DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

CENTER FOR DRUG AND HEALTH PLAN CHOICE

TO: All Part C Plans and Part D Plan Sponsors

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

SUBJECT: Updated Complaint Tracking Module (CTM) Guidance on Standard Operating Procedures

DATE: October 6, 2009

The Centers for Medicare and Medicaid Services (CMS) is pleased to share the updated Complaints Tracking Module (CTM) Part C and D Plan User Standard Operating Procedures (SOP) with all Medicare Part C and D Plan Sponsors. The attached document supersedes all prior versions of the SOP.

The CMS continues to monitor Sponsor performance of timely resolution of beneficiary complaints. Sponsors are accountable for the prompt resolution of CMS recorded complaints in the Complaints Tracking Module (CTM), and are required to have at least 95% of cases designated as "immediate" action resolved within two calendar days of receipt. Additionally, complaints categorized as "urgent" action should be resolved within ten calendar days. All other complaints should be resolved within thirty calendar days. These case resolution timeframes, which mirror CMS casework resolution timeframes, are referenced in scenario I. In addition, new scenario R outlines procedures to follow when plans are unable to make contact with Immediate Need beneficiaries to resolve their complaints.

It is imperative that all Sponsors understand that correct utilization of the CTM is critical to ensuring accuracy of complaint information. Sponsors are encouraged to continue to communicate regularly and work with the assigned regional office staff to appropriately resolve complaints.

Thank you again for your contribution to making the Medicare programs a success. If you have any questions or comments regarding this memorandum, please contact your Account Manager.

Attachment A

Complaints Tracking Module (CTM)
Standard Operational Procedure
Medicare Advantage (MA) Organization and Prescription Drug Plan (Part D) Sponsor Users
September 2009

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.

Note: Please carefully review the procedures below as there have been numerous revisions and additions since the last release of this document.

#	Scenario/ Issue	Procedure
	Complaint-specific Issues	
A	Plan A receives a complaint that should have gone to one if its subsidiaries or another organization.	1. Plan A selects the Plan Request tab and checks the option to indicate that this complaint belongs to another contract. If known, the name and/or contract number of the Plan to where the complaint must be reassigned should be included in the Casework Notes, along with any other pertinent comments. 2. Plans should work a complaint to resolution while a Plan Request is pending if it relates to one of its subsidiaries. 3. Complaints with pending Plan Requests cannot be closed. 4. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system as the complaint is reassigned to a different contract. If Plan A has access to the other contract number, then Plan A will be able to view the complaint under the new contract number. **Note:** Plans are not held accountable for complaints that are reassigned to another organization.
B	Plan A receives a complaint that involves one of its subsidiaries	This scenario has been deleted as it is covered in Scenario A.
C	Plan A cannot do further work with the complaint and requires RO assistance to resolve (CMS Issue)	1. Plan A selects the Complaint Resolution tab on the current entry page and explains why CMS intervention is needed, if access to services has been provided, and if the beneficiary has been contacted in the Casework Notes field. 2. Plan A selects the Plan Request tab and checks the option to indicate that this complaint is a CMS issue. 3. The RO will agree or disagree with the Plan Request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. 4. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system as

