DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR BENEFICIARY CHOICES

MEMORANDUM

DATE: **August 29, 2006**

Memorandum to: **All Part D Plan Sponsors**

From: **Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group**

Subject: **Response to Part D Sponsor Issues with the Part D Complaint Systems and Process Issues**

Thank you for your continued support in resolving complaints related to the Medicare prescription drug benefit. A summary document has been developed that outlines questions and concerns raised by Part D Plan Sponsors related to the Complaints Tracking Module (CTM), complaints resolution process, and complaints performance metrics. CMS appreciates your concern and is working to implement solutions to address each identified issue. Responses to these concerns, including dates of anticipated resolution, are provided in attachment A for your reference. We appreciate your patience as we work to improve the complaints resolution process and complaints tracking system.

Again, thank you for your participation in the Medicare prescription drug benefit. If you have any further questions or comments regarding complaints resolution or CTM, please contact CMS via email at ctm@cms.hhs.gov.

ATTACHMENT A

Response to Plan Issues with
CMS Part D Complaints Tracking Module (CTM) and Complaint Reporting/Resolution Process
August 29, 2006

	Reported Plan Issue	CMS Response	Date of Resolution
CMS Complaints Tracking Module (CTM) Systems Issues			
A	Plans report having difficulty in accessing the CTM via HPMS, mainly with the system being "slow" when performing function in the CTM.	CMS is aware of the continued performance problems with CTM and HPMS in general. We are working closely with plans and regions to identify specific problems and remedy them as quickly as possible. In addition to the on-going investigation of the connectivity issues with the Office of Information Systems, we are making some system changes to address the CTM response time in the short-term.	**On 8/9, CTM was modified in the following ways:** o Certain CTM functions were modified to limit the amount of data being returned to the web page, therefore decreasing the demand on the connections between the database and web servers. o Selection criteria were added to the "View/Search" page in CTM to limit the results returned to the user. The results are also now limited to 300 cases at a time, encouraging the users to refine their search and return an acceptable amount of data. o Error messages, which may appear when plans upload Plan Resolution files to the CTM, have been revised to more accurately describe the specific error. o Back-end database changes were made to increase the speed of the application. **On 9/1, CTM will be modified in the following ways:** o Plans will be able to alert CMS that a complaint that is assigned to them is

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CMS Complaints Tracking Module (CTM) Systems Issues			
			either incorrectly assigned (it belongs to another contract number) or is not an issue the plan can resolve (e.g., a CMS issue). They can also communicate necessary complaint category changes to CMS. This functionality will expedite the process for reassigning cases and closing cases that do not fall within the plan's responsibility. o The Plan Resolution page will allow users to enter a specific date range, rather than the current one month selection, to pull up complaints.
B	Plans report that the supplemental daily files they receive via Gentran/Connect: Direct sometimes do not contain the Health Insurance Claim (HIC) number for all of the casework that was assigned in the CTM to the plans for that date.	CMS is working toward the inclusion of HIC numbers and member ID numbers in the CTM by the end of the year. This approach will ensure that HIC numbers and member identifiers are secure.	To be resolved in December 2006
C	The Gentran/ Connect Direct files are not sent to plans in a timely manner. Oftentimes, this file lags from 1 – 5 days behind case assignment in CTM. This means that plans cannot start responding to complaints in a timely manner because most plans use the information contained in this file to work cases.	CMS uploads the Gentran/Connect:Direct files on a daily basis for all contract numbers that have complaints. Complaints received by 1-800-MEDICARE one day are sent to CMS and uploaded the next day. If a plan needs to find out if a CTM file is available for them on a particular day or if they have received a file that is delayed greater	Resolved

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		than 2 days, they can contact the MMA Help Desk at 1-800-927-8069 or mmahelp@cms.hhs.gov to have CMS help research why that unexpected delay has occurred.	
D	Plans report that complaints assigned to them in the CTM related to retroactive processing of enrollment/disenrollment, correction, or change transactions are of particular concern due to the processing backlog at Integriguard. Plans report that this backlog currently ranges from 12 months to 2 years, which poses a significant impediment to addressing affected beneficiary casework. As an alternative, plans are seeking assistance in resolving these cases with their Regional Offices; however, the period of time that it takes for Regional Office resolution is still too great.	CMS recognizes that complaints related to retroactive disenrollments, facilitated enrollments, and enrollment exceptions are a concern for plans, particularly with regard to compliance with CMS performance metrics. CMS has taken into account complaints that are not attributable to the Plan, such as these specific types of complaints, and we remove them from the performance metric analyses. In addition, a streamlined process that triages the critical retroactive disenrollments is being developed and will be shared with Part D sponsors via an HPMS letter within the next two weeks. Retroactive disenrollments deemed critical will be identified by the Part D sponsors but processed by the regional offices. Non-critical retroactive disenrollments will be forwarded to the plans for processing and referral	A streamlined process for handling retroactive disenrollments will be introduced via a revision to the existing CTM operating procedures and will be communicated via an HPMS letter within the next two weeks.

