



CENTER FOR MEDICARE

DATE: January 6, 2025

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Section 1876 Cost Plans, Programs of All-Inclusive Care for the Elderly, and Demonstration Organizations

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SUBJECT: Updated Complaints Tracking Module Standard Operating Procedures

This memorandum provides an updated Complaints Tracking Module (CTM) Standard Operating Procedures (SOP) that is effective beginning with Contract Year (CY) 2025 and replaces the SOP released in May 2019.

Background

The information in this memorandum refers only to complaints entered in the CTM. CMS developed the CTM in the Health Plan Management System (HPMS) to track complaints received by CMS from beneficiaries, providers, and their representatives regarding specific Medicare Advantage (MA) organizations, Cost Plans, Programs of All-inclusive Care for the Elderly (PACE) organizations, and Part D sponsors ('plans'). Complaints are recorded in the CTM and assigned to the appropriate plan. Data may be populated into the CTM from various sources, such as 1-800-MEDICARE, CMS staff or contractors, Medicare Ombudsman, State Health Insurance Assistance Programs (SHIPs), or the Medicare.gov online complaint form at <https://www.medicare.gov/my/medicare-complaint>.

As required under the contract provisions established at 42 CFR §§ 422.504(a)(15) and 423.505(b)(22), plans are required to address and resolve the complaints received by CMS against them in the CTM. In addition, plans are required to display a link to the Medicare.gov online complaint on the plan's main Web page (42 CFR §§ 422.2265(b)(8) and 423.2265(b)(8)). Plans must adhere to the timelines to resolve complaints in compliance with 42 CFR §§ 422.125 and 423.129.

Requirements for resolution of complaints received in the CTM do not override requirements related to the handling of appeals and grievances set forth in 42 CFR Part 422 subpart M (which apply to cost plans as well as MA organizations per §417.600), Part 423 subpart M, for Part D sponsors, and §§ 460.120–460.124 for PACE organizations. Rather, CTM requirements supplement the appeals and grievance requirements by specifying how organizations must handle complaints received by CMS in the CTM and passed along to the plan. In accordance with the regulations at 42 CFR §§ 422.564 and 423.564, plans must provide meaningful procedures for the timely hearing and resolving of enrollee grievances. As such, beneficiaries are encouraged first to contact their plan directly to file a complaint (i.e., grievance). See the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance for information about grievance procedures.

Complaints Tracking Module (CTM)
Plan Standard Operating Procedures (SOP)
(Effective – January 2025)

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The updated CTM SOP is detailed below.

A. Obtaining CTM Access

Plan users first need access to HPMS before requesting access to the CTM

1. To obtain access to HPMS, system credentials are needed. Follow the instructions in the "New User ID EFI Instructions (PDF)" document and training videos found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/UserIDProcess>. This is the only way to request a user ID and will take on average 3-5 days to process. Questions regarding the user ID process should be directed to HPMS_access@cms.hhs.gov.
2. After a new user is notified of their HPMS access, an e-mail must be sent to: HPMS_access@cms.hhs.gov to request CTM access. The e-mail's subject line should read "CTM Access Request" and the message should contain the individual's four character user ID. The user will be informed when the access request is complete.
3. To maintain access, users must change their CMS password a minimum of every 60 days and complete their Computer Based (Security) Training and recertification annually or risk having their user ID revoked. CMS will send users a notification when training and recertification are due. Users can check the status of their existing account by going to <https://eua.cms.gov> and checking the "View My Identity" section.
4. Users' accounts that remain inactive for 60 days or more will be deleted for failure to remain in good standing. To prevent losing system credentials, update passwords timely. If credentials are deleted, an application via the Identity and Credentialing Tool (ICT) website (formerly known as EFI) will have to be initiated again to establish a new account.

B. General Complaint Handling and Resolution Timelines

Given the time-sensitive nature of many of the complaints, plans should continuously access, view, respond, and resolve the complaints(s) assigned to their organization in the CTM. Plans are the primary resource Medicare enrollees rely upon for the prompt resolution of complaints. As such, CMS expects each plan to educate their enrollees to first contact the plan directly with any MA or Part D-related complaint (i.e., grievance). Generally, after a beneficiary has first made a complaint to the plan without resolution, the beneficiary (or their representative) may file the complaint with CMS.

- **Review All Complaints:** Upon receiving a complaint, plans are encouraged to review all complaints at intake, even those that are not Immediate Need or Urgent, to verify that the contract number and Issue Level are correct.
- **Supporting Documents:** Plans are encouraged to view attachments and add additional supporting documents to the complaint in CTM by going to the "Intake Information" screen (see "CTM Plan User Manual" on HPMS for more details).
- **Periodic Casework Notes:** CMS expects plans to enter periodic casework notes, including initial and subsequent contacts, developments, or research.
- **Multiple CTMs:** When plans have multiple CTMs from the same beneficiary:

- If the prior complaint(s) have already been resolved, the plan should verify that the beneficiary was informed of the initial resolution. If the beneficiary acknowledges that the previous resolution was communicated to them, the plan should close the open complaint and note that it was a repeat complaint in the resolution notes.
- If the prior complaint(s) are 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 older complaint, and reference the CTM number of the new complaint in the older complaint resolution notes.
- If the first complaint is a sufficiently distinct issue than the second complaint, the plan is to keep both complaints open until they are resolved.
- Multiple CTM cases for the same beneficiary will generally not be removed from plan measures or changed to CMS Lead for purposes of the Part C and D Star Ratings.

