMEP Community Monitoring Surveys have been conducted with beneficiaries in the case study sites in October 1998, January/February 1999, January/February 2000, January/February 2001, and January/February 2002. For each round of the survey at least 2,400 people with Medicare were interviewed.⁹ For the latest survey conducted in January/February 2002, 2,895 beneficiaries were interviewed. The surveys measure beneficiaries' activities in gathering information regarding the Medicare program. Questions also include demographics, health status, Medicare knowledge, and other information about situations that may bear on beneficiaries' probability of searching for information, including changes in health status, death of a spouse, changes in retiree benefits, and being involuntarily disenrolled from a health plan. Survey questions refer to the twelve-month period prior to the survey. The data collected from the case study sites cannot be generalized to the overall Medicare population; however, results from similar questions about beneficiary knowledge and use of the Handbook, for example, in this survey and the Medicare Current Beneficiary Survey -- a national survey -- are similar. Results from the 2002 survey will be available in Summer 2002.

Findings/Improvements Made

There is evidence from the four waves of surveys that many beneficiaries lack a basic understanding of the Medicare program:

- In the 1999 and 2000 surveys, 18 percent and 17 percent of people with Medicare surveyed, respectively, were not familiar with the terms *managed care plan*, *HMO*, or *health maintenance organization*, although managed care existed in all of these communities.
- The percentage of people with Medicare knowing that Medicare does not cover all health care costs has increased from 85 percent in October 1998 to 89 percent

⁹The survey is administered by telephone to English speaking aged and disabled people with Medicare who are 85 years old or less.

in February 2000, and was basically unchanged in February 2001.

- Fewer than half of people with Medicare correctly answered questions about whether joining an HMO meant leaving Medicare.
- With one significant exception, Medicare population knowledge was unchanged from 2000 to 2001. The only area of knowledge that changed was the response to the question, "True or False: Medicare managed care plans are allowed to raise their fees or change their benefits every year?" Forty-two percent of people with Medicare answered correctly in 2001 compared with 36 percent in 2000.

From focus groups with people with Medicare, as well as our interviews with counselors and organizations helping this Medicare population, it is observed that people with Medicare do not have a constant demand for Medicare information. Instead, it appears that most people with Medicare demand information about Medicare on an "as needed" basis. That is, when an event in their life triggers a need for information -- such as initial Medicare eligibility, a change in existing coverage, termination of a health plan and change in health status -- a person with Medicare is motivated to seek information about Medicare. In the 2001 NMEP Community Monitoring Surveys conducted in the case study sites, rates of seeking Medicare information were approximately 77 percent for new enrollees, 89 percent for aged beneficiaries who were involuntarily disenrolled from their health plans, 77 percent for aged beneficiaries whose employer changed retiree benefits, and 73 percent for aged beneficiaries who reported a decline in health. These rates are all higher than the 66 percent rate of Medicare information seeking for the Medicare survey population as a whole.

Based on the 2001 survey data for aged people with Medicare, the likelihood of seeking Medicare information in the case study sites is positively related to being younger, having more than a high school education, having a decline in health, and having a change in their insurance in the past year. Overall, and for almost every specific type of information channel, there is a very strong pattern showing that persons more knowledgeable about Medicare (based on a set of knowledge questions asked on the survey) are the highest

users of information. More knowledgeable persons may choose to obtain more information, or persons accessing more information may become more knowledgeable.

Use of formal and informal sources of information differ by subgroups. For example, people with Medicare living alone are, not surprisingly, more likely to use providers as a source and less likely to use family and friends or plan representatives as a source. Non-white people with Medicare are more likely to use family and friends than whites, and far less likely to use plan representatives.

To monitor the overall education effort, the MCBS includes a number of questions to track (over time) the ability of people with Medicare to get Medicare information when needed, awareness of basic Medicare messages, and perceived level of knowledge.