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		to IntegriGuard.	
Accuracy of Part D Beneficiary Complaints Assigned to the CTM			
E	Part D Beneficiary Complaints are being assigned in the CTM via HPMS to the incorrect plan. Plans also report that when they request the Regional Offices to reassign these cases, there is a delay in responding to the reassignments.	Refresher trainings for the 1-800-Medicare Customer Service Representatives (CSR) are already scheduled to make certain that they assign complaints to the plan to which the complaint is attributed. Complaint reassignment is a priority for the Regional Offices. Additionally, system enhancements will be released in early September to improve the process of complaint reassignment notification for plans and the process of complaint reassignment for Regional Offices.	On 9/1, CTM will be modified to allow plans the ability to alert CMS that a complaint that is assigned to them is either incorrectly assigned (it belongs to another contract number) or is not an issue the plan can resolve (e.g., a CMS issue). They can also communicate necessary complaint category changes to CMS. This functionality will expedite the process for reassigning cases and closing cases that do not fall within the plan's responsibility.
F	Plans report being assigned cases in the CTM that cannot be resolved by the plan, for example, SSA premium withhold issues, retroactive disenrollment issues. Plans are concerned that these issues are not being resolved, the beneficiary's concerns are not being addressed, and the complaints are reflected in the plan's complaint count.	CMS has taken into account complaints that are not attributable to the Plan, such as these types of complaints, and we have removed them from the performance metric analyses.	On 9/1, CTM will be modified to allow plans the ability to alert CMS that a complaint that is assigned to them is either incorrectly assigned (it belongs to another contract number) or is not an issue the plan can resolve (e.g., a CMS issue). They can also communicate necessary complaint category changes to CMS. This functionality will expedite the process for reassigning cases and closing cases that do not fall within the plan's responsibility.
G	Plans report that it can take up to 7-10	This is also a concern to CMS. We	On 9/1, CTM will be modified to allow plans

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	days for a Regional Office to respond to requests for assistance with immediate need complaints, which are required by CMS to be resolved within 2 days.	are currently seeing efficiencies and improvements to CTM which should help improve turnaround time of cases both at the Regional Offices and the Plans. For example, as the match-rate of the contract ID's has gone from about 70% to 90% over the past two weeks, the need for Regional Office staff to take time re-assigning cases has gone down, allowing more time to devote to resolving cases. In addition, an upcoming CTM release will allow the plans to communicate via the CTM that a case needs to be reassigned because the plan itself cannot resolve the complaint. Plans will not be held accountable for open cases that require CMS action when the complaints are appropriately categorized as such.	the ability to alert CMS that a complaint that is assigned to them is either incorrectly assigned (it belongs to another contract number) or is not an issue the plan can resolve (e.g., a CMS issue). They can also communicate necessary complaint category changes to CMS. This functionality will expedite the process for reassigning cases and closing cases that do not fall within the plan's responsibility.
H	Plans report that in some instances, cases that have been manually closed in the CTM by the plan are appearing as open cases several days later.	CMS is aware of this issue and will implement an enhancement to the system, as described in the next column.	On 9/1, CTM will be modified to more clearly reflect the open/closed status of a complaint. Language will be modified and more appropriately placed within CTM to better communicate the open/closed status of complaints. The language will indicate if a case has been closed by the plan or by CMS.
I	Plans report that new cases are logged	The CTM records various dates when	Resolved

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	into the CTM by Regional Office with dates that pre-date the availability of the CTM.	a case is entered into the system, one of which is the CONTRACT_ENTRY_DATE, a hard coded date of when a plan is actually assigned to/receives the case in the CTM. CMS is using this date for reporting and plans will be held accountable to that date when measuring performance. This date is available to view in the plan's download. This date is NOT the same as the "Date Complaint Received" as seen in the CTM interface.	
J	Plans have reported that complaints for their Private Fee-For-Service only plans or MA only plans are seen the CTM even though the CTM is for Part D related beneficiary complaints only.	The CTM houses beneficiary complaints for plans which offer Part D. Additionally, there is a parallel module in HPMS that houses beneficiary complaints against MA-only plans ("the MA-only CTM") designed for CMS Regional Office staff tracking. Plans are not responsible for Part D complaints if they do not offer Part D. CMS is discussing making additional enhancements to the system to ensure that MA-only complaints are not loaded into the Part D CTM when received through the 1-800-Medicare upload.	Resolved

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Accuracy of Part D Complaint Data in the HPMS Complaint Rates Module/Publicly Released Data			
K	Several plans indicate that their organization complaint data does not include/reflect information for all of their affected contracts.	It is possible that those contracts that do not appear in the complaint rates report do not have complaint data in the CTM for the time period. CMS combined the data for contracts for known parent-organization-to-contract relationships according to our records. Plans had the opportunity to review these relationships via HPMS in May 2006. To verify the data reported, please email CMS at: PartDMetrics@cms.hhs.gov.	Resolved
L	We received a report from a plan that one of their contracts was considered an outlier in two categories even though there is only one complaint listed in each of the two categories. The plan was confused as it was unclear why one complaint would statistically validate them as an outlier at any level of enrollment.	Although CMS stratified the plans by high and low enrollment in the analysis, outliers were established based on enrollment. The plans with enrollment of less then 1,200 enrollees were suppressed from public view due to instability of calculating complaint rates. Thresholds were originally set based on the plans who ranked within the highest 2.5 percentile. If plans believe there is an error, please direct questions related to the CMS performance metrics to the following email: PartDMetrics@cms.hhs.gov.	Resolved
M	Plans report that in some cases, the	The source of the enrollment	Resolved

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	data set released publicly for their organizations was limited to only a portion of the organization's enrollment; in one case, a single plan that represented only about 12% of the organization's total enrollment.	numbers used in the analyses is MIIR, which was extracted at the contract level and aggregated for the parent organization. Publicly reported data did not include plan size or enrollment. If plans believe there is an error, please direct questions related to the CMS performance metrics to the following email: PartDMetrics@cms.hhs.gov.	
N	Organizations are concerned that a significant number of complaints reflected in the public release of complaint rates/data are related to issues of timeliness relative to CMS processing of enrollment or disenrollment and were not reflective of the organization's performance.	To the best of CMS's ability, CMS has removed any enrollment/disenrollment-related complaints that are not attributable to the plan. However, it is possible that some such complaints could not be identified and parsed out and were included in the rate. CMS is also working to improve the collection of data so that reporting of these types of complaints can be identified and removed from various analyses, if needed.	Resolved