Plans must resolve complaints in the CTM within the following timelines based on the Issue Level. All timelines for resolution are measured from the date a complaint is assigned to a particular plan in the CTM, not the date the plan retrieves the complaint from the CTM. Plans should retrieve CTM complaints in a timely manner to have sufficient time to resolve complaints. Complaints are loaded and assigned in real-time the day they are received by CMS, regardless of the day of the week, including weekends and holidays.

- **Immediate Need Complaints:** An Immediate Need complaint involves a situation that prevents a beneficiary from accessing care or a service for which they have an immediate need. This includes when the beneficiary currently has enough of the drug or supply to which they are seeking access to last for 2 or fewer days. Immediate Need complaints must be resolved within 2 calendar days of the assignment date.
- **Urgent Complaints:** An Urgent complaint involves a situation that prevents a beneficiary from accessing care or a service for which they do not have an immediate need. This includes when the beneficiary currently has enough of the drug or supply to which they are seeking access to last for 3 to 14 days. Urgent complaints must be resolved within 7 calendar days of the assignment date.
- **All Other Complaints:** All other complaints must be resolved within 30 calendar days of the assignment date.
- **Beneficiary Contact:** Regardless of the type of complaint received, the plan must attempt to contact the individual who filed a complaint within 7 calendar days of the assignment date.
- **Timelines:** The resolution timelines 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). Assignment dates are reset when a complaint is re-opened, when the Issue Level is upgraded, the CMS Lead flag is set or removed (the Plan Request must be accepted for the date to reset), and when the contract is changed. The assignment date is not changed when a Plan Request to have a complaint designated as a CMS Lead is denied. When a complaint under this section is also a grievance within the scope of §§ 422.564, 422.630, 423.564, or 460.120, a PACE service determination request within the scope of §

460.121, or a PACE appeal within the definition of § 460.122, the plan must comply with the shortest applicable timeline for resolution of the complaint.

C. **Retroactive Enrollment**

1. The plan investigates the complaint to determine if it is a valid retroactive enrollment request.
 - a. **Valid Requests:** If the request is valid, the plan needs to update its system to verify that the beneficiary has access to drugs and/or health services and initiate actions to update the Medicare Advantage Prescription Drug (MARx) system with enrollment/disenrollment change(s).
 - i. Plans must make sure that enrollees have access to benefits as of the enrollment effective date and may not delay the availability of benefits while waiting for confirmation of enrollment from CMS' systems. In other words, plan systems should reflect enrollment as of the effective date, even if the enrollment is pending a transmittal to the Retro Processing Contractor (RPC) and submission to CMS' systems.
 - ii. CMS encourages plans to counsel beneficiaries on the impact of retroactivity on claims processing and premium payments and document the counseling that took place in the CTM notes.
 - b. **Invalid Requests:** If the request is not valid, the plan should advise the beneficiary accordingly and close the complaint. The plan may not request CMS enrollment consideration or assistance when beneficiary communications clearly demonstrate there is no valid election period, no extraordinary circumstance, or fails to meet Good Cause criteria.
2. Once the retroactive enrollment request is deemed valid, if the plan is unable to update MARx directly with the change(s), then a request must be prepared and sent to the RPC with required documentation for review and processing as described in the latest retroactive processing guidance. Plans should not seek CMS assistance via the Plan Request feature in HPMS for cases that are to be handled via MARx or RPC.
 - a. **Could not be Processed as Submitted:** If the plan receives notification from the RPC that the request could not be processed, the plan should research the problem immediately to resubmit for processing and resolution.
 - b. **CMS Approval Needed:**
 - i. If CMS approval is needed prior to submission to the RPC, such as complaints that require a retroactive effective date of more than 3 months (see HPMS Memorandum dated February 24, 2009, "Instructions for Submitting Retroactive Enrollment and Disenrollment Activity"), or complaints that fail to satisfy the RPC's requirements on retroactive processing, then the plan should submit a Plan Request in HPMS to CMS for approval to refer the issue to the RPC.

- ii. If CMS agrees that the complaint can be forwarded to the RPC, CMS will provide written authorization in the “Comments” field. The plan will use this as documentation to send their request to the RPC requesting an update to CMS’ systems. If CMS does not agree that a complaint should be forwarded to the RPC, CMS will provide the plan with instructions on next steps in CTM.
3. Plans may close complaints once they have been referred to the RPC. However, plans are encouraged to inform beneficiaries of any delays associated with having enrollment changes reflected in CMS’ systems, including Medicare.gov. The plan should inform the beneficiary that it may take up to one month for the change to be reflected in CMS’ systems; however, the plan should notify the beneficiary that they have access to care and plan benefits while the CMS systems update.

