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CENTER FOR MEDICARE

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, and PACE Organizations

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SUBJECT: Complaint Tracking Module (CTM) Casework Reminders and Updates to CTM Exclusion Criteria

DATE: December 22, 2011

The Open Enrollment Period has concluded and the new benefit year is set to commence. Your organization should review good customer service practices and requirements, especially in view of recent operational changes with regard to casework and Complaint Tracking Module (CTM) handling. Good customer service and attentiveness to beneficiary issues are essential to making the Medicare program a success, and CMS expects Part C and D organizations (hereinafter referred to as "plans") to play a prominent role in ensuring beneficiary satisfaction.

Growing numbers of beneficiaries are continuing to enroll in a variety of Medicare plans offered nationally. With this growth, it is imperative that plans not only address individual CTM issues promptly, but also routinely exercise root cause analysis activities as a part of their Quality Improvement (QI) processes to prevent complaints from occurring. Plans should use CTM information (in conjunction with grievance and call center data) to identify larger issues that have the potential to affect more individuals. The following reminders and prevention tips are intended to supplement the December 9, 2008, December 28, 2009, and December 29, 2010 HPMS memoranda on these same topics, as well as the CTM Standard Operating Procedures (SOP), updated in the September 30, 2011 HPMS memorandum.

Customer Service and Casework Reminders:

1. Part D complaints from beneficiaries with little or no medication remaining are identified in CTM as "immediate need" or "urgent" and need to be resolved as quickly as possible. Plans are urged to investigate the reason for these types of complaints as they may indicate a larger or more widespread issue with the plan. Refer to the August 27, 2010 HPMS memo "Part D Transition Policy Reminder" and the September 3, 2010 HPMS memo "Part D Compliance Issues – Grievances, Coverage Determinations and Appeals" for specific guidance with protected drug classes, transition supply and appeal and grievance adjudication timeframes.

2. Plan resolution notes in CTM should provide sufficient detail to help reviewers gain a complete understanding of the beneficiary's concerns and actions taken by the plan. Notes should include research into the root cause for the beneficiary's complaint to ensure that all originating issues have been addressed. As a best practice, plans are requested to provide ongoing, interim documentation throughout the complaint review process to ensure that cases are reviewed and closed timely. If a trend is identified, the plan should document

the trend in their notes and indicate what is being done to address it (i.e., referral to management, QI staff, compliance department, etc.).

3. Plans are encouraged to upload documents via the CTM "Complaints Attachments" function that are pertinent to the investigation and resolution of the CTM case, including any relevant beneficiary communications, screen prints from plan systems and notifications received from third parties such as CMS' Retro-Processing Contractor (RPC) or Independent Review Entity (IRE). Such documentation assists CMS caseworkers in the event additional inquiries are received and reduces the likelihood that CMS will enter another complaint. Plans should also pay particular attention to Scenario O of the CTM SOP which includes instructions regarding the Alleged Marketing Misrepresentation (RO Action Needed) Report.

4. CTM complaints marked as "SWIFT", Congressional, or Press or Hill Interest are not to be closed by the plan. Such complaints should be returned as a "CMS Issue" request for final closure by CMS. While plans may find it necessary to contact a complainant to address the CTM complaint, the plan should not notify the Congressional office of the complaint resolution as this is the responsibility of CMS staff.

5. Effective January 1, 2012, beneficiaries may request a reinstatement based on demonstration of "Good Cause" following a disenrollment for failure to pay premiums. Plans should refer such requests to 1-800-MEDICARE, where CSRs will perform an initial review of the request and if appropriate, will forward it to a CMS caseworker for review. Good Cause requests in CTM that do not have an issue level require no plan action. When a determination is made by CMS and plan action is needed, the CTM case will be marked "Urgent" and the plan is to initiate steps to collect monies owed from the beneficiary. More information can be located in Scenario V of the CTM SOP and the Medicare Enrollment/Disenrollment Guidance, Chapters 2 and 3.

6. Depending on when plans submit enrollment transactions, beneficiaries who request premium withhold may instead be placed in direct bill status. To reduce the number of premium withhold complaints, CMS expects plans to automatically resubmit the premium withhold request prospectively for the next possible effective date and not wait for the beneficiaries to respond to the direct bill notification. Plans are encouraged to promote premium withhold to reduce the number of disenrollments due to failure to pay premiums and consider this an opportunity for reliable and predictable plan payments. For more information regarding required notifications to individuals whose request for premium withhold at the time of enrollment is not processed, please see Section 40 of the Medicare Enrollment/Disenrollment Guidance, Chapters 2 and 3.

