

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

TO: Medicare Compliance Officers, Part C & D Sponsors

FROM: Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: Updated Guidance on Standard Operating Procedures (SOP) for the Complaints Tracking Module

DATE: June 8, 2012

CMS is pleased to announce the release of the updated Complaints Tracking Module (CTM) Standard Operating Procedures (SOP). The attached SOP supersedes all prior versions and replaces the memorandum issued September 23, 2011.

All Sponsors should understand that correct utilization of CTM is critical to ensuring the accuracy of complaint information and plan's responses to those complaints. Sponsors are encouraged to communicate regularly and work with CMS staff to not only appropriately resolve individual complaints but also engage in broader discussions designed to address the root causes of plan complaints.

This memo includes the following updates to the CTM SOP:

- The scenario relating to the 2010 Coverage Gap Rebate program has been removed.
- Scenarios relating to enrollment and disenrollment complaints are now broken out separately.
- Additional guidance is provided for handling good cause complaints, based on nearly six months of experience and feedback from the plans at the CMS 2012 Medicare Advantage & Prescription Drug Plan Spring Conference.
- The document has been reformatted for easier readability.

The Complaints Tracking Module (CTM) will be updated on June 22, 2012 with a few minor functionality changes that will be described in a separate memorandum.

For general questions about complaint handling and casework operating procedures, please contact your plan's casework lead or Account Manager. For technical assistance with HPMS CTM, please contact the HPMS Help Desk at either 1-800-220-2028 or HPMS@cms.hhs.gov. Technical data questions related to your plan's CTM performance should be sent to ctm@cms.hhs.gov, with a copy to your Account Manager.

Thank you for your continued work and support with complaints resolution.

Complaints Tracking Module (CTM) – Plan Standard Operational Procedures
Medicare Advantage (MA) Organization and Prescription Drug Plan (Part D) Sponsor Users
Effective June 8, 2012

MA Organizations and Part D Sponsors are required to follow the procedures outlined in the CTM Plan SOP at all times, while the CTM User Guide serves as a technical reference only.

Scenarios/Issues:

- A. Plan receives a complaint that should have gone to one of its subsidiaries or another organization.
- B. Plan cannot do further work with the complaint and requires CMS assistance to resolve (i.e. CMS Issue).
- C. Plan has resolved the complaint but has not yet notified the beneficiary.
- D. Plan cannot save or close the complaint after entering Casework Notes and/or a Resolution Date.
- E. Plan receives a complaint related to a Retroactive Enrollment.
- F. Plan receives a complaint related to a Retroactive Disenrollment.
- G. Plan receives a request from a beneficiary seeking an enrollment and/or disenrollment change that is not explicitly outlined in CMS' enrollment guidance (often referred to as an Enrollment Exception).
- H. Plan receives a mis-categorized complaint or a complaint with no assigned category and subcategory.
- I. Plan receives a complaint but disagrees with the issue level.
- J. Plan is ready to record Comments, Casework Notes and Resolution information on the Complaint Resolution tab.
- K. Plan receives a complaint with one or more of the following indicators flagged in CTM:
 - SWIFT
 - Congressional
 - Press or Hill Interest
- L. Plan receives a complaint that is related to an SSA Premium Withhold Issue.
- M. Plan receives a provider/pharmacy complaint in CTM.
- N. Plan receives a complaint categorized as "Enrollment Exception – Alleged Marketing Misrepresentation (No RO Action Needed)."
- O. Plan reviews a complaint categorized as "Enrollment Exception – Alleged Marketing Misrepresentation (RO Action Needed)."
- P. Plan receives a repeat complaint from the same caller.

- Q. [Plan needs CMS assistance to secure BAE \(Best Available Evidence\) on behalf of an LIS beneficiary who qualified with Medicaid.](#)
- R. [Plan receives a complaint, but is unable to contact the beneficiary after multiple attempts.](#)
- S. [Plan has supporting documentation that relates to a complaint.](#)
- T. [Plan sees a complaint in the “Good Cause - Disenrollment for Failure to Pay Premiums” subcategory.](#)
- U. [Plan receives a direct request for reinstatement for good cause for failure to pay plan premiums \(outside CTM\).](#)
- V. [Plan user needs HPMS Access but does not have it.](#)
- W. [Plan user has HPMS access but needs CTM access.](#)
- X. [Plan has a general CTM related question or issue.](#)
- Y. [Assignment/Reassignment date is reset.](#)

A. Scenario/Issue: Plan receives a complaint that should have gone to one of its subsidiaries or another organization.

Procedure:

1. From the Plan Request tab, the plan selects the option to indicate the complaint belongs to another contract and, if known, enters the name and/or contract number of the plan to reassign it to, along with any pertinent information about the case in Casework Notes.
2. Plans are encouraged to notify the beneficiary that their complaint has been reassigned to the appropriate plan.
3. Plans should seek to resolve a complaint while a plan request is pending if it relates to one of its subsidiaries.
4. If CMS agrees with the request, the plan will no longer be able to see the complaint in the system after it is reassigned to a different contract. If the plan has access to the other contract number, then it will be able to view the complaint under the new contract number.