NOTE:

- For retroactive enrollment complaints received directly by plans (i.e., not received by CMS and entered in the CTM) requiring an effective date of more than three months of retroactivity, plans should update their system and notify the beneficiary that they have access to drugs and/or health services. The plans should then contact their Account Manager via the Electronic Retroactive Processing Transmission (eRPT) to request approval if needed. Beneficiaries should not be referred to 1-800 MEDICARE in this circumstance.
- Individuals who become newly entitled to Medicare Part A or enrolled in Medicare Part B with a retroactive effective date are Part D eligible as of the month in which a notice of entitlement to Part A or enrollment in Part B is provided to the individual. Meaning that for these individuals, a retroactive enrollment for Part D is not necessary. If the entitlement to Medicare Part A and/or B has been updated in CMS’ systems, the plan should submit an enrollment or reinstatement to the RPC and update internal systems.
- Requests for reinstatements for Good Cause do not apply to this section.

D. Retroactive Disenrollment

1. The plan investigates the complaint to determine if it is a valid retroactive disenrollment request.
 - a. **Valid Request:** If the request is valid, the plan can initiate actions to update MARx to resolve the complaint. This should be done without CMS assistance by updating plan systems, closing the complaint, and notifying the beneficiary accordingly.
 - b. **Invalid Request:** If the request is not valid, the plan should advise the beneficiary accordingly and close the complaint. The plan may not request CMS consideration when beneficiary communications clearly demonstrate there is no valid election period, no extraordinary circumstance, or fails to meet Good Cause criteria.
2. If the request is valid, but the plan is unable to make the appropriate MARx action, the plan will determine if the complaint is Critical or Non-Critical. Immediate Need complaints and complaints concerning opt-out due to employer group coverage are considered Critical.

- a. **Critical Complaint:** If the complaint is Critical, a Plan Request is to be made to CMS for MARx action. “Critical Retroactive Disenrollment” should be notated in the complaint by the plan, and the plan should indicate any internal systems changes it has already made. CMS will either take the necessary MARx action and close the complaint, or disagree with the Plan Request, describing next steps in the CTM.
 - i. For a Critical retroactive disenrollment issue received directly by the plan that is not in the CTM, plans should contact their CMS Account Manager for assistance.
- b. **Non-Critical Complaint:** If the complaint is Non-Critical, with the appropriate documentation, the plan should submit a request to the RPC asking them to update CMS’ systems with their change(s). Upon the submission to the RPC, the plan can close the complaint.
 - i. For a Non-Critical retroactive disenrollment issue received directly by the plan that is not in the CTM, plans should make a request to the RPC for correction if the plan is unable to make the change themselves.

E. Best Available Evidence Assistance

1. The plan will record a CTM entry.

Lead: CMS

Category: Premiums and Costs

Subcategory: Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)

Absent unusual circumstances, plans are to enter cases within one business day of being notified that the beneficiary claims to be subsidy eligible but cannot provide the plan with acceptable Best Available Evidence (BAE).

When entering, include all the following information in the “Complaint Summary”:

- Medicare Beneficiary Identifier (MBI)
- Beneficiary’s First and Last Name
- Beneficiary’s Address
- Beneficiary’s Date of Birth
- Issue Level: Immediate Need, Urgent, No Issue Level.
- Any additional information germane to the beneficiary’s matter.

These cases will be reflected as “1.50” in the plan data extract.

2. After receiving the CTM case, CMS will:
 - a. Attempt to confirm with the appropriate state Medicaid agency whether the beneficiary is eligible for the low-income subsidy (LIS).
 - b. If CMS can confirm, the case will be changed to “Plan Lead” and re-categorized as “Premiums and Costs - Beneficiary needs assistance with acquiring Medicaid eligibility

information (EX)” category/subcategory for plan review/action. These cases will be reflected as “2.50” in the plan data extract. Additional information will be placed in the “Comments” section of the case and will include as applicable:

- Resolution
 - Start of Medicaid/ Medicaid Institutional Status (MM/CCYY)
 - Dual Eligible Status (Full/Partial)
 - Institutional Status (Yes/No/ Unknown)
 - LIS Co-Pay Level
 - Any additional information germane to the beneficiary’s matter.
- c. If CMS cannot confirm, the case will be changed to “Plan Lead” and re-categorized to 2.50. The “comments section” will note the following: CMS has been unable to confirm LIS status with Name/State. Refer the beneficiary to Medicaid.gov and educate them on how to navigate the website to select About Us > Get Help with Medicaid & CHIP > Select State in which they reside. Then, they can obtain information on eligibility, enrollment, or check the status of an existing application.
3. When updates are provided, the plan will ensure its internal systems to reflect LIS status if appropriate and submit a request for correction to CMS’ contractor in accordance with the procedures outlined in Chapter 13, Section 70.5.4 of the CMS Prescription Drug Benefit Manual. If CMS determines the beneficiary ineligible for LIS, no system updates are to be initiated.
4. As soon as the plan receives confirmation from CMS that a beneficiary is subsidy eligible (consistent with the direction in Chapter 13, Section 70.5.3 of the CMS Prescription Drug Benefit Manual), plans are to:
- a. **Provide Drug Coverage at Correct Cost-Share:** Must immediately provide the beneficiary access to covered Part D drugs at a reduced cost-sharing level no greater than the higher of the LIS cost-sharing levels for full subsidy eligibles, or at zero cost-sharing if CMS also verifies the beneficiary’s institutional status.
 - b. **Contact Beneficiary:** Attempt to notify the beneficiary of the results of the CMS review within one business day of receiving those results. If a plan is unable to reach the beneficiary as a result of this initial attempt, it must attempt to notify the beneficiary until it succeeds or until it has attempted to do so a total of four times. The fourth attempt, if necessary, shall be in writing, using one of two CMS Model Notices listed in Chapter 13 of the CMS Prescription Drug Benefit Manual.
 - i. If a request for a subsidy was made on the beneficiary’s behalf by an advocate or authorized representative, it shall be sufficient for the plan to contact that advocate or representative. If, however, the only request made on the beneficiary’s behalf was by a pharmacist, the plan must also contact the beneficiary directly. After informing the beneficiary, or their representative, of the outcome, the plan is to close the case. After informing the beneficiary, or their representative, of the outcome, the plan is to close the case.