#	Scenario/ Issue	Procedure
		the complaint is flagged as “CMS Issue.” If the RO disagrees with the request, the plan will be given instructions on how to resolve the case in a Casework Note. **Note**: Examples of CMS Issues include, but are not limited to, the following: • Enrollment exceptions, including instances where the beneficiary is not enrolled in Part D and seeks to enroll outside an election period, • Beneficiary needs a critical RD/RE (see Scenario F) and though the plan has updated its systems to ensure access, a timely retroactive enrollment or disenrollment action in MARx is still required, • Enrollment Exception - Marketing Misrepresentation complaints where retroactive RO action is needed.
D	Plan A has reached resolution of the complaint but has not yet notified the beneficiary	1. On the Complaint Resolution tab, Plan A documents Casework Notes (see Scenario J) and indicates the complaint is resolved. 2. Plan A notifies the beneficiary according to Plan A’s business practices and customer service policies. **Note:** As a best practice, CMS recommends attempting to contact the complainant at least 3 times, with the 4th attempt in writing. Calling the complainant at different times on different days is also recommended. Details, including the dates and times of contact attempts, actions taken, etc., of all contact attempts should be documented in the CTM.
E	Plan A cannot close and/ or save the complaint after entering Casework Notes and a Resolution Date	1. Plan A verifies a resolution date is entered in the Resolution Date field and that it is not BEFORE the Received Date. **Note**: Resolution date must be entered in order for the complaint to be recorded as closed/resolved in the CTM. a. If there is no resolution date, enter and save the date the complaint was resolved. The complaint should close. If the complaint still does not save, move to item E.2. b. If there is a resolution date, move to item E.2. 2. Plan A verifies that the complaint category is assigned properly. a. If no category is assigned, refer to Scenario H. b. If a category is assigned, move to item E.3. 3. Plan A verifies that the following restricted characters were not entered in the Casework Note and/or the Resolution Date fields: < > & ; 4. Plan A confirms that there are no pending Plan Requests. 5. Plan A verifies that the CMS Retro-Processing Contractor data has been completed (both Referral

#	Scenario/ Issue	Procedure
		and Received Dates entered). 6. If no obvious problems are found, Plan A contacts the HPMS Help Desk at 1-800-220-2028 or HPMS@cms.hhs.gov.
F	Plan A receives complaints related to retroactive disenrollments (RDs) or retroactive enrollments (REs)	1. Plan A investigates the complaint to determine if it is a valid RD or RE request. 2. If the RD or RE request is not valid and the complaint is resolved, the plan notifies the beneficiary, documents Complaint Resolution Casework Notes (see Scenario J), and indicates the complaint is resolved. 3. If the RD or RE request is valid, Plan A determines if the complaint is Critical or Non-Critical. **Complaints labeled Immediate Need by 1-800-MEDICARE are ALWAYS considered Critical and are automatically flagged as "CMS Issue"**. Other complaints that shall be considered Critical include: a. Complaints that meet CMS' definition of immediate need but were not categorized as such. See Scenario I for definition. b. Complaints concerning opt-out due to employer group coverage. 4. Critical Retro-Disenrollment or Retro-Enrollment complaints are to be worked by CMS a. A Plan Request is to be submitted. and "CRITICAL RD" or "CRITICAL RE", as appropriate, is to be indicated in the Casework Notes. Plan A also needs to include reasons why a valid CRITICAL RD/RE request should be granted and the appropriate effective date, the Contract number and PBP number for the request. Plan A also needs to indicate in the Plan Request that its systems have been updated to ensure the beneficiary has access to drugs or health services and inform the beneficiary as appropriate. b. The RO will to agree or disagree with the Plan Request. c. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system. d. If Plan A receives a critical RE complaint directly that is not in the CTM, they should refer it to the RPC, after Plan A has updated its systems to ensure the beneficiary has access to drugs or health services. e. If Plan A receives a critical RD complaint directly that is not in the CTM, they should contact the Lead RO for assistance. 5. A Non-Critical Retro-Disenrollment or Retro-Enrollment complaint that requires an RD/RE with an effective date of the first of the current month or 2 months back should be referred to the RPC by Plan A.