Please Note:

- Complaints with pending Plan Requests cannot be closed.
 - Plans can work directly with SHIP CTM users as needed for SHIP entered complaints without requiring additional beneficiary disclosure agreements from the SHIP.
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B. Scenario/Issue: Plan cannot do further work with the complaint and requires CMS assistance to resolve (e.g. CMS Issue).

Procedure:

1. From the Plan Request tab, the plan selects the option to indicate that this complaint is a CMS issue and explains in Casework Notes:
 - a. The reason CMS intervention is needed.
 - b. Whether access to services has been provided to the beneficiary.
 - c. Any beneficiary contact.
2. CMS will agree or disagree with the Plan Request.
 - a. If CMS agrees with the request, the plan will no longer be able to see the complaint in the system after it has been changed to a “CMS Issue” because CMS is responsible for resolving the complaint.
 - b. If CMS disagrees with the request, instructions as to next steps will be provided to the plan in CTM.

Examples of CMS Issues include but are not limited to:

- Instances where a beneficiary seeks a Special Enrollment Period (SEP) that is not explicitly outlined in CMS’ enrollment guidance.
- Beneficiary needs a critical retroactive disenrollment action taken in MARx (see Scenario F.1.).

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- Beneficiary has lost coverage due to a loss of Part A/B entitlement that may be erroneous.

Please Note:

- Refer to the December 22, 2011 HPMS memo regarding exclusion criteria addressing complaint issues outside the control of the plans.
 - To reduce the likelihood of repeat complaints, plans are encouraged to make interim contact with their members if a complaint takes more than seven days to resolve, even when a complaint has been referred back to CMS.
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C. Scenario/Issue: Plan has reached resolution of the complaint but has not yet notified the beneficiary.

Procedure:

1. The plan will notify the beneficiary or complainant according to the plan's business practice and customer service policy.
 2. CMS recommends that the plan attempt to contact the complainant at least three times at different times on different days, with the last attempt in writing. Details, including the dates and times of contact attempts, actions taken, etc. should be documented in CTM.
 3. For SHIP entered complaints, SHIP counselors may request in the Complaint Summary that the plan contact the counselor with the resolution rather than the beneficiary.
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D. Scenario/Issue: Plan cannot save or close the complaint after entering Casework Notes and/or a Resolution Date.

Procedure:

1. The plan should troubleshoot the issue by:
 - a. Confirming that the complaint category is properly assigned. If no category is assigned, refer to Scenario H.
 - b. Verifying that the following restricted characters were not entered in the Casework Note and/or the Resolution Date fields: < > & ;
 - c. Verifying that there is no pending Plan Request.
 - d. Confirming the CMS Retro-Processing Contractor (RPC) Received Date has been entered, if applicable.
 - e. When attempting to close the complaint, check that a date was entered into the Resolution Date field and that it is not earlier than the Received Date. A CTM cannot be closed unless this entry is made.

If no obvious problem is found, the plan should contact the HPMS Help Desk at 1-800-220-2028 or HPMS@cms.hhs.gov.

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E. Scenario/Issue: Plan receives a complaint related to a Retroactive Enrollment.

Procedure:

1. The plan investigates the complaint to determine if it is a valid retroactive enrollment request.
 - a. If the request is not valid and the complaint is considered resolved, the plan will notify the beneficiary and document the complaint resolution in Casework Notes (see Scenario J).
 - b. If the request is valid, the plan needs to update its system to ensure that the beneficiary has access to drugs and/or health services and update MARx with enrollment/disenrollment change(s).
2. If the plan is unable to update MARx directly with the change(s), then a request must be prepared and sent to the RPC with required documentation for review and processing as described in the latest retroactive processing guidance. As soon as the plan has submitted the retroactive request to the RPC, the plan must:
 - a. Document the development of the complaint in Casework Notes on the Complaint Resolution tab.
 - b. On the Complaint Resolution tab, select the checkbox and enter the date the complaint was referred to the RPC.
 - c. The complaint should remain OPEN until the RPC has processed the needed action.
 - d. After receiving notification from the RPC that the action has been processed as requested, the plan must check MARx to confirm this change, enter the date the RPC notification was received in the RPC Date Received field and close the complaint. The complaint will not close without the RPC notification date. If the plan receives notification from the RPC that the request could not be processed, the plan should research the problem immediately to resubmit for processing and resolution.

The RPC cannot process complaints (CTM cases) that fall outside CMS Enrollment or Retroactive Processing Guidance without approval from a CMS caseworker. If the retroactive request falls outside CMS enrollment guidance due to timeliness, plan error or because it lacks required documentation, the plan should refer to Step 3 below to request CMS approval to resolve.

3. If CMS approval is needed prior to submission to the RPC, such as complaints that require a retroactive effective date of more than 3 months (see the February 24, 2009 HPMS memo), or complaints that fail to satisfy the RPC's requirements on retroactive processing, then the plan should submit a Plan Request to CMS for approval to refer the issue to the RPC.
 - a. If CMS agrees that the complaint can be forwarded to the RPC, CMS will provide written authorization in the Comments field. The plan will use this as documentation to send their request to the RPC requesting an update to CMS'

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systems. After submitting the request, the plan should follow steps 2 a-d above.

- b. If CMS does not agree that a complaint should be forwarded to the RPC, CMS will provide the plan with instructions on next steps in CTM.

