DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid 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 Complaint Tracking Module (CTM) Guidance on Standard Operating Procedures (SOP)

DATE: September 30, 2011

The Centers for Medicare & Medicaid Services 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 memo issued October 22, 2010.

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

Your organization will find the following updates to the CTM SOP:

- Plans are encouraged to notify beneficiaries when their complaint is reassigned to another Plan for resolution.

- Critical retroactive enrollments are now to be referred to the Retroactive Processing Contractor (RPC). Critical retroactive disenrollments should continue to be referred to CMS. When RPC actions are requested, plans are encouraged to notify beneficiaries that it may take one month for CMS systems to be updated.

- Added step documenting how to complete the new "Contact Made" and "System Update" fields.

- Plans are encouraged to review ALL complaints at initial intake, even those that are not Immediate Need or Urgent, to verify contact number and Issue Level.

- Congressional CTM cases requiring an enrollment change should NOT be sent to the RPC and should be sent back to CMS for MARx action..

- Added instructions for attaching documentation to "Alleged Marketing Misrepresentation – (RO Action Needed)" complaints.

- Added instructions indicating that an attachment description as well as selection from the new dropdown list further describing the attachment are required.

- The new Good Cause process for failure to pay premiums, effective in 2012, is a new scenario.

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.

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

Complaints Tracking Module (CTM)
Standard Operational Procedure
Medicare Advantage (MA) Organization and Prescription Drug Plan (Part D) Sponsor Users
Effective October 1, 2011

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 are encouraged to notify the beneficiary that their complaint has been reassigned to the appropriate Plan. 3. Plans should work a complaint to resolution while a Plan Request is pending if it relates to one of its subsidiaries. 4. Complaints with pending Plan Requests cannot be closed. 5. 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.
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. • 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" and CMS will be responsible for resolving the complaint. • If the RO disagrees with the request, the RO will provide instructions on how to resolve the case in a Casework Note or in Comments. . **Note**: Examples of CMS Issues include, but are not

#	Scenario/ Issue	Procedure
		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 retroactive enrollment or disenrollment action be taken in MARx (see Scenario F) even though the plan has updated its systems to ensure access. • Enrollment Exception – Alleged Marketing Misrepresentation complaints where retroactive RO action is needed. • Beneficiary has lost coverage due to a loss of Part A/B entitlement (perhaps an erroneous loss of eligibility). • Also, please refer to the April 27, 2011 HPMS memo regarding exclusion criteria addressing complaint issues outside the control of the Plans. **Note**: Plans are encouraged to make interim contact with their members if their complaints will take more than seven days to resolve, even when a complaint has been referred to CMS as a "CMS Issue" as it will reduce the likelihood of a repeat complaint by the beneficiary.
D	Plan A has reached resolution of the complaint but has not yet notified the beneficiary	1. Plan A notifies the beneficiary or complainant according to Plan A's business practices and customer service policies. 2. Plan A proceeds to resolve the complaint by following the steps in Scenario J. **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. **Note:** Some SHIP Counselors, when entering a complaint in CTM, may request in the Complaint Summary that the Plan call the Counselor, rather than the Beneficiary, with resolution details.
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.

#	Scenario/ Issue	Procedure
		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 or enrollments	1. Plan A investigates the complaint to determine if it is a valid retroactive enrollment or disenrollment request. 2. If the 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 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.** 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 retroactive enrollment complaints should be handled in Plan A's systems to ensure access to drugs or health services. These are to be sent to the RPC for updates to be made to CMS systems. Plan A should inform the beneficiary that it may take one month for the change to be reflected in CMS' systems. a. If Plan A receives a critical retroactive enrollment complaint directly that is not in the CTM, they should also refer it to the RPC, after Plan A has updated its systems to ensure the beneficiary has access to drugs or health services. 5. Critical retroactive disenrollment complaints are to be sent to CMS: a. A Plan Request is to be submitted. and "CRITICAL Retroactive Disenrollment" is to be indicated in the Casework Notes. Plan A also needs to include reasons why a valid CRITICAL 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