- Baseline data collected from the Winter 1999 MCBS supplement suggest that 67 percent of people with Medicare had their Medicare questions answered by the information that they received through Medicare information sources¹⁰.
- As part of the 1999 supplement, people with Medicare were read the statement, “Most people covered by Medicare can select among different kinds of health plan choices within Medicare.” Forty-seven percent of MCBS respondents said this statement was true, 10.5 percent said it was false, and 42.4 percent were not sure.
- When read the statement “Medicare without a supplemental insurance policy does pay for all of your health care expenses,” 6.9 percent said this was true, 75.3 percent said it was false, and 17.7 percent were not sure.
- When asked in the Spring 1999 “How much do you feel you know about the availability and benefits of Medicare managed care plans,” 25 percent said “I know everything or most of what I need to know;” 16 percent said “some of what

¹⁰ This includes people with Medicare who went to the following sources to get answers to their Medicare questions: the insurance company that processes Medicare claims; the Medicare office (including the telephone hotline); the Medicare counseling program; and Medicare publications.

I need to know;” and 58 percent said “little or almost none of what I need to know.”

- In contrast, when asked “How much do you feel you know about what medical services Medicare covers or does not cover,” 41 percent said “everything or most of what I need to know;” 28 percent “some of what I need to know;” and 30 percent “little or almost none of what I need to know.”

These and other measures are being tracked over time to measure improvements in the ability of people with Medicare to access information and in their awareness and knowledge about basic features of the Medicare program, including the Medicare + Choice options.

There have been some improvements in beneficiary knowledge over time. The 2000 MCBS results indicate:

- In the 2000 survey, people with Medicare were read the statement, “Most people covered by Medicare can select among different kinds of health plan options within Medicare.” Forty-nine percent of MCBS respondents said this statement was true, 9 percent said it was false, and 42 percent were not sure.
- When read the statement, “Medicare without a supplemental policy does pay for all of your health care expenses,” 4 percent said it was true, 79 percent said it was false, and 17 percent were not sure.
- When asked in the 2000 MCBS survey, “How much do you feel you know about the availability and benefits of Medicare managed care plans?” 28 percent said “I know everything or most of what I need to know;” 16 percent said, “some of what I need to know;” and 58 percent said “little or almost none of what I need to know.”
- When asked “How much do you feel you know about what medical services Medicare covers or does not cover,” 48 percent said “everything or most of what I need to know;” 26 percent “some of what I need to know;” and 25 percent “little or almost none of what I need to know.”

The intensive monitoring of the NMEP pilot and the first two years of national implementation has found that people with Medicare primarily seek information when needed, and are often not responsive to information supplied at other times. Medicare information needs to be targeted to specific populations, or to populations coping with specific situations such as newly enrolling in Medicare, termination of a health plan, or an important health event. CMS is in the process of determining how best to address this important issue more effectively. As part of the Regional Education About Choices in Health (REACH), regional NMEP officials are continuing to develop programs to target specific groups. The monitoring also found that people with Medicare lack basic information about the Medicare program. Thus, CMS is continuing to try to convey this basic information to Medicare beneficiaries through the NMEP.

CHAPTER XII

THE COST OF THE NMEP

For the first three years of the education program (fiscal years 1998-2000), Congress authorized user fee collections from Medicare + Choice organizations in the amount of \$95 million each year. To date, CMS has relied on contributions from other appropriated program funding sources to support a fully operating education program. Section 522 of the Balanced Budget Refinement Act amended the user fee, limiting the maximum amount that can be assessed from Medicare + Choice organizations to a percentage of \$100 million based on the annual average enrollment in Medicare + Choice organizations, starting in fiscal year 2001 and every year thereafter. Application of the new formula equates to user fee collections in the approximate amount of \$17 million in fiscal year 2001 (a \$78 million per year reduction from the first 3 years of the program). Congress, however, made a decision to increase CMS's appropriation in fiscal year 2001, specifically adding \$52 million in program management funds to supplement the \$17 million in user fees.

Budget obligations to date for the NMEP are as follows: \$95.1 million for fiscal year 1998; \$132.9 million for fiscal year 1999; \$120.6 million for fiscal year 2000; and \$124.2 million for fiscal year 2001. For fiscal year 2001, \$30.6 million was available due to a \$25 million reserve in a printing account and \$5.6 million reserve in a postage account that was obligated in previous fiscal years.