Please Note:

- Plans should refer to the Special Note regarding Regional Office Casework Actions in Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Managed Care Manual for instructions on how to submit Caseworker actions/approvals to the RPC.
- Organizations must ensure that enrollees have access to benefits as of the enrollment effective date and may not delay the availability of benefits while waiting for confirmation of enrollment from CMS systems. In other words, the plan's systems should reflect enrollment as of the effective date, even if the enrollment is pending a transmittal to the RPC and submission to CMS systems.
- For retroactive enrollment complaints received directly by plans (e.g. not via CTM) requiring an effective date of more than 3 months retroactive, the plan should update its system to ensure that the beneficiary has access to drugs and/or health services and contact their Account Manager (AM) to request approval.
- Requests for reinstatements for Good Cause are noted in Scenarios T & U. Reinstatements are NOT retroactive enrollments.
- Reinstatements into a previous plan subsequent to enrollment in a new plan are contingent upon the individual's successful cancellation of the new enrollment. See Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Managed Care Manual for more information on enrollment cancellation requirements and the process for reinstatement following automatic disenrollment due to enrollment in a new plan.
- Immediate Need cases and cases left open because they are referred to the RPC for retroactive action are excluded from plan turnaround/closure metrics. However, these cases will continue to be included in overall Plan Rating complaint counts.
- Plans are encouraged to inform beneficiaries of any delays associated with having enrollment changes reflected in CMS' systems. The plan should inform the beneficiary that it may take up to one month for the change to be reflected in CMS' systems.
- Congressional cases dealing with enrollment changes should NOT be sent to the RPC.

F. Scenario/Issue: Plan receives a complaint related to a Retroactive Disenrollment.

Procedure:

1. The plan investigates the complaint to determine if it is a valid retroactive disenrollment request.
 - a. If the request is not valid and/or the complaint is considered resolved, the plan will notify the beneficiary and document the complaint resolution in Casework Notes (see Scenario J).

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2. If the request is valid and the plan can take the appropriate MARx actions themselves to resolve the complaint, they should do so, updating their systems, closing the complaint and notifying the beneficiary accordingly.
3. If the request is valid, but the plan is unable to make the appropriate MARx action, the plan will determine if the complaint is Critical or Non-Critical. Complaints labeled Immediate Need and complaints concerning opt-out due to employer group coverage are considered Critical.
 - a. If the complaint is Critical, a Plan Request is to be made to CMS for MARx action. "Critical Retroactive Disenrollment" should be notated in the Casework Notes and the plan should indicate any internal systems changes it has made.
 - i. If CMS agrees with the request, the plan will no longer be able to see the complaint in the system as the complaint is flagged as "CMS Issue" and CMS will be responsible for resolving the complaint.
 - ii. If CMS disagrees with the Plan Request, CMS will describe next steps in CTM.
 - b. If the complaint is Non-Critical, the plan should submit a request to the RPC with the appropriate documentation asking them to update CMS' systems with their change(s). As soon as the request is made, the plan should follow the steps in E.2.a-d.
 - i. If CMS approval is needed prior to submission to the RPC, such as complaints that require a retroactive effective date of more than 3 months (see the February 24, 2009 HPMS memo), or complaints that fail to satisfy the RPC's requirements on retroactive processing, then the plan should submit a Plan Request to CMS for approval to refer the issue to the RPC.
 - a. If CMS agrees that the complaint can be forwarded to the RPC, CMS will provide written authorization in the Comments field. The plan will use this as documentation to send its request to the RPC requesting an update to CMS' systems. After submitting the request, the plan should follow steps E.2 a-d.
 - b. If CMS does not agree that a complaint should be forwarded to the RPC, CMS will provide the plan with instructions on next steps in CTM.

Please Note:

- For a Critical retroactive disenrollment complaint received directly that is not in the CTM, plans should contact their CMS Lead Caseworker for assistance.
- For a Non-Critical retroactive disenrollment complaint received directly that is not in CTM, plans should make a request to the RPC for correction.

See the "Please Note" section of the previous scenario for more details relating to retroactive changes.

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G. Scenario/Issue: Plan receives a request from a beneficiary seeking an enrollment and/or disenrollment change that is not explicitly outlined in CMS' enrollment guidance (often referred to as an Enrollment Exception).

Procedure:

1. The plan should submit a Plan Request to indicate the complaint is a "CMS Issue" and describe in Casework Notes why the beneficiary is seeking an exception to make an enrollment or disenrollment change outside of a valid enrollment period.
 - a. If CMS agrees with the request, the plan will no longer be able to see the complaint and CMS will be responsible for resolving the complaint.
 - b. If CMS disagrees with the request, instructions as to next steps will be provided to the plan in CTM.

Please Note:

- Valid Enrollment Exceptions are excluded from plan performance metrics.
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H. Scenario/Issue: Plan receives a mis-categorized complaint or a complaint with no assigned category and subcategory.

Procedure:

1. The plan needs to explain the reason for their request in the Casework Notes field of the Complaint Resolution tab.
2. From the Plan Request tab:
 - a. Select the option to request a change to the complaint's category/subcategory.
 - b. Select the appropriate category/subcategory from the drop-down list.
 - c. Submit the request when done.

