DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR DRUG AND HEALTH PLAN CHOICE

MEMORANDUM

Date: **April 3, 2009**

Memorandum to: **All Medicare Part C and D Plan Sponsors**

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

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

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 SOP supersedes all prior versions.

As a reminder, 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" need resolved within two calendar days of receipt. Additionally, complaints categorized as "urgent" need 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 section I of the SOP.

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.

We appreciate your continued dedication to responding to the needs of our beneficiaries. If you have any further questions or comments regarding these procedures or the CTM, please contact the CMS via email at ctm@cms.hhs.gov.

Attachment A

Complaints Tracking Module (CTM)
Standard Operational Procedure
Medicare Advantage (MA) Organization and Prescription Drug Plan (Part D) Sponsor Users
Effective: April 3, 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 Plan B	1. Plan A selects the Complaint Resolution tab on the current entry page and adds a new Casework Note, indicating: a. if known, the name and/or contract number of the Plan to where the complaint must be reassigned and, b. any additional pertinent notes related to the complaint. 2. Plan A selects the Plan Request tab and checks the option to indicate that this complaint belongs to another plan. 3. The CTM will not allow Plan A to close the complaint while a Plan Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to 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. For updates on the request, Plan A will be able to view if the RO disagrees with the request on the Plan Request tab and can view any Comments or Casework Notes on the Complaint Resolution tab. 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.

#	Scenario/ Issue	Procedure
		Note: When a complaint is assigned from one contract to another, the "clock" restarts for the new contract. This is captured through the assignment/reassignment date.
B	Plan A receives a complaint that involves one of its subsidiaries	1. Plan A selects the Complaint Resolution tab on the current entry page and adds a new Casework Note, indicating: a. the contract number of the Plan to where the complaint must be reassigned and, b. any additional pertinent notes related to the complaint. 2. Plan A selects the Plan Request tab and checks the option to indicate that this complaint belongs to another plan. 3. The CTM will not allow Plan A to close the complaint while a Plan Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to 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. For updates on the request, Plan A will be able to view if the RO disagrees with the request on the Plan Request tab and can view any Comments or Casework Notes on the Complaint Resolution tab. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system under the previous contract number as the complaint is reassigned to a different contract. If Plan A has access to the subsidiary's contract number, then Plan A will be able to view the complaint under the new contract number. **Note: When a complaint is assigned from one contract to another, the "clock" restarts for the new contract. This is captured through the assignment/reassignment date.**
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 enters a pertinent Casework Note related to the complaint. 2. Plan A selects the Plan Request tab and checks the option to indicate that this complaint is a CMS issue. 3. The CTM will not allow Plan A to close the complaint while a Plan Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to

#	Scenario/ Issue	Procedure
		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. For updates on the request, Plan A will be able to view if the RO disagrees with the request on the Plan Request tab and can view any Comments on the Complaint Resolution tab. 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 flagged as "CMS Issue." **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, Plan A attempts to contact the complainant at least 3 times, with the 4th attempt in writing. Plan A should attempt to contact the beneficiary/complainant at different times on different days in order to ensure maintaining best practice. Plan A records detail, including the dates and times of contact attempts, actions taken, etc., of all attempts in CTM and then closes the complaint.
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

#	Scenario/ Issue	Procedure
		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 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 a complaint is incorrectly categorized as an RD or RE or requires referral to another Plan, see Scenario H or A, respectively, in this SOP. 4. 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. For MA and MAPD: the complaint concerns immediate need to access to care. b. For MA, MAPD, and PDP: the complaint concerns opt-out due to employer group coverage. 5. Critical Retro-Disenrollment or Retro-Enrollment complaints are to be worked by CMS a. On the Plan Request tab, Plan A checks the option to indicate that this complaint is a CMS issue. On the Complaint Resolution tab, Plan

#	Scenario/ Issue	Procedure
		A enters a new Casework Note, indicating "CRITICAL RD" or "CRITICAL RE", as appropriate. Plan A also needs to include reasons why a valid CRITICAL RD/RE request should be granted and the appropriate effective date 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 complaint is flagged in the CTM for the RO to 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. c. 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 flagged as a "CMS Issue." d. If Plan A receives a critical RD/RE complaint directly that are 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. 6. 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. 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