Attachment A provides a chart describing how resources are allocated across five major budget lines: beneficiary materials; 1-800-MEDICARE toll-free line; Internet; community-based outreach, and program support services. All of the activities for the education program crosswalk to one of the five budget lines. For beneficiary materials, the following services are purchased to produce the *Medicare & You* Handbook, targeted materials, and other critical materials needed as a result of unanticipated circumstances

such as program changes: printing; postage; translation; consulting; print support (e.g., design); and consumer testing. Funds for 1-800-MEDICARE provide support for call center operations; printing and mailing of requested materials; telecommunications support; and staffing, training and overhead costs associated with calls requiring more expert-level attention. The Internet line item consists of maintenance of current web sites, technology support to improve the accessibility and usefulness of the websites and to make major technological improvements, architecture support, technical support, and e-commerce applications. Community-based outreach encompasses partnership support, education and outreach to special populations, SHIP support, and REACH. The final line item, program support services, includes program assessment; project integration, training, tools, and pilots; the Consumer Assessment of Health Plans Surveys (CAHPS); consumer research and social marketing; knowledge management development and publicity campaign support. Publicity campaign support is a new budget item for FY 2001.

CHAPTER XIII

ADDITIONAL EDUCATIONAL EFFORTS

There are numerous additional educational efforts to inform people with Medicare. Part B carriers, Medicare managed care plans and consumer advocacy organizations, employers and unions, health-care providers, and foundations all provide some type of Medicare education. Part B carriers provide written materials about Original Medicare benefits and quality improvement (Stevens and Mittler, 2000). Quality Improvement Organizations (QIOs) foster educational information on preventive health benefits and rights for people with Medicare (Scala, 2000). Medicare managed care plans incorporate Medicare information as part of their marketing efforts, which includes plan benefits and how managed care works (Stevens and Mittler, 2000). With employer-sponsored group health insurance for retirees, employers and unions educate people with Medicare on aspects of decision-making. Health care providers also are an important source of Medicare information. Doctors, nurses, and discharge planners have direct contact with people with Medicare and can discuss Medicare questions with their patients and their families. Foundations, such as the Robert Wood Johnson Foundation, are beginning to fund initiatives relating to Medicare education (Scala, 2000,2001).

The Center for Medicare Education conducted interviews with other federal agencies, private industry, and charitable health care organizations, to investigate their educational efforts for people with Medicare -- for the Advisory Panel on Medicare Education. For example, the Social Security Administration produced a campaign with the theme of "Medicare From the Caregivers Point of View." SSA developed workshops, videotapes, pamphlets, and newsletters for 13,000 caregivers of seniors. The messages concerned nursing homes, adult day care, dealing with seniors in the community, support systems, and Medicaid eligibility. The cost was approximately \$200,000 per year. SSA is also conducting a consumer educational campaign to increase the awareness of the Social Security system and the availability of the benefits statement. The outreach strategies

used and methods of communication are media, including radio, TV, video; earnings statements to covered workers; a monthly communication packet to 13 field offices; and a call center which receives 250,000 calls per day. The annual cost of the campaign is \$3.5 million for printed material; \$3 million to educate the public; \$61.9 million cost for the earnings statement; and \$10 million for the Public Understanding Measurement System. These figures do not take into account the thirteen field offices; the public affairs specialists, who educate the public; the toll-free line; and the cost of the website.

Other educational efforts include General Motors' targeting GM retirees and those planning to retire. The messages sent were those highlighting retiree health benefits and Medicare benefits. Presentations, a toll-free number for questions, and working with CMS Regional Offices, SHIPs, and PROs are some of the outreach strategies used to communicate Medicare knowledge. The annual cost to GM for this campaign was \$500,000 over four years.

Another campaign involved the Department of Labor, which targeted all employees and those employees covered under ERISA plans. They used a call-in center, outreach seminars, and focus groups to send their explanation of benefit plans. For 2000, the cost was \$1.5 million.

The American Diabetic Association also engaged in an education campaign which targeted approximately six million diabetics over 65 years of age. They developed a Medicare awareness campaign using a national call center and a website. The cost was \$25 million per year.