- c. **Notice of Eligibility:** If CMS determines that the beneficiary is LIS eligible, plans are to send the “Determination of LIS Eligibility” Model Notice provided as Attachment A. If CMS determines that the beneficiary is not LIS eligible, or is unable to confirm the beneficiary’s LIS status, plans are to use the “Determination of LIS Ineligibility” Model Notice provided as Attachment B. See the February 17, 2017 HPMS Memorandum, “Best Available Evidence Process Update” for attachments.
- d. **Disagreement with Decision:** Should the beneficiary disagree with the outcome, the plan should submit a Plan Request to refer the matter back to CMS with appropriate CTM notes. A CMS caseworker will attempt to contact the beneficiary, affirm the outcome, and close the case.

NOTE:

- This process is not intended to serve as a general alternative to the subsidy eligibility confirmation process. Thus, it does not permit pharmacies or any other parties to send beneficiary records directly to the plan for research in the absence of a request for assistance from the beneficiary (or other individual on the beneficiary’s behalf) or in lieu of making reasonable efforts to acquire the documentation from, or on behalf of, the beneficiary.
- In rare circumstances, a beneficiary’s record may be incorrect in CMS’ systems after they have applied for and been awarded the Part D extra help through the Social Security Administration. In these instances, make certain the beneficiary is able to access their Part D plan benefit. You may use this process to advise CMS when our systems need to be updated since corrections cannot be submitted to the RPC for processing.

F. Marketing

1. The plan investigates the complaint and then corrects any underlying issues identified that may have led to the beneficiary complaint, including any agent/broker corrective actions deemed necessary. The plan should provide all investigative findings in the CTM notes, including the negative impact the beneficiary experienced and how the plan reconciled those matters. The plan should also include that the beneficiary was advised of their access to the plan benefits and all developments should be included in the final closure notes.
2. Prior to closing the complaint, plans are expected to update the Administration Information panel of the CTM with the name of the agent or broker and their National Producer Number (NPN) that was involved in the marketing complaint investigation. Whether founded or unfounded, plans should include all investigation notes in both CMS and Plan Lead Marketing complaints. This could include details of the signed application, including dates, verification call notes, and plan benefit packages requested at the time of the enrollment for CMS review.

NOTE:

- Most Marketing complaints will be assigned to the plans to review and close. However, some complaints will be designated as “CMS Lead” and can be found in the “Marketing – Allegation of inappropriate marketing by plan, plan representative, or agent/broker” category/subcategory. While these “CMS Lead” complaints cannot be closed by plans, plans

are expected to review the complaint allegations as they would any other marketing complaint and record notes in the CTM for CMS review and consideration.

- Plans should not submit Plan Requests seeking re-categorization of marketing complaints when a plan determines a complaint was unfounded. However, if a marketing complaint has been misclassified, and the narrative reflects that the alleged misrepresentation occurred by a CMS Call Center representative, SHIP, etc., then a Plan Request to request to change the complaint to “CMS Lead” may be submitted. CMS will determine if the request is appropriate and if so, will accept the Plan Request to change to “CMS Lead”. Enrollments processed via the Online Enrollment Center (OEC) should be handled as any other complaint with plans validating the enrollment and alerting beneficiaries to the final result of their request.
- CMS makes the alleged marketing misrepresentation complaints in CTM available to state insurance regulators. As such, CMS expects plans to update the complaint with all pertinent information identified during their investigation of the marketing allegations. This includes updating the agent/brokers names and NPNs in the Administration Information panel of the CTM for state regulator review.

G. Premium Withhold

1. The plan reviews the complaint, checks that their system reflects the same premium amount and payment option specified in the complaint, and corrects if necessary. The plan should inform the beneficiary that it may take up to 90 days to fully correct their premium withhold issue or for Social Security Administration (SSA)/Railroad Retirement Board (RRB) to issue a refund. The plan should recommend that the complainant call the plan back if there is no resolution after 90 days and close the complaint.
 - a. If the plan’s system and MARx correctly reflect the premium amounts and payment option, but the beneficiary still complains that the premium deductions are incorrect, the plan should review the date of the last transaction to see if it has been 90 days since the last submittal. If this time period has not elapsed, the plan should educate the beneficiary and close the complaint.
2. If the complaint relates to SSA/RRB premium deductions or Part B Reduction cases that extend past the expected period, the plan should submit an MAPD Help Desk ticket for assistance and should follow the guidance provided (MAPDHelp@cms.hhs.gov or 1-800-927-8069). If the MAPD Help Desk is unable to resolve the issue, plans will be directed to refer the beneficiary to SSA/RRB for further assistance. Add notes and close the complaint.