#	Scenario/ Issue	Procedure
		(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. 7. A Non-Critical Retro-Disenrollment or Retro-Enrollment complaint that requires an RD/RE and exceed 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 or Lead Region designate for assistance, 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 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

#	Scenario/ Issue	Procedure
		CMS systems.
G	Plan A receives an enrollment exception request (not including "Enrollment Exception – Marketing Misrepresentation (No RO Action Needed)" complaints)	1. After validating the complaint is truly an enrollment exception request, Plan A adds a new Casework Note on the Complaint Resolution tab, indicating: a. "EE Complaint" and b. any additional pertinent notes related to the complaint. 2. On the Plan Request tab, Plan A checks the option to indicate that this is a CMS issue. 3. The CTM will not allow Plan A to close the complaint while a Plan Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to 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. For updates on the request, Plan A will be able to view if the RO disagrees with the request on the Plan Request tab and view any Comments entered on the Complaint Resolution tab. 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 now flagged as a "CMS Issue."
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. The CTM will not allow Plan A to close the complaint while a Plan Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to recategorize the complaint. 5. For updates on the request, Plan A will be able to view the RO action/decision on the Plan Request tab and can view any Comments entered on the Complaint Resolution tab. 6. If the CTM Complaint Summary indicates a Marketing Misrepresentation complaint, but the

#	Scenario/ Issue	Procedure
		Complaint Category DOES NOT reflect such (i.e., shows “Inappropriate Enrollment”, etc.), Plan A should submit a Plan Request to change the category to “Marketing Misrepresentation (RO Action Needed)”.
I	Plan A receives a complaint with an issue level of “Immediate Need” or “Urgent”, but Plan A does not agree with the issue level.	1. Plan A adds a new Casework Note on the Complaint Resolution tab and details any pertinent notes related to the complaint. 2. From the Plan Request tab, Plan A selects the check box that the complaint requires reassignment to another issue level and from the drop down box provided selects the appropriate issue level for the complaint. (Please refer to the Issue Level Definitions note below to determine the appropriate issue level for the complaint). Select “Submit” when the request is complete. 3. The CTM will not allow Plan A to close the complaint while a Plan Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to reassign the complaint. The time clock for Plan A will stop once the indicator is checked and will commence once the complaint is reassigned. 4. For updates on the request, Plan A will be able to view the RO action/decision on the Plan Request tab and any Comments or Casework Notes entered on the Complaint Resolution tab. 5. If the complaint was indeed Immediate Need (i.e., pharmacy system needed to be activated), and Plan A has taken action to address the immediacy but retroactive enrollment changes are still needed, then Plan A should forward the needed MARx enrollment action, as required, to the RPC (see Scenario F). On the Complaint Resolution tab, Plan A should also indicate, that the complaint has been referred to the RPC and the date of that referral. New procedures will be put in place to insure that plans’ performance metrics are not compromised when an Immediate Need issue level is checked AND the RPC information has been entered (i.e., if the immediacy is resolved within two days and additional actions are needed, but out of the plan’s direct control, the delay will not be counted against the plan). **Note:** Issue Level Definitions • For MA, an immediate need complaint is defined as

#	Scenario/ Issue	Procedure
		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 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. • 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. • CMS reserves the right to classify any complaint that does not fit the above definition to "Immediate Need" or "Urgent" should the complaint be egregious in nature.
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. Minimize the use of word abbreviations. 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.

#	Scenario/ Issue	Procedure
		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 participating in the SHIP CTM Pilot (Current CTM Pilot states include: IA, LA, ME, MT, NV, NY, OH, and SC), then Plan A should also contact that SHIP to notify them of the particulars regarding the complaint resolution. SHIPs will be instructed to include their contact information in their Complaint Summary. **Note:** As a best practice, Plan A attempts to contact the complainant at least 3 times, with the 4th attempt in writing. Plan A should attempt to contact the beneficiary/complainant at different times on different days. Plan A records details, including the dates and times of contact attempts, actions taken, etc., of all attempts in CTM and then closes the complaint.
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 checks the option on the Plan Request tab 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 CTM will not allow will not allow Plan A to close the complaint while a Plan Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to 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. 5. For updates on the request, Plan A will be able to

#	Scenario/ Issue	Procedure
		view if the RO disagrees with the request on the Plan Request tab and view any Comments or Casework Notes on the Complaint Resolution tab. 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 flagged as a "CMS Issue." **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 for correct premium amount and appropriate premium deduction based on beneficiary's preference and corrects if necessary. 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 (60-90 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 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".