#	Scenario/ Issue	Procedure
		a. Plan A should update its systems to ensure the beneficiary has access to drugs or health services, informing the beneficiary as appropriate. b. **Plan A leaves the complaint OPEN**, documents all complaint development, and indicates on the Complaint Resolution tab that the complaint has been referred to the Retro-processing Contractor (RPC) so that CMS' enrollment records can be updated. c. Plan A sends all required information to the RPC. d. Plan A documents RPC status as Casework Notes on the Complaint Resolution tab. Provide any status you receive from the RPC (e.g., receipt confirmation and date, disposition report response and dates received, contact notes and dates with the RPC). e. When a RD or RE complaint is resolved by the RPC, they will notify Plan A of the resolution. Subsequently, Plan A will note the Date Received from the RPC on the Complaint Resolution page and enter a Resolution Date and final Casework Note as the Resolution Summary. 6. A Non-Critical Retro-Disenrollment or Retro-Enrollment complaint that requires an RD/RE and exceeds the timeframe in Scenario 3, described in the 2/24/09 HPMS memo, should be handled as follows: a. Plan A should update its systems to ensure the beneficiary has access to drugs or health services. b. **Plan A leaves the complaint OPEN**, documents all complaint development, and indicates on the Complaint Resolution tab that the complaint has been referred to CMS for approval to send to the RPC. c. The Lead RO will approve or deny Plan Requests and determine if the RD/RE can be approved as necessary. **Note:** If Plan A receives a critical or non-critical RD/RE complaint directly that is not in the CTM, and exceeds the timeframe in Scenario 3, described in the 2/24/09 HPMS memo, they should contact their Account Manager for approval, after Plan A has updated its systems to ensure the beneficiary has access to drugs or health services. **Note:** On the plan system side, it is a program requirement that enrollments be opened as of the effective date. Organizations must ensure that enrollees have access to benefits as of the effective date of enrollment and may not delay provision of plan benefits in anticipation of the submission to or reply from CMS

#	Scenario/ Issue	Procedure
		systems. In other words, the plan system enrollment should be in effect timely, even if the enrollment is pending a transmittal to the RPC and submission to CMS systems.
G	Plan A receives an Enrollment Exception (EE) request (not including "Enrollment Exception – Marketing Misrepresentation (No RO Action Needed)" complaints)	1. After validating the complaint is truly an enrollment exception request, a Plan Request to indicate this is a "CMS Issue" is to be submitted and pertinent notes related to the complaint, including why the complaint is an EE, should be included in a Casework Note 2. If the RO agrees with the request, Plan A will no longer be able to see the complaint. If the RO disagrees with the request, Plan A will be provided instructions on how to resolve the case in a Casework Note. **NOTE:** Plans are not held accountable for EEs for the purposes of plan performance metrics.
H	Plan A receives a miscategorized complaint or a complaint with no assigned category and subcategory	1. Plan A adds a new Casework Note on the Complaint Resolution tab indicating any pertinent notes related to the complaint. 2. On the Plan Request tab, Plan A checks the option to indicate that this complaint requires reassignment to another complaint category. 3. Additionally, Plan A clicks the "Complaint Category" drop down box and then selects the most appropriate category. Plan A should also click the "Complaint Subcategory" drop down box and select an appropriate subcategory. Submit the request when complete. 4. If the complaint is still the responsibility of Plan A to resolve, casework should continue as CMS evaluates the Plan Request to change the category/subcategory.
I	Plan A receives a complaint but disagrees with the issue level.	1. Plan A is to submit a Plan Request for RO review from the Plan Request tab. An explanation as to why the complaint should have its issue level upgraded or downgraded needs to be entered as a Casework Note. Please note Immediate Need or Urgent issues can only be downgraded if they never were Immediate Need or Urgent. 2. The time clock for Plan A will stop once the indicator is checked and will commence once the issue level is changed, if appropriate. 3. If the complaint remains the responsibility of Plan A to resolve, casework should continue as CMS evaluates the Plan Request to change the issue level. **Note:** Issue Level Definitions • For MA, an immediate need complaint is defined as a complaint where a beneficiary has no access to care and an immediate need for care exists. Plans are required to resolve these complaints within 2 calendar days. • For Part D, an immediate need complaint is defined