Please Note:

- If the plan is responsible for resolving the complaint, casework should continue as CMS evaluates the plan's request to change the category/subcategory.
 - CMS will only consider a category/subcategory re-assignment request if it was incorrectly categorized at intake. Requests should be infrequent and should not be used for the sole purpose of improving a plan's performance metrics.
 - If the individual relays a request for Good Cause while the plan is responding to another CTM related to disenrollment for failure to pay premiums (or Part D-IRMAA), such as plan error, the plan will first rule out plan error. If no error exists, the plan will submit a Plan request for "CMS Issue." The plan must indicate notes in the CTM summary indicating clearly that no error exists and the individual has made a reinstatement request for GC. CMS will accept the CTM and start the GC triage process.
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I. Scenario/Issue: Plan receives a complaint but disagrees with the issue level.

Procedure:

1. The plan needs to explain the reason for their request in the Casework Notes field of the Complaint Resolution tab.
2. From the Plan Request tab, select the option to change the complaint's issue level then submit to CMS for review.
3. Once this option has been selected, the time clock for the plan will stop. If CMS approves of the plan's request, the clock will start over once the issue level has changed. If CMS disapproves the request, an explanation will be provided.
4. If the complaint remains the responsibility of the plan to resolve, casework should continue as CMS evaluates the plan's request to change the issue level.

Please Note:

- For Medicare Advantage, an **Immediate Need** complaint is defined as a complaint where a beneficiary has no access to care and an immediate need for care exists. For Part D, an **Immediate Need** complaint is defined as a complaint that is related to the beneficiary's need for medication where the beneficiary has 2 or less days of medication left. Plans are required to resolve 95% of Immediate Need complaints within 2 calendar days.
- For Medicare Advantage, an **Urgent** complaint involves a situation where the beneficiary has no access to care, but no immediate need exists. For Part D, an **Urgent** complaint is defined as a complaint that is related to the beneficiary's need for medication where the beneficiary has 3 to 14 days of medication left. It is expected that 95% of Urgent complaints be resolved within 7 days.
- Plans are encouraged to provide interim responses to beneficiaries for all complaints, especially if resolution is not achieved within 7 days. It is expected that 95% of all **non-Immediate Need/non-Urgent** cases be resolved within 30 days.
- Immediate Need or Urgent issues can only be downgraded if they never were Immediate Need or Urgent. Plans requesting that CMS downgrade an issue level after the access portion of the complaint has been addressed will not be approved unless the issue level was originally incorrect.
- Plans are encouraged to review ALL complaints at intake even those that are not Immediate Need or Urgent to verify that the contract number and issue level are correct.
- CMS reserves the right to classify any complaint that does not fit the above definitions for "Immediate Need" or "Urgent."
- Timeframes are calculated mathematically, i.e., "2 calendar days" would be calculated as follows: Complaint received on 8/22 at 8:00 AM must be resolved by 8/24 at 11:59 PM to be in compliance (24 less 22 = 2 days).

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J. Scenario/Issue: Plan is ready to record Comments, Casework Notes and Resolution information on the Complaint Resolution tab.

Procedure:

1. The plan records a clear and concise narrative (up to 4,000 characters) in the Casework Note field of the Complaint Resolution tab. All entities that review CTM complaint records should be able to easily understand the notes clarifying the issue, action(s) taken and decisions made to investigate and resolve the complaint. Vague responses such as “Case closed by plan” are strongly discouraged.
2. Plans should also:
 - a. Document the root cause of the issue impacting the beneficiary to ensure that the originating issue is addressed.
 - b. Use only widely accepted CMS abbreviations (i.e. LEP, SEP, BAE, etc.) and avoid proprietary ones.
 - c. Include systems issues, updates and dates actions taken.
 - d. Include system update timeframes and transaction reply code(s) when appropriate.
 - e. Report any contacts with the beneficiary, complainant and other individual relative to the case and the contact dates.
3. To close a resolved complaint:
 - a. Make a selection from the “Contact Made” dropdown list and select “System Update Action Taken” if appropriate. At least one of these must be selected to close the complaint.
 - b. Select “Yes” to indicate that the complaint has been resolved and enter a Resolution Date. The final Casework Note entered will automatically populate into the Resolution Summary. Other notes may be added to the Summary by simply checking the box under the Casework Note.
 - c. If the complaint was entered by a SHIP with CTM access, the plan should also contact that SHIP to notify them of the complaint resolution. SHIPs are instructed to include their contact information in the Complaint Summary and may request that the plan not contact the beneficiary, but rather inform the SHIP Counselor of actions taken so that the Counselor can relay that information to the beneficiary.

Please Note:

- To reduce the likelihood of CMS contacting the plan for a status update on a particular complaint, plans are encouraged to provide ongoing, interim documentation and notes as they work toward the ultimate resolution of the complaint
- See Scenario R for Best Practices for informing beneficiaries of complaint resolution.
- If the resolution involves a refund from the plan to the beneficiary (any overpayment of co-payments, premiums, late enrollment penalties, etc.), the complaint can be closed once that refund is issued.