CHAPTER XIV

NATIONAL MEDIA CAMPAIGN

In Fall 2001, CMS launched a large-scale national multi-media campaign to advertise the Medicare information resources available to people with Medicare, as well as to advertise to this population that they have options in how they receive their health insurance.

The goal of the 2001 campaign was to help the nearly 40,000,000 people with Medicare take advantage of the resources available to them to get answers to their questions about options in Medicare. The campaign highlighted important coverage options and Medicare's improved information resources, including the expanded 24-hour a day, 7 days a week service of 1-800-MEDICARE and new decision tools on www.medicare.gov. The campaign included general market television and print, Spanish language television and radio, and Internet advertising. Leslie Nielsen, a well-recognized actor, starred in the English television ads while the Spanish language television ads featured a grandmother with her daughter and granddaughter to reflect the importance of intergenerational relationships in many Hispanic families.

During the campaign, English and Spanish customer service representative were available 24-hours a day, 7 days a week. More than 1,200 Customer Service Representatives (CSRs) were available in seven sites during peak campaign period. Wait time for a CSR was below one minute; average call time was seven minutes. Average customer satisfaction was greater than 92 percent. During initial airing of the ads, calls to 1-800-MEDICARE increased by nearly 75 percent from a highest call volume day in 2000 — an increase from an average of 32,388 calls to 56,236 calls. Call volume in CY 2000 was 3.7 million and in CY 2001 it was 4.9 million. Call volume during the fourth calendar quarter was 2.1 million. The top ten questions during the fourth quarter concerned: Prescription Drugs, Medigap, Managed Care Plan Disenrollment, SSA Replacement Card, Medicaid, Medicare & You Additional Mailing, Medicare Savings

Programs, Medicare Summary Notice, How Managed Care Works, and SSA Enrollment. During the peak of the campaign, page views for www.medicare.gov were more than double the number of views from the previous year.

Four target audiences were surveyed about the television advertisements: seniors (age 64+); African American seniors (age 64+); Hispanic seniors (age 64+); and Hispanic caregivers. Audiences were surveyed during three key time periods over the course of the campaign: October 2001 (pre-media); November – December 2001 (midpoint): tracking during 1,500- 2,000 points; and December 2001- January 2002 (post-media) to track impact and any “drop off” after the campaign. In addition, a post-media survey of adults age 18-63 years old was also conducted.

- Seniors were asked to rate the ads featuring Leslie Nielsen using a thermometer scale of 1 to 100, where 1 means you have very cold/unfavorable reaction and 100 means you have a warm/favorable reaction -- where fifty is neither warm nor cold. Results show a “soft” overall rating of 56 degrees among seniors. Men gave the ads higher ratings, as did “younger” and more affluent seniors. Respondents ages 18 to 63 gave the ad a much higher rating of 65.
- Recall of the ads and awareness of Medicare’s phone number increased more among respondents self-described as being less familiar with Medicare relative to other seniors surveyed.
- Only 23 percent of African Americans recall seeing the TV advertisements after the campaign ended compared to 52 percent of all seniors.
- There was a modest increase from 39 percent prior to the campaign to 46 percent post campaign of people saying they have seen, read, or heard about 1-800-MEDICARE.
- Caregivers recall of the website was significantly higher than people with Medicare.
- Among Hispanic caregivers, 50 percent claimed to have seen, read, or heard about the 1-800-MEDICARE phone number after the campaign compared to only 38 percent before.

- Hispanic caregivers also showed an increase in knowledge of the website after the campaign. Prior to the campaign, only 13 percent had seen, read or heard about the Medicare website compared to 20 percent after the campaign.

CMS is designing the FY 2002 campaign in order to:

- Increase knowledge of 1-800-MEDICARE so people with Medicare will know where to go to get help with their questions. (“Knowledge” means current knowledge and retained knowledge.)
- Identify the purpose of 1-800-MEDICARE such that people know its purpose, the telephone numbers, and remember to use it when they have a need for it.
- Convey that 1-800-MEDICARE provides accurate, reliable, understandable, and relevant consumer information and resources to help people make informed decisions about their health care coverage.
- Associate www.medicare.gov with 1-800-MEDICARE as the Internet alternative resource.
- Build knowledge of the array of information available.
- Increase awareness of the family of information resources available to get help with questions about Medicare, including 1-800-MEDICARE, www.medicare.gov, the *Medicare & You* Handbook, the State Health Insurance Assistance programs, and other partnerships.