#	Scenario/ Issue	Procedure
		Request that its systems have been updated and that they have informed the beneficiary as appropriate. Plan A should inform the beneficiary that it may take one month for the change to be reflected in CMS' systems. b. The RO will 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 retroactive disenrollment complaint directly that is not in the CTM, they should contact the Lead RO for assistance. 6. A Non-Critical retroactive complaint dealing with enrollment or disenrollment that requires 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. Plan A should inform the beneficiary that it may take up to one month for the change to be reflected in CMS' systems. 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. Complaints should not be closed until the RPC has processed the needed action (see Step 5.e below). 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 retroactive 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 retroactive complaint that exceeds the timeframe 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

#	Scenario/ Issue	Procedure
		services. Plan A should inform the beneficiary that it may take up to one month for the change to be reflected in CMS' systems. 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. Complaints should not be closed until the RPC has processed the required action. c. The Lead RO will determine if any Plan Requests can be approved as necessary. **Note:** If Plan A receives a critical or non-critical enrollment-related 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 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. **Note:** 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. Reinstatements for Good Cause are noted in Scenario V. **Note:** Immediate Need cases referred to the RPC for retroactive action, and where Plan A has made the appropriate changes in their system, will be excluded from plan turnaround/closure metrics. These cases will continue to be included in overall Plan Rating complaint counts.
G	Plan A receives an Enrollment Exception (EE) request (not including "Enrollment Exception – Marketing Misrepresentation (No RO Action Needed)"	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

#	Scenario/ Issue	Procedure
	complaints)	longer be able to see the complaint and CMS will be responsible for resolving the complaint. 3. If the RO disagrees with the request, the RO will provide 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. Starting in December 2011, plans will no longer be able to view the Enrollment Exceptions subcategory in CTM.**
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:** Plans are encouraged to review ALL complaints at intake, even those that are not Immediate Need or Urgent, to verify contract number and issue level are correct. **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 95% of 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

#	Scenario/ Issue	Procedure
		for medication where the beneficiary has 2 or less days of medication left. Plans are required to resolve 95% of 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 expected that 95% of urgent complaints be resolved within 7 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 expected that 95% of urgent complaints be resolved within 7 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 7 days. It is expected that 95% of all non-Immediate Need/non-Urgent cases be resolved within 30 days. **Note:** Plans requesting that CMS downgrade an Issue Level, after the access portion of the complaint has been addressed, will not be approved unless the issued level was originally incorrect. **Note:** 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).
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. Document the root cause of the issue impacting the beneficiary to ensure that originating issues are addressed. c. Identify systems as "pharmacy", "enrollment," etc. d. Use only widely accepted abbreviations (i.e. LEP, SEP, BAE, etc.). e. Include systems issues, updates and dates actions taken. f. Include system update timeframes and transaction reply code(s) when appropriate. **Note:** Plans are encouraged to provide ongoing, interim

#	Scenario/ Issue	Procedure
		documentation and notes as they work toward the ultimate resolution of the complaint. 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. Make a selection from the "Contact Made" dropdown list and/or select "System Update Action Taken". At least one of these must be populated in order to resolve and close the complaint. 6. Indicate that the complaint has been resolved and enter a Resolution Date. The final Casework Note entered will automatically be included in the Resolution Summary. Other notes can be included as desired by clicking the checkbox under the Casework Note. 7. 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 resolution. SHIPs are instructed to include their contact information in their 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. **Note:** See Scenario R for Best Practices for informing beneficiaries of complaint resolution. **Note:** If the resolution involves a refund that is due from Plan A to the beneficiary (any beneficiary overpayment of co-payments, premiums, late enrollment penalties, etc.), the complaint can be closed once that refund is issued.
K	Plan A receives a complaint with one or more of the following indicators flagged in the CTM: • Controlled in SWIFT (viewable under Other Complaint Information) • Congressional complainant type • Press or Hill Interest	1. Plan A contacts the beneficiary or provider 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. Plan A's casework should be completed within 2 to 7 calendar days. 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. Congressional cases dealing with enrollment changes should NOT be sent to the RPC, but should be referred to the RO as a CMS Issue via a Plan Request.