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K. Scenario/Issue: Plan receives a complaint with one or more of the following indicators flagged in CTM:

- **SWIFT**
- **Congressional**
- **Press or Hill Interest**

Procedure:

The plan will need to:

1. Contact the beneficiary/provider to obtain details of their case and begin the investigation. The plan should inform them of planned actions and anticipated timeframes. Casework should be completed within 2 to 7 calendar days, depending on the issue level.
2. Record clear and concise Casework Notes of the research and actions taken on the Complaint Resolution tab. The entry must include all actions taken including contact, dates and instructions to the beneficiary, complainant and contacts. Include systems updates and the dates the actions were taken. Congressional cases dealing with enrollment changes should not be sent to the RPC, but referred to the CMS when needed.
3. After resolving the complaint, the plan should submit a Plan Request to change the complaint to a CMS Issue since CMS is responsible for final closure of such cases. CMS is also responsible for making enrollment changes for congressional cases and notifying the congressional office of the resolution. As a best practice, plans should request this within 2 to 7 calendar days to allow time for proper closure of the case by the RO.
4. CMS will agree or disagree with the Plan Request. If CMS agrees, the plan will no longer be able to view the complaint. If CMS disagrees, instructions as to next steps will be provided to the plan in CTM.
5. A time stamp is recorded when the plan makes this request and another time stamp is recorded once the CMS makes a decision.

Please Note:

- SWIFT, Congressional, Press, or Hill interest complaints are treated as immediate need or urgent in the CTM.
- For Congressional cases, the plan should NOT notify the congressional office of the resolution as this is CMS' responsibility.
- Plans are unable to close SWIFT cases in CTM. A Plan Request for a change to CMS Issue must be made so the Regional Office CMS can review and close the complaint.

L. Scenario/Issue: Plan receives a complaint that is related to an SSA Premium Withhold Issue.

Procedure:

1. The plan reviews the complaint and checks that their system reflects the same premium amount and payment option specified in the complaint and corrects if necessary.
 - a. The plan should inform the beneficiary that it may take up to 90 days to fully correct their premium withhold issue or for Social Security to issue a refund to them.

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- b. The plan should recommend that the complainant call back if there is no resolution after 90 days and close the complaint.
2. If the plan's system and MARx correctly reflects premium amounts and payment option, but the beneficiary still complains that the premium deductions are incorrect, the plan should review the date of the last transaction to see if 90 days since submittal has elapsed for posting corrections to CMS and SSA systems.
 - a. If this time period has not elapsed, the plan should educate the beneficiary and close the complaint.
3. If the complaint relates to SSA premium deductions that extend past the expected period, the SSA withholding issue relates to a non-current year, or actions by the plan will not correct the issue, submit a Plan Request to have the issue treated as a CMS Issue.

Please Note:

- Refer to the March 23, 2007 HPMS memorandum regarding, "Clarification of Involuntary Disenrollment Policy for Beneficiaries who Elect Social Security Premium Withholding".
 - CTM complaints that include both a complaint that the beneficiary is getting billed while in SSA premium withhold status and include a plan premium payment problem should remain open until the beneficiary issue is resolved and the beneficiary is made whole.
 - The plan should report plan premium payment problems to the plan's CMS DPO representative and their Account Manager.
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M. Scenario/Issue: Plan receives a provider/pharmacy complaint in CTM.

Procedure:

1. The plan reviews the complaint and contacts the provider/pharmacy for additional information if needed. The complaint is considered a provider complaint if it actually came from the provider (i.e., "plan is not acknowledging the receipt of prior authorization forms I sent them").
 2. The plan takes any necessary steps to address the complaint, acknowledges the complaint in the complaint summary (noting any steps toward resolution), and closes the complaint in the CTM.
 3. The same best practice that CMS recommends for notifying beneficiaries of resolutions (Scenarios R) is also recommended for provider/pharmacy complaints.
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N. Scenario/Issue: Plan receives a complaint categorized as "Enrollment Exception – Alleged Marketing Misrepresentation (No RO Action Needed)."

Procedure:

1. The plan carefully reviews the allegation of marketing misrepresentation and conducts an investigation, contacting the beneficiary if additional information is needed, per the conditions stipulated in the 10/3/2008 HPMS memo.

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2. After investigating the complaint, the plan corrects any underlying issues that may have led to the beneficiary complaint, including agent/broker termination or retraining.
3. The plan enters any action taken to correct the situation as a Casework Note on the Complaint Resolution tab and closes the complaint in the CTM by entering a Resolution Date.
4. Details in the Casework Note should include the name of any agents/brokers involved if it was not provided in the original complaint.
5. If the plan determines the Marketing Misrepresentation is unfounded, then that too should be indicated in Casework Notes on the Complaint Resolution tab.

O. Scenario/Issue: Plan reviews a complaint categorized as “Enrollment Exception – Alleged Marketing Misrepresentation (RO Action Needed).”

Procedure:

1. The plan carefully reviews the allegation of marketing misrepresentation and conducts an investigation.
2. The plan may contact the beneficiary if additional information is needed and the complaint is indicated as closed per the conditions stipulated in the 10/3/2008 HPMS memo.
3. After investigating the complaint, the plan corrects any underlying issues identified that may have led to the beneficiary complaint, including agent/broker termination or retraining, or any further corrective action deemed necessary.
4. When the plan has prepared pertinent documentation related to their investigation of a given case, they should request the “Marketing Misrepresentation Report” and open the case by clicking on the Complaint ID link. The plan will only be able to attach documents to the complaint and will not be able to enter or change any other data. See Scenario S for information on uploading documentation).