CHAPTER XV

CONCLUSION

CMS' monitoring efforts undertaken over the last three years have been intensive, as appropriate for the scale and uniqueness of the NMEP. The monitoring work has contributed formatively to the evolution of the NMEP, within the basic structure specified by Congress.

The monitoring work to date has indicated that most beneficiaries use some Medicare information and the use of it rose sharply with the mailing of the Handbook in 1998. Some very modest trends in the extent of information usage have also been detected since then, particularly in Internet and 1-800 usage. We know, however, that unmet needs for information still exist as evidenced by: knowledge limitations; lower levels of use for older, low education, and possibly other beneficiary segments; lower satisfaction with information by these and other vulnerable groups. The monitoring work also indicated that personal situations and events such as plan terminations and worsening health have an important effect on increasing demand for Medicare information, and that much of the work of providing information is a local matter, with heavy dependence on information intermediaries, or partners, to service these needs.

CMS's monitoring activities have provided the agency with feedback on the progress of the NMEP efforts and on potential areas for improvement. Over the three years, the activities have provided a deeper understanding of the complexities of informing and educating people with Medicare. CMS has used this information to change approaches as the NMEP program matures. The NMEP evolved from a broad-based educational campaign to a more focused campaign of ensuring that information is available when needed and that people with Medicare and those acting on their behalf are aware of where to access Medicare information when needed. The role of the Handbook in CMS' information efforts is as a reference document; the use of health fairs and other public presentations has become more targeted; and increased attention is being paid to

partnerships and to the media. The role of information intermediaries – the contractors, grantees and other organizations that provide Medicare information – is now more fully understood. Such entities have an important role in the local targeting and delivery of Medicare information. Accordingly, CMS has increased its efforts to support these entities, by developing/improving the CMS websites, partner toolkits, and numerous documents and slides intended specifically for partner use. External events also affected the direction of the NMEP, the most noteworthy being the need to direct resources for information support about managed care plan terminations from the Medicare program.

Changes have occurred not only in the communications mechanisms but also in the monitoring strategies themselves. Based on early monitoring results, questions were added to the NMEP Community Monitoring Survey to study situational segments of people with Medicare (those experiencing plan terminations, changes in retiree benefits, death of a spouse, etc.) and to measure awareness of new program offerings such as the private fee for service option. As the NMEP increased its efforts to reach vulnerable populations, new sampling strata were added to the survey. Over the past three years, the emphasis of mystery shopping the 1-800-MEDICARE helpline has increasingly focused on the content of the answers and the appropriateness of referrals.

The NMEP program will continue to evolve to address the needs of the Medicare population. In Fall 2001, CMS launched a large-scale national multi-media campaign, “Helping You Help Yourself,” to advertise the Medicare information resources available to people with Medicare, as well as advertise to this population that they have options in how they receive their health insurance. The advertising campaign included television, radio, print and Internet ads in English and Spanish. CMS projected that about 95 percent of all Medicare beneficiaries saw the ads at least 30 times during the two month campaign from October 15 through the week of December 9, 2001.

The 1-800-MEDICARE operations expanded to 24-hours a day, 7 days a week. One thousand new customer service representatives were added to ensure that callers got their

questions answered. The service presently accommodates both English and Spanish-speaking callers and offers a TTY line (telecommunications device for the speech and hearing impaired). The telephone line also provides pre-recorded information which can help callers request information about health plans in their area.

The Internet site, www.medicare.gov, expanded its resources with the addition of “Medicare Personal Plan Finder,” a tool to identify local plans, and calculate out-of-pocket costs for different health plan options based on a person with Medicare’s age and health status. In addition to the Medicare Personal Plan Finder, there are nine separate databases to help individuals, including Medicare Health Plan Compare, Nursing Home Compare, and Dialysis Facility Compare. Other informational databases include a list of Medicare participating physicians, medical equipment suppliers, a local Medicare event calendar, and information about available prescription drug assistance programs.