#	Scenario/ Issue	Procedure
		Note: For Congressional cases, Plan A should NOT notify the congressional office of the resolution as this is CMS' responsibility. 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. For Congressional cases, the RO is also responsible for any necessary enrollment changes and the RO will notify the congressional office of the resolution. 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. **Note:** Closure of SWIFT cases by Plans is now systematically prevented. A Plan Request of a CMS Issue must be made so the Regional Office can review and close the complaint.
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/issue a needed refund 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 the SSA withholding issue is related to a non-current year or an action by Plan A will not correct the issue, submit a Plan Request to change this to a CMS Issue 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

#	Scenario/ Issue	Procedure
		line should state "SSA Premium Issue – Not in CTM" and the message should indicate the research has been 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 categorized as "Enrollment Exception – Alleged 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

#	Scenario/ Issue	Procedure
		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 – Alleged Marketing Misrepresentation (RO Action Needed). NOTE: These complaints can only be viewed through the "Marketing Misrepresentation Report" 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. When Plan A 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. Plan A will only be able to attach documents to the complaint and will not be able to enter or change any other data. Plan A should navigate to the Complaint Attachments tab and upload the documentation as they would attach documents elsewhere in CTM (see Scenario T).
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.

#	Scenario/ Issue	Procedure
		Note: The 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, proactively outreach to them, and offer specialized assistance in an effort to reduce the likelihood of additional repeat complaints.
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 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. Plan A should inform the beneficiary that it may take up to one month for the change to be reflected in CMS' systems. 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. Under the Documentation link, a "Template Resolution Letter' link is available for your use as needed.
		• The date the letter was sent should be documented in the CTM Casework Note and the CTM case may be closed.

S	Plan A receives a complaint related to the 2010 $250 rebate checks issued to beneficiaries entering the coverage gap/meeting the $2830 threshold for year-to-	1. Plan A should verify that the beneficiary is NOT receiving any level of low-income subsidy (LIS). LIS beneficiaries are the only members not eligible for the rebate check. If the complainant receives LIS, the plan should contact the beneficiary to inform them they are not eligible for the check.

#	Scenario/ Issue	Procedure
	date total medication costs	2. If Plan A confirms that the beneficiary does not receive LIS, Plan A should verify that the beneficiary has reached the coverage gap and that all PDEs have been submitted to CMS. Beneficiaries should be informed of their coverage gap status and that it could take 90 days to receive the rebate check after reaching that coverage gap. If the coverage gap has been reached and all PDEs have been sent to CMS, Plan A should submit a Plan Request to make the complaint a CMS Issue. 3. If Plan A receives a complaint that the beneficiary has received the rebate check, but has returned it because they thought they were not entitled, Plan A should inform the beneficiary that they are entitled and that a request to reissue the check will be submitted to CMS. Plan A should submit a Plan Request to make the complaint a CMS Issue. 4. If Plan A receives a CTM case stating that the rebate check was received but the payee is now deceased, Plan A should submit a Plan Request to make the complaint a CMS Issue and advise the complainant that they will be contacted by CMS. **Note:** Non-LIS beneficiaries enrolled in employer group waiver plans ARE eligible for the rebate. Even though these plans don't really have a coverage gap, the criteria for issuing the check is when the $2830 TOTAL medication cost has been met.
T	Plan A has supporting documentation that relates to a complaint	1. Plan A should open the Complaint Attachments tab within CTM and attach any documents that are pertinent to the complaint (i.e., .pdf files, Word documents, Excel spreadsheets, .zip files). 2. Examples of appropriate documents to attach are beneficiary communications, system screen prints, and notifications received from third parties such as the RPC. 3. Enter descriptive text in the free-form description field. This is a mandatory field. 4. Select a description to further document the attachment from the dropdown list. If "Other" is selected, the "Other" text box must also be completed with a brief description. This is a mandatory entry. 5. The uploaded documents will appear as listed attachments only after saving changes to the CTM record. **Note:** Plans can also view any documents attached by CMS or SHIP users.
U	Assignment/Reassignment date is reset	Following are general timelines for the resetting of Assignment/Reassignment dates, other than those noted in specific scenarios above: • Complaint is re-opened • Issue Level is changed from non-Issue/Urgent to Urgent/Immediate (Issue Level is upgraded)