Please Note:

- These complaints can only be viewed through the “Marketing Misrepresentation Report” link on the CTM Start Page.

P. Scenario/Issue: Plan receives a repeat complaint from the same caller.

Procedure:

The plan identifies the new complaint as the same issue of a previous complaint entered into CTM.

1. Using the Repeat Complainant report, the plan searches for complaints from the same member having the same issue as the new complaint.
2. If the issue was resolved in a different complaint after the member called in the repeat complaint, the plan will close the case and annotate that it is a repeat complaint.

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3. If the issue is still open, but the plan is working to resolve the issue or the plan has not yet begun to investigate the issue, the plan should close the oldest complaint(s), stating that the issue is being worked and referencing the most recent complaint as a Comment or Casework Note under the Complaint Resolution tab.
4. If the issue is a different issue than the previous issue, the plan should not close the older issue as a repeat case, but should treat the complaint as a separate issue.

Please Note:

- CTM gives plans the ability to view multiple complaints from the same complainant within their organization (see March 3, 2009 HPMS Memo). Plans are encouraged to identify these complainants, reach out to them and offer assistance to reduce the likelihood of additional repeat complaints from them.

Q. Scenario/Issue: Plan needs CMS assistance to secure BAE (Best Available Evidence) on behalf of an LIS beneficiary who qualified with Medicaid.

Procedure:

1. The plan completes the plan's portion of the BAE Assistance Worksheet (Attachment B of the August 4, 2008 HPMS memo).
2. The plan sends the completed worksheet via an encrypted e-mail to the Home Regional Office (RO), noting in the subject line "Immediate BAE Assistance Needed" for an immediate case or "Non-Immediate BAE Assistance Needed" for all others.
3. CMS RO staff:
 - a. Enters a new complaint in CTM with the information provided by the plan in the worksheet.
 - b. Contacts the state Medicaid office to verify the beneficiary's Medicaid status.
 - c. Enters the beneficiary's Medicaid status in the CMS Only section of the BAE Assistance Worksheet.
 - d. Sends the worksheet back to the plan securely using the same method in which it was received.

Upon receiving the completed BAE Assistance Worksheet back, the plan updates their internal systems. Within one business day of receiving the BAE worksheet from the RO, the plan will attempt to notify the beneficiary of the LIS update to plan systems and inform them that it can take up to 30 days for their LIS to reflect on CMS' systems. After notifying the beneficiary, the plan can close the case in CTM.

If in 30-60 days, the beneficiary's CMS record does not automatically update with the LIS, the plan submits the change to the RPC along with the worksheet as proof.

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R. Scenario/Issue: Plan receives a complaint, but is unable to contact the beneficiary after multiple attempts.

Procedure:

A complaint may be closed after failed attempts to reach the beneficiary for additional details after the plan has completed the following:

1. Attempted at least 3 telephone contacts and leaving messages where possible.
 - a. Attempts should be made at varying times within 48 hours of receipt of the complaint.
 - b. All contact efforts need to be documented in Casework Notes.
 2. After the failed call attempts, the plan should send a letter to the beneficiary explaining the failed call attempts and providing a telephone number for the beneficiary to call back. A "Template Resolution Letter" is available as a link in the Documentation section of CTM.
 3. The date the letter was sent should be documented in Casework Notes and the electronic document uploaded into CTM.
 4. Close the CTM complaint.
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S. Scenario/Issue: Plan has supporting documentation that relates to a complaint.

Procedure:

1. From the Complaint Attachment tab, browse to locate the document to upload. The name of the file cannot contain any special characters. Examples of appropriate documents are beneficiary communications (except email), system screen prints, and notifications received from third parties such as the RPC (.pdf, .jpg, .txt, .docx, .xlsx, .zip).
2. Select the type of document being uploaded from the drop-down list that describes the file. If "Other" is selected, the "Other" field text box must also be completed. This becomes a mandatory entry.
3. Click on the Upload File button and the attachment will appear listed. Close the window.
4. Save the CTM record and (only then) will the attachment display on the Complaint Data Entry page.

Please Note:

- Plans can also view any documents attached by CMS or SHIP users.
-

T. Scenario/Issue: Plan sees a complaint in the "Good Cause - Disenrollment for Failure to Pay Premiums" subcategory.

Procedure:

1. A Good Cause (GC) complaint is generally not viewable in the CTM by a plan unless CMS has approved the GC request (favorable determination) and marked the CTM as "urgent,"

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indicating plan action is needed.