#	Scenario/ Issue	Procedure
		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 this type of complaint within 2 calendar days. • For MA, an urgent complaint involves a situation where the beneficiary has no access to care, but no immediate need exists. It is recommended that urgent complaints be resolved within 10 days. • 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 recommended that urgent complaints be resolved within 10 days. • CMS reserves the right to classify any complaint that does not fit the above definitions to "Immediate Need" or "Urgent." • Plans are encouraged to provide interim responses to beneficiaries for all complaints, especially if resolution is not achieved within 10 days. It is recommended that all non-Immediate Need/non-Urgent cases be resolved within 30 days.
J	Plan A is ready to record Comments, Casework Notes, and Resolution information on the Complaint Resolution tab	1. On the Complaint Resolution tab, Plan A records a clear and concise narrative in the Casework Note field up to 4,000 characters. a. All entities reviewing CTM complaint records should be able to understand the Plan Response notation and all action(s) taken and decisions made related to the complaint investigation and resolution. **Vague responses such as "Case closed by Plan" are strongly discouraged.** b. Identify systems as "pharmacy", "enrollment," etc. c. Use only widely accepted abbreviations (i.e. LEP, SEP, BAE, etc.). d. Include systems issues, updates and dates actions taken. e. Include system update timeframes and transaction reply code(s) when appropriate. 2. The entry should contain information from Plan A's contact with the beneficiary/complainant and date(s) of contact. 3. In addition, if other person(s) are contacted, record those contact(s) information as a Casework Note. 4. Refer to the "Plan Response/ Resolution Examples" document which is available on the CTM Start Page as a link under Documentation. 5. Indicate that the complaint has been resolved and enter a Resolution Date. The final Casework Note entered can be copied to the Resolution Summary by clicking the checkbox under the Casework Note. 6. If the complaint was entered by a SHIP with CTM access, then Plan A should also contact that SHIP to notify them of the particulars regarding the complaint

#	Scenario/ Issue	Procedure
		resolution. SHIPs are instructed to include their contact information in their Complaint Summary. **Note:** See Scenario R for Best Practices for informing beneficiaries of complaint resolution.
K	Plan A receives a complaint with one or more of the following indicators flagged in the CTM: • Controlled in SWIFT • Congressional complainant type • Press or Hill Interest	1. Plan A contacts all parties related to the complaint in accordance with timeliness standards informing on expected plan actions and resolution. 2. Plan A effectuates investigation, resolution and records a clear and concise Casework Note on the Complaint Resolution tab and includes a SWIFT or Congressional notation. The entry must include all actions taken including contact, dates and instructions provided to the beneficiaries, complainant(s) and contacts. Include systems updates and the dates the actions were taken. 3. After resolving the complaint, Plan A submits a Plan Request to change the complaint to a CMS Issue since the RO is responsible for final closure of such cases. As a best practice, Plan A should request this within 2 to 7 calendar days to allow time for proper closure of the case by the RO. 4. The RO will agree or disagree with the Plan Request. If the RO agrees, the plan will no longer be able to view the complaint. If the RO disagrees, instructions on the plan's necessary steps will be included as a Casework Note. 5. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. **Note:** SWIFT, Congressional, Press, or Hill interest complaints are treated as immediate need or urgent in the CTM.
L	Plan A receives a complaint that is related to an SSA Premium Withhold Issue	1. Plan A reviews the complaint to correct premium amount and appropriate premium deduction based on beneficiary's preference and corrects if necessary. Plan A should inform the beneficiary that it may take up to 90 days to fully correct a premium withhold issue and recommend that the complainant call Plan A back or contact 1-800-Medicare after 90 days with no resolution. 2. If Plan A's system and MARx correctly reflects premium amounts and deduction method, but the beneficiary still complains that the premium deductions are incorrect, Plan A should review the date of the last transaction to see if sufficient time has elapsed (90 days since submittal) for posting corrections to CMS and SSA systems. If this time period has not elapsed, the plan should educate the beneficiary and close the complaint. 3. If the complaint is regarding SSA premium deductions that extend past the expected period or an action by