NOTE:

- CTM complaints that include both a complaint that the beneficiary is getting billed while in premium withhold status and a plan premium payment problem should remain open until the beneficiary issue is fully resolved and the beneficiary is made whole. Complaints that include only plan premium payment issues can be closed upon resolution. If further assistance is needed, the plan should contact the MAPD Help Desk.

H. Good Cause

1. The plan is to follow the same processes for reviewing Good Cause (GC) cases as if the plan received the request directly (i.e., outside the CTM). For additional details, see the HPMS Memorandum dated August 18, 2015, “Revisions to Good Cause Processes for Contract Year 2016.”
2. The plan is to close the case with the plan’s decision (approved or denied), indicating in the CTM notes what communication has occurred with the beneficiary. For approved GC requests, the complaint can be closed at that time. Plans do not need to wait for the beneficiary to complete their repayment or be reinstated to close the case.

NOTE:

- Plans should not grant access to care in cases where an individual was disenrolled by CMS for failure to pay Part D Income Related Monthly Adjustment Amount (IRMAA) and still owes Part D– IRMAA. These cases will be accompanied by CMS notes in CTM case. If, however, the individual was disenrolled by the plan for failure to pay plan premium, receives a favorable GC determination and makes full payment of the plan premium amounts owed within 3 months of disenrollment, the plan should reinstate the individual’s coverage, regardless of whether there are Part D-IRMAA amounts owed.

I. Congressional

1. Casework should be completed within the required complaint resolution timelines based on the Issue Level (such as Immediate Need or Urgent). CMS expects plans to update the case notes as developments occur, as root causes are identified, or as resolution actions are known despite beneficiary contacts made or attempted.
2. After resolving the complaint, the plan should submit a Plan Request to change to “CMS Lead”. If CMS agrees, the plan will no longer be able to view the complaint typically until it is closed and changed back to “Plan Lead”. If CMS disagrees, instructions on next steps will be provided to the plan. Plans should not refer any of these cases to the RPC. Instead, plans should indicate in the CTM notes what enrollment updates are needed in MARx in order for CMS to make those changes directly.
3. CMS is responsible for final complaint closure with the congressional office. While plans are expected to notify the beneficiary of the outcome, plans are not to notify the congressional office of the resolution or delay the final resolution or case documentation pending successful contact with the beneficiary.

J. Plan Request

1. To submit a Plan Request, go to the “Plan Requests” tab in CTM case after entering a “Casework” note. Provide any additional information relating to the complaint to aid in the review of the request (e.g., reason why CMS intervention is needed, which contract the complaint should be assigned to instead (if known), why the Issue Level or category/subcategory should be changed, etc.). Do not check the “Include in Resolution Summary” box in the plan notes. Plans are

encouraged to notify the beneficiary that their complaint has been referred to CMS or to a different plan, when applicable.

2. Upon acceptance of a Plan Request by CMS, plans may no longer be able to see the complaint. Plan Requests should not be submitted nor delayed when a beneficiary or provider cannot be contacted, unless directed by CMS.

Types of Plan Requests:

- **Incorrect Contract Assignment:** If the complaint should have been assigned to another organization, the plan should submit a Contract Change Plan Request. If the complaint should be assigned to a different contract under the same organization, the plan should submit a Contract Change Plan Request but should continue to work the case while that request is pending unless directed otherwise. Upon acceptance of these Plan Requests by CMS, plans will no longer be able to see the complaint if assigned to a contract under a different parent organization.
- **Issue Level Change:** Fully recognizing that the Issue Level corresponds to self-reported information from the beneficiary at intake, the plan may submit an Issue Level Change Plan Request if they substantially disagree with the urgency of the complaint. CMS will evaluate if the complaint can be downgraded, and if so, will correct the Issue Level. Plans should continue to work the case at the current Issue Level and in accordance with the required resolution timelines until directed otherwise. Plans requesting that CMS downgrade an Issue Level after the access portion of the complaint has been addressed will not be approved unless the Issue Level was originally incorrect. Plans can request an Issue Level Change if they can demonstrate their previous or current efforts to resolve the root cause of the complaint and how that was communicated to the beneficiary. CMS will review the CTM supporting documentation to determine if the plan addressed the issue or if the beneficiary remains dissatisfied and subsequently filed another complaint.
- **Lead Change:** For matters that are delegated to CMS for handling and/or final resolution, plans are to submit a CMS Lead Change Request. These situations include, but are not limited to:
 - Part D Income Related Monthly Adjustment Amount (IRMAA) Good Cause Requests.
 - Cases flagged as “Congressional” in CTM where plans have developed and completed the root cause issue of the inquiry for CMS’ review and final closure.
 - Low-Income Subsidy (LIS) correction requests involving Social Security Administration (SSA) extra help determinations.
 - Beneficiary needs a Critical retroactive disenrollment action or retroactive enrollment action requiring CMS authorization (see Scenarios C and D).
 - Beneficiary has lost coverage due to possible erroneous loss of Part A/B entitlement that spans multiple plans. Note, if the temporary loss of entitlement has resulted in a loss of Part C and/or Part D coverage, but only affects enrollment in one parent organization, the plan should submit a reinstatement request to CMS’ RPC.
- **Category/Subcategory Change:** In very infrequent circumstances, plans may request a category/subcategory change if they believe the complaint was incorrectly categorized at intake. To do so, plans should use the CMS Lead Change Plan Request option to make this request. Such requests should be infrequent and should not be used for the sole purpose of improving a plan’s performance metric. Additionally, plans should clearly demonstrate in CTM

notes their efforts in resolving the root cause of the complaint, despite the category, Issue Level, or repeat complaint filings.