#	Scenario/ Issue	Procedure
		• CMS Issue flag is set or removed (Plan Request must be accepted for the clock to be reset) • Contract is changed
V	*Effective 2012:* Plan A sees a complaint in the "Good Cause - Disenrollment for Failure to Pay Premiums" subcategory or "Good Cause – Failure to Pay Part D-IRMAA" subcategory	NOTE: For purposes of this SOP, requests for good cause reinstatement are called "complaints" because CMS is using the CTM system to communicate with plans for these requests for reinstatement. 1. If the complaint has no issue level, it is under review by the RO and no action is needed by the plan. If a request for reinstatement for good cause has received an approved determination (i.e., good cause criteria is met) by the RO, the complaint will show as "urgent." 2. Upon identification of an approved good cause determination, Plan A will send the required notification to the beneficiary within 3 days of receiving the "urgent" plan action in CTM. The notice will indicate that they have 3 months from the effective date of disenrollment to bring their account up to date. (See model notice in Chapters 2 & 3 of enrollment manuals.) Plans may choose to supplement the letter with a telephone call to the beneficiary. 3. If the owed arrearage and premiums that have accumulated since the disenrollment have been paid in full for a beneficiary with an approved good cause request within the 3-month timeframe, Plan A will submit a Plan Request indicating this is a "CMS Issue." No reinstatement may occur until the arrearage is paid in full. Pertinent notes related to the collection of past due amounts should be included in a Plan Casework Note. (i.e.: receipt of all owed payments and date received.) Plan A will also grant access to drugs/services for the beneficiary*. The RO will accept the CTM as a "CMS Issue" and reinstate the beneficiary by cancelling the disenrollment. The CMS caseworker will update notes in the CTM and close the case. (The plan will send the beneficiary a notice of reinstatement once they receive the TRR from CMS, as outlined in Chapters 2 & 3.) 4. If necessary payment was not received within the 3-month timeframe, Plan A 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

#	Scenario/ Issue	Procedure
		inform them that the disenrollment stands/no reinstatement will occur and of their future re-enrollment options, and close the case. **Note:** See Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Manage Care Manual for more information. The "complaints" entered into CTM for good cause reinstatement requests will not be included for the purposes of plan performance metrics. **Note:** : Plans still have to collect any premiums owed to themselves for the 3 months during the good cause determination process when there is a Part D IRMAA good cause request. * ***Plans should not grant access to care in cases where an individual owes Part D–IRMAA. These cases will be notated in CTM by special casework notes by the CMS RO.***
V1	*Effective 2012:* Plan A receives request for reinstatement for good cause	1. Plan A will convey main points about the parameters of requesting reinstatement for good cause and that the formal request must be made within 60 days of the effective date of disenrollment. (See Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Manage Care Manual for more information.) 2. Plan A refers beneficiary to call 1-800-MEDICARE to formally make reinstatement request. NOTE: Plans cannot enter/initiate "complaints" for requests for reinstatement for good cause.
		Access
W	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.

#	Scenario/ Issue	Procedure
		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.
X	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	
Y	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 = CM/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. PDE = Prescription Drug Event
15. PHI = Protected Health Information
16. Plan A, B, etc. = Any MA Organization/Part D Sponsor
17. RO = Regional Office
18. RPC = Retro-processing Contractor (currently Reed and Associates)
19. SWIFT = Strategic Work Information Folder Transfer, CMS' tracking and triage system for CMS received correspondences from external entities, such as Congressmen, Senators, beneficiaries, etc.

20. "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
21. 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 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, Commonwealth of the Northern Mariana Islands, Guam, Hawaii, Nevada
10 – Seattle – PartDComplaints_RO10@cms.hhs.gov
Alaska, Idaho, Oregon, Washington

October 2011 Revisions

Scenario / Issue	Change Made
A	Plans are encouraged to notify beneficiaries when their complaint is reassigned to another Plan for resolution.
D	Referred Plans to Scenario J for steps on final plan resolution.
F	Critical retroactive enrollments are now to be referred to the RPC. Critical retroactive disenrollments should continue to be referred to CMS. When RPC actions are requested, Plans should notify the beneficiaries that it may take one month for CMS systems to be updated.
I	Plans are encouraged to review ALL complaints at intake, even those that are not Immediate Need or Urgent, to verify contract number and Issue Level.
J	Added step documenting how to complete the new "Contact Made" and "System Update" fields.
K	Added note explaining how SWIFT cases are now systematically blocked from Plan closure. Congressional cases requiring enrollment action should NOT be sent to the RPC, but should be forwarded to CMS. Plans should NOT contact congressional offices with case resolution as this is CMS' responsibility.
O	Added instructions for attaching documentation to "Alleged Marketing Misrepresentation – (RO Action Needed)" complaints.
T	Added instructions indicating that an attachment description as well as a selection from the new dropdown list further describing the attachment are required.
V and V1	New Good Cause process added, effective in 2012.