2. Upon receipt of a favorable GC determination, the plan will send the required notification to the beneficiary within 3 business days of receiving the “urgent” plan action in CTM. The notice will indicate that the individual has 3 months from the effective date of disenrollment to pay all owed amounts required for the reinstatement to occur. Plans are encouraged to supplement the letter with a telephone call to the beneficiary and accept payment via options other than check, such as credit, debit, electronic funds transfer.
3. If the beneficiary was disenrolled from an employer/union sponsored plan, upon request by CMS or receipt of the GC CTM for “plan action,” the plan must contact the employer/union to determine whether the employer/union will permit reinstatement. The plan must respond to CMS within 3 business days of receipt of the request or CTM for plan action. Upon approval by the employer/union to permit reinstatement, the GC process may continue.
4. If the individual pays premiums to the employer group directly and not the plan, the individual may only request reinstatement for GC if s/he was disenrolled for failure to pay Part D-IRMAA. If CMS approves the GC request (favorable determination), the plan does not need to collect any premiums for the reinstatement to occur. Upon payment of the Part D-IRMAA owed amounts, CMS will reinstate the beneficiary in MARx by cancelling the disenrollment. The CMS caseworker will close the case and the plan should send the beneficiary a notice of reinstatement once they receive the TRR from CMS.
5. If all the owed amounts (past due amounts PLUS 3 months of premiums) have been paid in full for a beneficiary with an approved good cause request within the 3-month timeframe, the plan, within 5 calendar days, will submit a Plan Request indicating this is a “CMS Issue.”* Without CMS special approval, reinstatement may NOT occur prior to the full payment of the required owed amounts. Reinstatement may not occur if the required amount is not paid within the 3-month timeframe.
6. Pertinent notes related to the collection of past due amounts should be included in the CTM (i.e. copy of the letter sent to the individual, receipt of all owed payments and date received). Once paid, the plan will immediately grant access to drugs/services for the beneficiary.**
7. CMS will accept the CTM as a “CMS Issue,” check the CTM summary notes regarding the full payment and reinstate the beneficiary in MARx by cancelling the disenrollment. The CMS caseworker will close the case and the plan should send the beneficiary a notice of reinstatement once they receive the TRR from CMS.
8. If the required payment was not received within the 3-month timeframe, the plan should send a Plan Request indicating such, with all correspondence sent to the beneficiary related to the matter attached to the CTM complaint. The CMS caseworker will accept the case as a “CMS Issue,” contact the beneficiary to inform them that the disenrollment stands/no reinstatement will occur, and close the case.
9. For individuals who pay premiums for additional months beyond their past owed arrearage and CMS does not approve their GC request (unfavorable determination), plans must promptly refund any premium overpayments received. In the event the individual has to also pay Part D-IRMAA to meet the requirements for reinstatement, does not pay the Part D-IRMAA owed amounts, and remains disenrolled, plans must promptly refund any premiums received for months in which the individual did not have coverage.

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Please Note:

- For purposes of this SOP, requests for GC reinstatement are called “complaints” because CMS is using the CTM system to communicate with plans for these requests for reinstatement. “Complaints” entered into CTM for GC reinstatement requests are not included in plan performance metrics.
- See Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Manage Care Manual for more information, including model notices.
- Plans still need to collect premiums owed to themselves for the 3 months during the GC determination process when there is a Part D IRMAA GC request.
- CTM will not allow a plan to close a complaint in a GC subcategory.

** Upon receipt of full payment by check, plans may wait 5 calendar days before granting access to services and submitting a Plan request for “CMS Issue” to assure the payment clears the bank. If the plan doesn’t receive confirmation within 5 calendar days, it must grant access to services and submit the Plan Request to CMS. If the plan later finds that the payment did not clear the bank, it may contact CMS to cancel the reinstatement.*

***Plans should not grant access to care in cases where an individual still owes Part D–IRMAA. These cases will be notated in CTM by special casework notes by CMS.*

U. Scenario/Issue: Plan receives a direct request for reinstatement for good cause for failure to pay plan premiums (outside CTM).

Procedure:

1. If the plan verifies that a plan error caused an inappropriate disenrollment, the plan can immediately reinstate the beneficiary.
2. If the beneficiary has been disenrolled for more than 60 days, the plan informs the beneficiary that they do not qualify for good cause because they have exceeded Medicare’s timeframe for requesting a reinstatement. The plan may advise the beneficiary that they may:
 - a. Enroll into a Part D plan during the next Open Enrollment Period that runs from October 15 to December 7.
 - b. Call 1-800-Medicare to find out if there is a 5 star plan available in their area. Beneficiaries can use the 5 star SEP (once during a 12 month period) to enroll into a 5 star plan.

If the beneficiary disagrees and insists on requesting reinstatement for good cause, plans must refer the beneficiary to 1-800-Medicare.

3. If the beneficiary has been disenrolled for less than 61 days, the plan will:
 - a. Convey that the reason for non-payment must have been out of their control, like an emergency, which caused them to not be able to pay on time.
 - b. Convey that Medicare has to approve the request for reinstatement.

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- c. Inform the beneficiary of the deadline for requesting good cause.
- d. Refer the individual to 1-800 Medicare to formally make a request.

Please Note:

- Plans cannot enter/initiate “complaints” for requests for reinstatement for good cause.
- See Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Manage Care Manual for more information.

V. Scenario/Issue: Plan user needs HPMS Access but does not have it.

Procedure:

1. Plan user completes the standard “Application for Access to CMS Computer Systems” form found at <http://www.cms.hhs.gov/AccessstoDataApplication>.
2. Plan user sends the completed, signed, original form (with wet signature/date) to the following address:

ATTENTION: Lori Robinson
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: C4-18-13
Baltimore, MD 21244

The use of a traceable mail carrier is encouraged to ensure a timely delivery. HPMS user access may take 2 weeks or longer.

3. Once the plan user is notified of their HPMS access, the plan user sends an e-mail to HPMS_Access@cms.hhs.gov to request CTM access. The e-mail’s subject should read “CTM Access Request” and the message should contain the user’s HPMS ID.