#	Scenario/ Issue	Procedure
		Plan A will not correct the issue, report the complaint to the Regional Office where the beneficiary resides (i.e., the Home Region) using current methods (i.e., via the Plan Request function) and leave the complaint **OPEN**. If the complaint is NOT in the CTM, send the complaint to the RO mailbox (specified at the end of this document). The subject line should state "SSA Premium Issue – Not in CTM" and the message should indicate the research already conducted. 4. Plan A should note if the complaint category needs to be changed on the Plan Request tab by checking that option and selecting an appropriate Category/Subcategory. Refer to Scenario H. **Note:** Refer to the March 23, 2007 HPMS memorandum regarding, "Clarification of Involuntary Disenrollment Policy for Beneficiaries who Elect Social Security Premium Withholding". **Note:** Plan A should report plan premium payment problems to Plan A's CMS DPO representative. • CTM complaints that include both a complaint that the beneficiary is getting billed while in SSA premium withhold status AND include a Plan A premium payment problem should remain **OPEN** until the beneficiary issue is resolved and the beneficiary is made whole. When Plan A has exhausted all avenues (cannot make the beneficiary whole) to resolve the beneficiary issue, the complaint should be considered a "CMS Issue" and the Region assigned should contact the appropriate CMS DPO representative on plan premium payment issues. • CTM complaints that include ONLY Plan A payment issues may be closed. Plan A should contact their CMS DPO representative on these issues, if necessary.
M	Plan A receives a provider/pharmacy complaint in the CTM	1. Plan A 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. Plan A 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 D and R) is also recommended for provider/pharmacy complaints.
N	Plan receives a complaint	1. Plan A carefully reviews the allegation of marketing

#	Scenario/ Issue	Procedure
	categorized as "Enrollment Exception – Marketing Misrepresentation (No RO Action Needed)"	misrepresentation and conducts an investigation, contacting the beneficiary if additional information is needed, per the conditions stipulated in the 10/3/2008 HPMS memo. 2. After investigating the complaint, Plan A corrects any underlying issues that may have led to the beneficiary complaint, including agent/broker termination or retraining. 3. Plan A 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 Plan A determines the Marketing Misrepresentation is unfounded, then that too should be indicated in Casework Notes on the Complaint Resolution tab.
O	Plan reviews a complaint categorized as "Enrollment Exception – Marketing Misrepresentation (RO Action Needed). NOTE: These complaints can only be viewed through the "Marketing Misrepresentation Reports" link located on the CTM Start Page.	1. Plan A carefully reviews the allegation of marketing misrepresentation and conducts an investigation. 2. Plan A 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, Plan A 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. Since Plan A cannot record actions taken to correct the situation on the Complaint Resolution tab, Plan A should maintain an internal record of what steps were taken, so they may be provided to CMS upon request.
P	Plan A receives a repeat complaint from the same caller	Plan A identifies the new complaint is the same issue of a previous complaint entered into the CTM. 1. Plan A searches for all complaints by the same member and researches the issue. This search is done with the Repeat Complainant report. 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. 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 caller case, but should treat the complaint as a separate issue.
Q	Plan A needs RO	1. Plan A follows the details specified in the August 4,

#	Scenario/ Issue	Procedure
	assistance to secure BAE (Best Available Evidence) on behalf of a beneficiary	2008 HPMS memo and completes the worksheet (Attachment B from that memo). 2. Plan A sends the worksheet to the home Regional Office via an encrypted e-mail, noting in the subject line “Immediate BAE Assistance Needed” or “Non-Immediate BAE Assistance Needed”. 3. Upon receiving the worksheet back from the Regional Office, Plan A updates their internal systems and submits the change to the RPC if necessary. 4. Plan A attempts to notify the beneficiary within one business day of receiving RO results. After notifying the beneficiary (by telephone or in writing), the plan closes the case in the CTM (the RO will have recorded the case in the CTM upon initial receipt).