- **Late Enrollment Penalty:** Plan Requests should not be made for the purpose of assigning a Late Enrollment Penalty (LEP) issue to a beneficiary's former plan. Per Chapter 4, Section 30.5 of the Medicare Prescription Drug Benefit Manual, the beneficiary's current plan is able to resolve this type of complaint.

K. Complaint Resolution Documentation

- **Contact Complainant:** The plan will notify the beneficiary or complainant according to the plan's business practice and customer service policy. If the plan is having difficulty contacting the beneficiary, CMS recommends that the plan attempt to contact the complainant at least four times at different times on different days. Details, including the dates and times of contact attempts and actions taken, should be documented in the CTM. For the fourth attempt, plans are encouraged to send a letter when they are unable to reach a beneficiary to notify a beneficiary of the resolution. These notices should be loaded to the CTM using the attachment feature.

For SHIP entered complaints, SHIP counselors may request in the "Complaint Summary" that the plan contact the counselor with the resolution rather than the beneficiary. MMP State Reviewers may request the same. It is acceptable for the plan to contact either of these entities with the resolution.

- **Case Narrative:** The plan records a clear and concise narrative (up to 4,000 characters) in the "Casework" note of the Complaint Resolution tab. All entities that review CTM complaint records should be able to easily understand the notes clarifying the issue, action taken, and decisions made to investigate and resolve the complaint. See Appendix B for guidance on documenting resolution notes.

Please note that HPMS will log users out of the system after about 30 minutes of inactivity. Users should frequently save or draft their notes in a separate document for cutting and pasting when drafting notes.

- **Supplemental Information:** Prior to closing the complaint, answer three questions:
 - **Was the complainant satisfied with the outcome of the resolution?** As appropriate, select "Yes," "No," or "Unknown/Unable to Reach" (default).
 - **"How was the complainant or point of contact notified?"** Select appropriate option: "Unknown", "Telephone", "Written", "Telephone and Written", or "None".
 - **Is the complaint HPI Related?** Answer "Yes" if the reported complaint is in relation to either the services or benefits associated with the MA Value-Based Insurance Design (VBID) Model. If the complaint is not in relation to this model, select "No." If unknown, leave as the default "Unknown/Unsure."
- **Case Completion:** Plans have the ability to upload documents and enter additional CTM notes, even if a complaint is already resolved and the case is closed. Plans are encouraged to make use of this approach when additional, relevant information is presented relating to a complaint, for the purposes of creating a more complete record of the beneficiary's matter.

- **Difficulty with Complaint Closure:** Troubleshoot any one of the following issues.
 - There are no restricted characters in plan entered fields: <>& ;
 - There are no open Plan Requests for the complaint.
 - The complaint is not already closed (by CMS).
 - The Congressional indicator is selected.

- **Beneficiary Refund:** If the resolution involves a refund from the plan to the beneficiary (e.g., any overpayment of co-payments, premiums, LEPs, etc.), the complaint can be closed once that refund is issued. Similarly, if the complaint involves educating the beneficiary about the appeals process, the complaint can be closed when the communication is complete (i.e., the plan does not need to wait for the appeal to adjudicate).

- **Provider/Pharmacy Complaints:** CMS expects plans to provide the same level of research and quality service as they would for a complaint filed by a Medicare beneficiary or other program partner. With that, plans should demonstrate in the CTM notes and/or the attachment upload feature their efforts to resolve the matter with the provider/pharmacy directly. Plans should not request the removal of cases they consider resolved when the provider/pharmacy still filed additional CTMs. CMS is not a party to contractual matters and expects plans to resolve these complaints with the providers directly. Consequently, plans should manage provider/pharmacy expectations by clearly communicating the appeal and grievance process for resolving their issues which may prevent them from filing additional complaints.

APPENDIX A - Category and Subcategory Listing

Below is a list of categories and subcategories in the CTM that are viewable by plans. Since CMS published the listing in May 2019, there have been no changes except for renaming 2.54.

*Cases with subcategories that end with “(EX)” and/or where field Complaint Lead is marked as “CMS Lead” are excluded from plan performance metrics.