W. Scenario/Issue: Plan user has HPMS access but needs CTM access.

Procedure:

Plan user sends an e-mail that includes their four character HPMS ID to HPMS_Access@cms.hhs.gov to request CTM access. The e-mail’s subject should read “CTM Access Request.” and the message should contain the user’s HPMS ID.

X. Scenario/Issue: Plan has a general CTM related question or issue.

Procedure:

1. The plan should seek resolution with their Lead Caseworker or Account Manager for casework/CTM process questions.
2. The plan should seek answers to technical questions by sending an inquiry to the following address: CTM@cms.hhs.gov, with a copy to their Account Manager.

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Please Note:

- For any inquiry, be sure to include the plan's contract number and complaint ID(s).
-

Y. Scenario/Issue: Assignment/Reassignment date is reset.

Procedure:

1. The following are general timelines for the resetting of Assignment/Reassignment dates, other than those noted in specific scenarios above:
 - a. Complaint is re-opened.
 - b. Issue Level is changed from non-Issue/Urgent to Urgent/Immediate (Issue Level is upgraded).
 - c. CMS Issue flag is set or removed (Plan Request must be accepted for the clock to be reset).
 - d. Contract is changed.
-

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Key & Definitions:

1. **BAE** = Best Available Evidence
2. **“CMS Issue”** = A complaint is outside a plan’s control to resolve and is not attributed to the MA Organization or Part D Sponsor
3. **Congressional Complainant** = CMS complaint submitted by congressperson on behalf of his/her constituents
4. **CTM** = Complaints Tracking Module, a module within HPMS
5. **DPO** = CM/CPC’s Division of Payment Operations
6. **EE** = Enrollment Exception
7. **GC** = Good Cause
8. **HICN** = Health Insurance Claim Number; beneficiary’s unique identifier
9. **Home Region** = Regional Office that services the state or territory where the beneficiary or provider resides
10. **HPMS** = Health Plan Management System
11. **Immediate Need complaint** = For MA, a complaint that is related to a situation where the beneficiary has no access to care and an immediate need for care. For Part D, a complaint related to the beneficiary’s need for medication where the beneficiary has 2 or less days of medication left. MA Organizations and Part D Sponsors are required to resolve these complaints within 2 calendar days from the time it is assigned. CMS reserves the right to classify any complaint to “Immediate Need” should the complaint be egregious in nature.
12. **IRMAA** = Income Related Monthly Adjustment Amount
13. **LEP** = Late Enrollment Penalty
14. **Lead Region** = Regional Office that has primary responsibility for the management of complaints for a particular plan. For smaller plans, the Home Region and Lead Region are often the same.
15. **Non-Immediate Need/Non-Urgent/Routine complaints** = Indicates no Issue Level designated. It is expected that plans resolve these complaints within 30 days.
16. **“Other” contract assignment** = A complaint is identified as “other” in the contract number field when the beneficiary complains about a MA Organization or Part D Sponsor but the contract number was not identified or found at the time of intake.
17. **PDE** = Prescription Drug Event
18. **PHI and PII** = Protected Health Information and Personally Identifiable Information
19. **RO** = CMS Regional Office

- 20. RPC** = CMS' Retro-Processing Contractor (currently Reed and Associates)
- 21. SEP** = Special Enrollment Period
- 22. SWIFT** = Strategic Work Information Folder Transfer, CMS' tracking system for some CMS received correspondence from external entities, such as elected officials.
- 23. TRR** = Transaction Reply Report
- 24. "Unknown" contract assignment** = A complaint is identified as "unknown" in the contract number field when the beneficiary complains about a MA Organization or Part D Sponsor that is not known or when beneficiary complaint is not directed toward a MA Organization or Part D Sponsor.
- 25. Urgent complaint** = Type of issue level. For MA, an urgent complaint involves a situation where the beneficiary has no access to care, but no immediate need exists. For Part D, a complaint that is related to the beneficiary's need for medication where the beneficiary has 3 to 14 days of medication left. It is expected that a plan resolve these cases within 7 days.

Regional Office Mailboxes

- 1 – Boston** – PartDComplaints_RO1@cms.hhs.gov
Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont
- 2 – New York** – PartDComplaints_RO2@cms.hhs.gov
New Jersey, New York, Puerto Rico, Virgin Islands
- 3 – Philadelphia** – PartDComplaints_RO3@cms.hhs.gov
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
- 4 – Atlanta** – PartDComplaints_RO4@cms.hhs.gov
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
- 5 – Chicago** – PartDComplaints_RO5@cms.hhs.gov
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
- 6 – Dallas** – PartDComplaints_RO6@cms.hhs.gov
Arkansas, Louisiana, New Mexico, Oklahoma, Texas
- 7 – Kansas City** – PartDComplaints_RO7@cms.hhs.gov
Iowa, Kansas, Missouri, Nebraska
- 8 – Denver** – PartDComplaints_RO8@cms.hhs.gov
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
- 9 – San Francisco** – PartDComplaints_RO9@cms.hhs.gov
American Samoa, Arizona, California, Northern Mariana Islands, Guam, Hawaii, Nevada
- 10 – Seattle** – PartDComplaints_RO10@cms.hhs.gov
Alaska, Idaho, Oregon, Washington

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