R	Plan A receives an Immediate Need complaint, but is unable to contact the beneficiary after multiple attempts	1. An Immediate Need complaint may be closed after failed attempts to reach the beneficiary for additional details after Plan A has completed the following:
		
		• Attempted at least 3 telephone contacts, leaving messages when possible
		    • Attempts should be made at varying times within 48 hours of receipt of the complaint
		    • Documented all contact efforts in CTM Casework Notes
		• After the failed telephone attempts and prior to case closure, Plan A should send a letter to the beneficiary, explaining that multiple contacts were attempted and providing a call-back number for the beneficiary to reach out to Plan A.
		• The date the letter was sent should be documented in a CTM Casework Note and the CTM case may be closed.

	Access	
S	Plan user needs HPMS Access but does not have it	1. Plan user completes the standard “Application for Access to CMS Computer Systems” form found at http://www.cms.hhs.gov/AccesstoDataApplication. 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: C4-14-21 Baltimore, MD 21244 **Note**: We strongly recommend the use of a traceable mail carrier to ensure a timely delivery. HPMS user set up may take 2 weeks or longer. 3. Once the Plan user is notified of their HPMS access, Plan user sends an e-mail to

#	Scenario/ Issue	Procedure
		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.
T	Plan user has HPMS access but needs CTM access	1. 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.
	General	
U	Plan A has a general CTM related question or issue	1. Plan A sends the inquiry to CMS at CTM@cms.hhs.gov. 2. The subject line should state if the question or issue is related to Part C, Part D, or both. 3. The e-mail includes: a. the name and contract number of Plan A, b. the question or issue, c. pertinent information related to the concern at hand, and d. complaint ID(s), if the matter is complaint-specific.

Key & Definitions

1. BAE = Best Available Evidence
2. "CMS Issue" contract assignment = a complaint is flagged as a "CMS Issue" when the complaint is a CMS issue 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 = CPC's Division of Payment Operations
6. EE = Enrollment Exception
7. HICN = Health Insurance Claim Number; beneficiary's unique identifier
8. Home Region = Regional Office that services the state or territory where the beneficiary or provider resides
9. HPMS = Health Plan Management System
10. Immediate Need complaint = a.k.a. "immediate action"; type of issue level. 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
11. Lead Region = Regional Office that has primary responsibility for the management of complaints for a particular plan
12. Non-Immediate Need/Non-Urgent/Routine complaints = indicates no Issue Level designated. It is recommended that plans resolve these complaints within 30 days.
13. "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
14. PHI = Protected Health Information
15. Plan A, B, etc. = Any MA Organization/Part D Sponsor
16. RD = Retroactive Disenrollments
17. RE = Retroactive Enrollments
18. RO = Regional Office
19. RPC = Retro-processing Contractor (i.e., Integriguard)
20. SWIFT = Strategic Work Information Folder Transfer, CMS' tracking and triage system for CMS received correspondences from external entities, such as Congressmen, Senators, beneficiaries, etc.
21. "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
22. 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 recommended that a plan resolve these cases within 10 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, Commonwealth of the Northern Mariana Islands, Guam, Hawaii, Nevada
10 – Seattle – PartDComplaints_RO10@cms.hhs.gov
Alaska, Idaho, Oregon, Washington

September 2009 Revisions

Scenario / Issue	Change Made
A	Merged with Scenario B
B	Deleted and merged with Scenario A
I	Added recommendations for resolution timeframes for Urgent and for Non-Immediate Need/Non-Urgent complaints.
L	Clarified procedures regarding timeframes for Premium Withhold issue resolution – beneficiaries should be notified that it could take up to 90 days to resolve these issues and should be advised to call back the plan or 1-800-Medicare if 90 days have passed and the issue is still unresolved
M	Specifically included Pharmacies as Providers in the scenario
R	New Scenario added regarding inability to contact Immediate Need beneficiaries
S, T, U	Re-labeled from R, S and T
Throughout	Streamlined procedures, provided clarification and reduced redundancy