Enrollment/Disenrollment

- 2.10: Beneficiary is experiencing an enrollment issue that may require reinstatement or enrollment change
- 2.11: Beneficiary has not received enrollment card or other membership materials
- 2.19: Other

Marketing

- 1.30: Allegation of inappropriate marketing by plan, plan representative, or agent/broker (EX)*
- 2.30: Allegation of inappropriate marketing by plan, plan representative, or agent/broker
- 2.39: Other

Benefits, Access, Quality of Care

- 2.40: Beneficiary has difficulty securing Part D prescriptions
- 2.41: Beneficiary has difficulty finding a network provider/pharmacy
- 2.42: Beneficiary has concerns about the quality of care they have received
- 2.43: Beneficiary has concerns about a denied claim
- 2.49: Other

Premium and Costs

- 1.50: Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)*
- 2.50: Beneficiary needs assistance with acquiring Medicaid eligibility information (EX)*
- 2.51: Beneficiary has a coordination of benefits issue
- 2.52: Beneficiary has a premium issue, direct bill or withhold related
- 2.53: Beneficiary has an issue with Late Enrollment Penalty (LEP) being charged
- 2.54: Beneficiary has a cost-sharing/co-insurance issue, including Medicare Prescription Payment Plan costs
- 2.55: Beneficiary's Best Available Evidence (BAE) not honored by the plan
- 2.59: Other

Plan Lead Legal and Administrative

- 2.60: Allegation or concern relating to HIPAA, Confidentiality, Security Breach, or Privacy Violation
- 2.61: Plan has provided poor customer service
- 2.62: Difficulties acquiring materials in alternative formats
- 2.69: Other

Provider Specific

- 2.70: Improper, insufficient, or delayed claims payment
- 2.71: Network contracting issue
- 2.79: Other

Good Cause

- 2.80: Plan Premium Good Cause Request (EX)*
- 2.89: Other (EX)*

Other Matter Requiring Plan Review

- 2.90: Other Matter Requiring Plan Review

APPENDIX B - Suggested Examples of Plan CTM Resolution Notes

Complete and accurate plan resolution notes assist CMS staff, SHIP users, and the 1-800 MEDICARE Call Center when following up on inquiries. Moreover, quality resolution notes help prevent the recording of repeat complaints. For these reasons, CMS is providing general guidance for plans to follow, as appropriate, for the recording of plan resolutions in the CTM.

CTM plan notes should be clear, concise, and easy to understand. Entries should show that the plan has researched the complaint, taken appropriate steps towards resolution, addressed all beneficiary issues, and informed the beneficiary of the resolution. In cases where CMS intervention is needed, complete and accurate notes accompanying Plan Requests will assist CMS caseworkers to quickly assess and take the necessary action to resolve the complaint. Overall, plan notes should:

- Report contacts with the beneficiary or complainant with contact dates. This may include contacts that precede the date the complaint was first recorded.
- Clarify the beneficiary or complainant's issue(s).
- Explain the root cause(s) for the issue(s) if known at the time of complaint resolution.
- Describe decisions made and actions taken by the plan.
- Use only widely accepted CMS abbreviations (e.g., LEP, SEP, BAE, LIS, PBP, etc.).
- Include dates of system updates and enrollment/disenrollment effective dates.

Below are examples of plan resolution notes. Recognizing the unique nature of individual beneficiary complaints, the guidance provided here is only intended to serve as examples of satisfactory resolution notes and do not constitute plan requirements.

Access to Benefits: “Plan system shows the member is enrolled in <contract-PBP> effective <date> which <matches or does not match> MARx. Review of the plan's benefits show <reason it was not covered and research into the issue>. The member was <called or sent a letter> on <date> to notify them of our <findings, explain denial or action taken to correct the issue> in resolving their complaint. The member has also been advised to contact us directly should they have any access issues or concerns about their plan benefits.”

Alleged Marketing Complaint: “The plan contacted the member on <date> and he/she stated <details of marketing allegation>. Member's record shows enrollment in <contract-PBP> from <date> to <date>. Application was submitted by <agent or member> via <telephone, paper application or online> on <date>. Our research revealed that <allegation is founded or not, describe findings and any corrective action>. The plan has called the member on <date> to inform them of <findings and corrective actions>.” If the member states that they want a retroactive start date for their new plan, a Plan Request should be submitted, requesting the following in their notes: “The member is requesting CMS take a MARx action to retroactively <enroll/disenroll> them in/from <contract-PBP> to <date>. We have advised the member that their case is being sent to Medicare for review.”

Belongs to Different Plan: “After contacting the member on <date>, we learned that their issue is with their previous plan, <contract-PBP>, and not our plan. We are requesting a reassignment of this complaint to that contract. We informed the member that the matter will be referred back to Medicare and/or the other plan for review.”

Best Available Evidence (BAE): “The plan’s system does not show that the member has LIS, but he/she has provided valid BAE. We have updated our system and notified the member that he/she can now access their medication at the correct LIS copay.”

Best Available Evidence (BAE) Assistance: If CMS confirms an LIS change: “CMS confirmed with Medicaid that member has LIS <level>. The plan has updated the member’s record to <show LIS or change the LIS level> and contacted the member on <date> to notify them of this change.” If CMS confirms there is NO change to LIS: “CMS confirmed that the member <does not have or there is no change to their> LIS since <additional details>. Member’s record shows <LIS level or no LIS> which matches MARx. The plan contacted the member on <date> to notify them that CMS confirmed with Medicaid that <they have no LIS or there is no change to their LIS level>. We advised the member that they can <re-apply for Medicaid or apply for the Extra Help>.”