In Fall 2001, Medicare beneficiaries living in zip codes where at least one Medicare+Choice plan is available received a supplemental mailing of area-specific Medicare+Choice plan comparison information.

All of these changes were made to better address the needs of the large and diverse Medicare population. To continue to assess how we are communicating with people with Medicare we have recently added several new assessment activities. These include a regional survey of people with Medicare to get a better understanding of information gaps and information seeking behavior at the regional level; a survey of new Medicare enrollees; and mystery shopping of the SHIP program.

ATTACHMENT A
FUNDING SOURCES

ATTACHMENT B

DATA SOURCES

- ***The Regional Survey of Medicare Beneficiaries:*** This survey measures awareness of how to obtain information via www.medicare.gov, 1-800 MEDICARE, and *Medicare & You* handbook. Key messages, knowledge of region-specific activities, including demographic characteristics and types of health insurance, will be measured. This activity surveys 2,000 people with Medicare per region and provides outcome measures for the REACH 2001 Business Plan.
- ***The Survey of New Enrollees in Medicare:*** This survey measures whether the NMEP educational materials are understood by people new to Medicare, and what materials new enrollees use. This activity surveys 3,600 beneficiaries in a six-month time frame. This information will be useful in redesigning the Initial Enrollment Package and provide information on how to help people with Medicare make health plan choices. About 55 questions are included in the survey; the survey is in English only.
- ***Regional Partners Assessment:*** This survey will produce a report that includes conclusions about the effectiveness of the Partnerships and Coalitions for the REACH campaign. As part of the methodology, the assessment contractor examines two organizations that each Regional Office identifies as partnering organizations working with underserved people with Medicare. The contractor also develops a methodology for determining the level of partner involvement in community outreach. The methodology includes selecting 12 partners per CMS region for a total of 120 partnerships. The assessment looks at best practices, types of partnering, and coalition building.
- ***Mystery Shopping:*** Professional callers place calls to 1-800 MEDICARE with identical questions to test the consistency and accuracy of answers to calls made to a telephone service. Seventy-five calls per week are made.
- ***Mystery Shopping (SHIP Assessment):*** This Mystery Shopping activity assesses the appropriateness of referrals made by the SHIP volunteers in response to specific situations presented by callers.
- ***REACH 2001 Audience Feedback:*** The Regional Offices administer self-assessment questionnaires to attendees at REACH events to evaluate the effectiveness of Region-sponsored outreach events in meeting the needs of people

with Medicare. A minimum of 300 forms per Regional Office are submitted for the campaign period.

- **Case Studies: NMEP Community Monitoring Survey:** This survey consists of a telephone interview in six case study sites - with people with Medicare who are living at home. The sites are: Dayton, Ohio; Eugene, Oregon; Olympia, Washington; Sarasota, Florida; Tucson, Arizona; and Springfield, Massachusetts. The case study sites have been surveyed from late 1998 to 2002. Some groups of people with Medicare have been excluded, such as those whose telephone numbers could not be located, those whose physical or mental impairments prevented telephone interviews, those with End Stage Renal Disease (ESRD), non- English speakers; and those over 85 years of age.
- **Focus Groups:** Focus groups with people with Medicare enable CMS to gain qualitative insight through in-depth questions and discussion. These questions and discussions can be more adaptive to local specifics than is possible through the survey vehicles. Focus groups meet in the six case study sites at various times throughout the year.
- **Enrollment Data Base:** Samples are drawn from a complete list of people with Medicare living in each of the study communities. CMS administrative files provide the basis for this information and telephone numbers are matched for those who could be found in directories. This database includes aged and disabled people with Medicare, dates of eligibility, and movement into and out of managed care plans. The Data Base is updated continuously.
- **In-depth Discussions with Local Medicare Information Suppliers and Other Experts:** Discussions are held with Medicare experts, as well as knowledgeable state officials, and staff at CMS Regional Offices, Quality Improvement Organizations (QIOs), Peer Review Organizations, AARP, hospitals, State Department of Insurance, and Social Security Administration.
- **Media Audit:** The NMEP Media Audit is an effort to evaluate media coverage of CMS messages and program exposure by evaluating the tone and content of print media reporting on Medicare. Tracking and analyzing both the amount and content of Medicare media coverage serves a number of purposes. It allows CMS to: calculate how many opportunities there are for people to be exposed to stories containing information about Medicare, identify which NMEP programs are working best, identify which messages are appearing in the media and which are not, and monitor competing messages to tailor future efforts. The media audit project began in September 1999 with analysis of the top 15 national newspapers and all periodicals in the following local markets: Dayton, Ohio; Eugene, Oregon; Olympia, Washington; Sarasota, Florida; Springfield, Illinois; and Tucson, Arizona.