#	Scenario/ Issue	Procedure
		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 Home 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 complaint in the CTM	1. Plan A reviews the complaint and contacts the provider 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.
N	Plan receives a complaint categorized as "Enrollment Exception – Marketing Misrepresentation (No RO Action Needed)"	1. Plan A 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. 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.

#	Scenario/ Issue	Procedure
		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 easily 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 newer issue as a repeat caller case, but should treat the complaint as a separate issue.
Q	Plan A needs RO assistance to secure BAE (Best Available Evidence) on behalf of a beneficiary	1. Plan A follows the details specified in the August 4, 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

#	Scenario/ Issue	Procedure
		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).
		Access
R	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 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.
S	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
T	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 Medicare Advantage or Part D. 3. The e-mail includes:

#	Scenario/ Issue	Procedure
		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. CIS = Customer Inquiry System; CMS' old tracking and triage system for CMS received correspondences from external entities, such as Congressmen, Senators, etc. (now defunct and being replaced by SWIFT)
3. "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
4. Congressional Complainant = CMS complaint submitted by congressperson on behalf of his/her constituents
5. CTM = Complaints Tracking Module, a module within HPMS
6. DPO = Division of Payment Operations (CO)
7. EE = Enrollment Exception
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 = 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
12. Lead Region = Regional Office that has primary responsibility for the management of complaints for a particular plan
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. (replaces CIS)
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.

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

April 2009 Revisions (Scenario references apply to the current state of the SOP unless referring to complete Scenario deletions.)

Scenario / Issue	**Change Made**
Throughout	Replaced references to "Current Entry (Plan Response)" with "Complaint Resolution tab" Changed references to "Plan Resolution Request" with "Plan Request tab" Replaced references to "Notes to Plan" with "Plan Request tab" and additional references to "Comment" or "Casework Note" entry fields Reference new paths to report Complaint Resolution New navigational paths for changing Category/Subcategory designations

Scenario / Issue	Change Made
C	Deleted reference to “enrollment reconciliation processing” – does not really apply any more as that really pertains to 2006 activities.
D	Deleted – MA/Part D assignment is done systematically now.
E	Deleted – MA/Part D assignment is done systematically now.
Scenarios after C	Re-lettered due to Scenario D/E removal.
F	Added Note regarding Plans’ responsibility to update their systems with enrollment information in a timely manner Added Procedures for non-critical RDs/REs greater than 2 months back that require Lead RO approval prior to forwarding to the RPC.
H	Added new Procedure 6 dealing with Marketing Misrepresentation (RO Action Needed) complaints
I	Added new procedures dealing with the new RPC fields in the CTM
J	Changed “should be avoided” to “are strongly discouraged” in regards to vague Casework Notes entered in the CTM Added new Procedures to advise Plans to contact SHIPs who entered complaints directly IF their contact number is provided in the Complaint Summary
K	Added information on turnaround time for Congressional cases. Added information advising Plans that SWIFT/Congressional cases should not be closed by the Plans, but by the ROs.
old Scenario O	Deleted the scenario dealing with Premium Reconciliation – Refund or Billing Issue complaints.
M	Modified procedures and added additional clarification to what may constitute a Provider complaint.
N	Elaborated on procedures that should be followed when responding to and documenting outreach done on Marketing Misrepresentation (No RO Action Needed) complaints
O	New – added procedures surrounding Marketing Misrepresentation (RO Action Needed) complaints
P	Refined procedures to better define how to deal with repeat complainants
Q	New – added procedures regarding RO assistance on BAE requests.
old Scenario R	Deleted – regarding complaints that the Plan receives that need to be entered into CTM. Plan should contact RO directly.

Scenario / Issue	Change Made
Scenarios after Q	Re-lettered still due to Scenario R removal.
Keys & Defs	Minor changes to CIS and SWIFT definitions
RO Mailboxes	Corrected RO9 and RO10 mailbox addresses