Claims: “The plan has contacted the member for additional information, reviewed the claim <describing the service that was denied or not covered in full> in question and determined that the plan’s decision was <correct or incorrect> because <what was learned that led to their decision, making reference to any plan materials that describe the benefit in question>. We have <called or sent a letter> to the member to notify them of the <resolution> to their complaint. The member has also been informed of their appeal rights (when applicable). The member has also been advised to contact us directly should they have any access issues or concerns about their plan benefits.”

Good Cause (Approved): “The member has been informed they must pay <\$> by < date> to be eligible for reinstatement by CMS. The plan has sent the member a Notice of Favorable Decision letter on <date>.”

Good Cause (Denied): “The member’s request for a good cause reinstatement was carefully reviewed and denied. The beneficiary has been advised of the next available enrollment period and received a plan decision letter. The member is no longer eligible for a Good Cause reinstatement because the time period for making a request has lapsed.”

Immediate Need (Enrollment): “On <date>, the plan contacted the member for clarification of their issue. We reviewed the member’s record which shows <describe findings>. The plan will reinstate the member into <contract-PBP> due to <reason> and the member’s immediate need for services. We have contacted the member on <date> to inform them that they now have access to their plan. We have submitted a request for <reinstatement or enrollment> <in MARx or to the RPC> on <date>.”

Retroactive Disenrollment (Critical): “Member’s record shows enrollment in <contract-PBP> effective <date> which <matches or does not match> MARx. The plan contacted the member on <date> and the member explained the <circumstances leading to their request>. Plan is requesting CMS approval to cancel them from <contract-PBP> due to the member’s immediate need and <reason for the request>.”

Retroactive Enrollment: “Member’s record shows enrollment in <contract-PBP> from <date> to <date>. The plan contacted the member on <date> and learned <circumstances leading to member’s request>. Review of the member’s record shows that the disenrollment was due to <cause> and the plan has decided < decision, reason for decision and action by the plan>.” If the plan has approved reinstatement, add: “We have submitted a disenrollment cancellation to CMS <in MARx or to the RPC> and updated our system with the member’s reinstatement. On <date>, we called to inform the member of the resolution to their complaint, their current access to the plan and the reimbursement procedure for claims or medications they paid before the reinstatement.”

Congressional: “The plan spoke with the member on <date> and the member stated <key information about the member’s issue>. The member’s record and plan <claim/enrollment> systems were reviewed to show <additional findings>. The plan decided to <describe decision made and actions taken to resolve their issue>. We contacted the member on <date> to provide <details of our investigation, actions that were taken and recommendations to the member>. The member understood the resolution to their complaint. The case is now being submitted to CMS for final CTM closure and contact with the congressional office.”

Out of Area Disenrollment: “The member’s record shows enrollment in <contract-PBP> from <date> to <date>. Upon further review, it was determined that this was incorrect due to <reason>. The plan has submitted a reinstatement for the member <in MARx or to the RPC> on <date> and updated our system to open services for the member. We called to inform the member on <date> of their access to services and sent a letter confirming their reinstatement on <date>.” If the plan disenrolled the member correctly: “The member’s record shows enrollment in <contract-PBP> from <date> to <date>. We received <TRC, returned mail or other> on <date> and began tracking for “out of service area” for this member on <date>. Correspondence was sent to <the member’s address> that <matches or does not match> MARx. <Successful or unsuccessful> calls were made on <dates> and member was disenrolled on <date>. A termination letter was sent to the member on <date> using <address>. The plan believes this was a valid disenrollment action and informed the member on <date>.”

Provider/Pharmacy: “The plan has contacted the provider/pharmacy on <date> for additional information, reviewed the claims in question and found <root cause of the issue>. We have taken <corrective action> notified the provider/pharmacy on <date> to inform them of <the corrective action taken and any operational improvements that will prevent a reoccurrence>.” Also, “We have educated the provider about the details relating to their claims issue. Specifically, the provider was <describe the explanation given>. The matter has been resolved and the provider has been encouraged to work directly with our Provider Services Dept. with any future issues they may encounter.”

Premium Withholding: “The plan submitted a cancellation of the member’s plan to CMS on <date>. The member has been advised that it may take up to 90 days for Social Security (or Railroad Retirement Board) to reflect this and refund premiums that were inappropriately deducted. We instructed the member to call us back if the deductions have not stopped at that time.”

“The member’s record shows that they selected to have premiums deducted from their Social Security benefits, but the plan has not received these payments. We have requested our billing department to stop sending bills to the member and we have reported the plan payment issue to the MA PD Help Desk. We have notified the member that as we work to address the matter with Medicare, they will remain enrolled in their plan and can disregard any billing notices they have received.”

Unable to Contact: “The plan has made unsuccessful calls to the member on <dates and times>. We have left messages including our contact number asking them to call us, but the member has still not returned our calls. A letter was sent to the member on <date> to <address> <requesting additional information or notifying them of the resolution to their complaint>.”

APPENDIX C – Support Resources

Support Resource	Contact Information
General HPMS user access questions	hpms_access@cms.hhs.gov
Technical support for the CTM in HPMS	HPMS Help Desk 1-800-220-2028 hpms@cms.hhs.gov
Questions about the Medicare Part C and Part D Star Ratings complaints measures	PartCandDStarRatings@cms.hhs.gov
Account Manager and Caseworker assignments by contract	HPMS – Basic Contract Management – CMS Contacts