- ***Medicare Current Beneficiary Survey (MCBS):*** The MCBS is an ongoing, multi-purpose survey of a representative sample of the Medicare population, including both aged and disabled enrollees, whether living in the community or in institutions. The study is sponsored by CMS and is a longitudinal panel survey. Sample persons are interviewed three times a year over several years to form a continuous profile of each individual's personal health care experience. The MCBS is being used to evaluate the progress of the NMEP. To monitor the overall education effort of the NMEP, a supplement to the winter round of the MCBS was added in 1999. Rounds are continuously being added and results are made available on an ongoing basis.
- ***Medicare.gov Bounceback Survey:*** CMS is conducting a survey of visitors to Medicare.gov, with the goal of gaining insight into making site improvements likely to increase visitor satisfaction and loyalty. This survey was developed to provide information on site navigability, functionality, appearance, interactivity and site content. Data collected via the survey are analyzed to identify major indicators of visitor satisfaction and future use of the site and specific areas where improvements can be made.

ATTACHMENT C

MEDICARE TOPIC-SPECIFIC PUBLICATIONS

In addition to the handbook, CMS publishes detailed publications on a variety of topics, including:

Guides to Help with Decision-Making

- Choosing a Doctor
- Choosing a Hospital
- Choosing Treatments
- Choosing a Medicare Health Plan
- Choosing Long-Term Care
- Choosing a Medigap Policy
- Choosing a Nursing Home

Coverage and Benefits

- Kidney Dialysis and Kidney Transplant Services
- Skilled Nursing Facility Care
- Home Health Care
- Hospice Care
- Mental Health Benefits
- Preventive Services
- Pap Test, Pelvic Exam, and Clinical Breast Exam
- Clinical Trials

Payment and Rights

- Medicare Savings Programs
- Does Your Doctor or Supplier Accept Assignment?
- Medicare and Other Health Benefits: Your Guide to Who Pays First
- Outpatient Prospective Payment System
- Pay it Right! Protecting Medicare from Fraud
- Medicare Rights and Protections

ATTACHMENT D
INTERNET SITE AWARDS

- 2001 WWW Health Awards – Silver Medal
- 2001 June - National Health Care Purchasing Institute Health and Government Award
- 2001 June - The Beeline recognizes Medicare.gov as an outstanding website
- 2001 March - Center of Excellence for Information Technology for a well designed and useful Internet site;
- 2000 June - Government Award from Center of Excellence for Information and Technology
- 2000 June - National Partnership for Reinventing Government—Vice Presidential Hammer Award
- 2000 eHealth World Conference—Gold for Best Health Plan Site
- 2000 Surfers Choice Internet Award
- 2000 Web Marketing Association WebAward—Standard of Excellence
- 2000 International Association of Web Masters and Designers
- 2002 eHealthcare Leadership – Platinum Award: Best Overall Site
- 2002 eHealthcare Leadership – Silver Award: Best Health/Healthcare Content
- 2002 e-Government Award – Best Practice Application for the print-on-demand Medicare Personal Plan Finder

ATTACHMENT E

NATIONAL ALLIANCE NETWORK MEMBERS

1. AARP
2. Administration on Aging
3. AFL-CIO
4. Allied Signal, Inc
5. Alzheimer's Association
6. American Association of Health Plans
7. American Bar Association - Commission on Legal Problems of the Elderly
8. American Federation of Teachers Retiree Programs
9. American Hospital Association
10. American Medical Rehabilitation Providers Association
11. American Society on Aging
12. Assisted Living Federation Association of America
13. Baker and Daniels
14. Bell Atlantic Network Services
15. Blue Cross and Blue Shield Association
16. Center for Health Services Research & Policy
17. Center for Medicare Advocacy
18. Citizen Advocacy Center
19. Consumer Coalition for Quality Health Care
20. DHHS, Office of the Assistant Secretary for Planning and Evaluation
21. DC SHIP
22. DOD, TRICARE
23. EbenX
24. EDS, Medicare Administrative Services
25. US Department of Agriculture, Education & Extension Service
26. Employers' Managed Health Care Association
27. Families USA Foundation
28. GE Medicare Plus
29. General Services Administration
30. Health Insurance Association of America
31. Honeywell
32. International Brotherhood of Teamsters
33. Johnson, Bassin and Shaw, Inc.
34. Joint Commission on Accreditation of Healthcare Organizations
35. Medicare Rights Center
36. National Asian Pacific Center on Aging
37. National Association of Area Agencies on Aging
38. National Association of Community Health Centers
39. National Association of Health Underwriters
40. National Association of Insurance Commissioners
41. National Association of State Units on Aging

42. National Cancer Institute, NIH
43. National Caucus and Center on Black Aged, Inc.
44. National Committee to Preserve Social Security & Medicare
45. National Council of LaRaza
46. National Council on Aging, Inc.
47. National Indian Council on Aging
48. National Institute of Diabetes and Digestive and Kidney Diseases
49. National Institute on Aging
50. National Organization for Rare Disorders (NORD)
51. National Osteoporosis Foundation
52. National Senior Citizens Law Center
53. Office of Minority Health Resource Center
54. Office of Personnel Management
55. Philip Morris
56. Plymouth State College
57. PricewaterhouseCoopers
58. Public Service Enterprise Group (PSEG)
59. Railroad Retirement Board
60. Raytheon
61. Seabury & Smith
62. The 60 Plus Association
63. Towers Perrin
64. US Department of Labor, Pension & Welfare Benefits Administration
65. UltraLink
66. Union Carbide Corporation
67. VHA, Inc.
68. Visiting Nurses Association of America
69. Watson Wyatt Worldwide
70. William M. Mercer, Inc.
71. Alliance of Genetic Support Groups
72. American Music Therapy Association
73. Consultants for Corporate Benefits, Inc.
74. Genetic Alliance
75. Indian Health Service
76. LTV Steel Company, Inc.
77. National Alliance for Caregiving
78. National Association of Manufacturers
79. National Council on Patient Information & Education
80. Paralyzed Veterans of America
81. People's Medical Society
82. Resource Connectors, Ltd.
83. Sears, Roebuck and Company
84. Social Security Administration
85. SPRY Foundation
86. 60 Plus Association

87. Aging Services, Inc.
88. Alliance for Aging Research
89. Alliance for Health Reform
90. American Academy of Family Physicians
99. American Airlines
100. American Network of Community Options & Resources
101. Assisted Living Federation of America
102. Association of Jewish Aging Services
103. Ball State University, Center for Gerontology
104. Catholic Charities
105. Eastman Kodak Company
106. Generations Online
107. Guide to Retirement Living
108. Intellihealth
109. International Longevity Center
110. Lockheed Martin Corporation
111. Marathon Oil Company
112. Mead Corporation
113. National Agricultural Library
114. National Association for Home Care
115. National Association of People with AIDS
116. National Association of Retired Federal Employees
117. National Association of Social Works
118. National Council of Negro Women
119. National Consumers League
120. National Health Council
121. National Library of Medicine
122. National Rural Health Association
123. Occidental Petroleum Corporation
124. Office of Disease Prevention and Health Promotion
125. Office of Minority Health Resource
126. Presbyterian Church USA, Board of Pensions
127. Procter & Gamble
128. SeniorNet
129. SeniorPath
130. Substance Abuse and Mental Health Services/Office of Managed Care
131. Summit Health Coalition
132. United Auto Workers
133. United Cerebral Palsy Association
134. United Senior Health Cooperative
135. Venator Groups, Inc.
136. Washington Business Group on Health

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