7. CMS encourages plans that have not already done so to adopt use of the *UniqueID* database on the HPMS system to provide assistance to State Health Insurance Assistance Program (SHIP) counselors on behalf of their beneficiaries. CMS encourages plans to improve customer service by adopting the *UniqueID* process and/or supporting a dedicated toll-free phone line for SHIP callers. More information can be located in the December 9, 2008 HPMS Memo "State Health Insurance Assistance Program (SHIP) Unique ID Database."

8. Delays in complaint resolution due to untimely responsiveness by a plan's delegated entities may signal an insufficient level of oversight by the plan. CMS has observed cases where a plan's delegated entity may be responsible for the issue identified by the original complaint. In such cases, it is not acceptable for plans to defer responsibility for resolution of the CTM complaint back to the delegated entity. Instead, CMS expects the plan to intervene and orchestrate the resolution - whether by directing the activities of the delegate or rendering an overriding decision.

9. As referenced in Scenario F of the CTM SOP, critical retroactive <u>enrollment</u> complaints should be handled entirely by the plans, with submissions made by the plan to CMS systems directly or the Retro Processing Contractor (RPC) (pursuant to the RPC's SOPs located at www.reedassociates.org), when needed. When an RPC request is required, ensure that the beneficiary is advised that they have access to care even though CMS

systems (www.medicare.gov) may take up to one month to update. Retroactive disenrollment requests that meet CMS' critical criteria should continue to be sent to CMS via CTM plan request.

10. To reduce the volume requiring resolution at the RPC, plans are encouraged to make full use of the new capabilities in MARx such as residence address change and the cancellation of enrollments and disenrollments. For cases that do require RPC handling, plans should review the applicable RPC SOP at www.reedassociates.org and make the request to the RPC using the processes set out in the applicable SOP. Organizations should carefully monitor CMS' systems, RPC Final Disposition Reports, Daily Transaction Reply Reports and Monthly Membership Reports to ensure that all transactions are processed. Plans are reminded to flag these complaints with the RPC indicator in CTM to indicate that no casework action by CMS or the plan is needed and to prevent any duplication of work by CMS and the RPC.

11. Plans are reminded to submit timely beneficiary reinstatement requests using the process discussed in the RPC's SOP available at www.reedassociates.org. **Please note:** Effective January 01, 2012, per CMS Enrollment guidance, plans are required to obtain approval from their Account Manager for reinstatements due to plan error that cannot be processed internally by using Transaction 81 – Cancellation of Disenrollment. Plans are reminded that they are able to accept verbal requests for reinstatement as long as the request is documented by the plan. This includes reinstatements related to erroneous loss of entitlement. The losing plan(s) are notified of the reinstatement of entitlement via their TRRs. Plans should be proactive in contacting those beneficiaries and pursuing reinstatements in accordance with existing CMS guidance. Affected beneficiaries should not have to contact 1-800-MEDICARE in order to initiate reinstatements in these instances.

12. Plan customer service representatives (CSRs) should be provided with instructions as to the forms of evidence that are considered acceptable proof of Low Income Subsidy (LIS) and attempt to obtain "Best Available Evidence" (BAE) from the beneficiary, advocate or related Medicaid Agency, rather than refer them to 1-800-MEDICARE. Effective January 1, 2012 beneficiaries eligible for Home and Community Based Services (HCBS) will also be eligible for LIS Co-Pay Level 3 according to Section 3309 of the Affordable Care Act. These beneficiaries will not reside in a long term care facility but will be eligible for $0 co-pays. It is vitally important that plan CSRs accept BAE in the appropriate circumstance for those beneficiaries. Attachment A of the January 22, 2010 HPMS Memo "Announcement of a New Stage of Monitoring for Best Available Evidence (BAE)" and the May 11, 2009 HPMS Memo "Additional Guidance on Best Available Evidence" are excellent instructions on the BAE process and CMS' expectations.

13. In January 2012, non-LIS Part D beneficiaries will continue to receive a 50% discount on brand-name drugs at the point-of-sale and a 14% increase in coverage for all other covered Part D drugs (i.e., generic drugs and diabetic supplies) while they are in the coverage gap. CMS emphasizes that Part D Sponsors are the primary point-of-contact for beneficiaries' specific discount questions; 1-800-MEDICARE will direct callers to their plans. Plans that are able to address questions about the discount for their beneficiaries are less likely to receive related CTM complaints. CMS has implemented subcategories in the Pricing/Co-Insurance category to capture CTM complaints related to this increased coverage, particularly those where beneficiaries indicate they sought answers from their plan first but their issue remains unresolved.

Updates to CTM Exclusion Criteria and Performance Standards:

Plans are to resolve at least 95% of cases designated as "immediate need" within 2 calendar days of receipt, at least 95% of CTM complaints designated as "urgent" within 7 days, and at least 95% of CTM complaints designated without an issue level within 30 days. Complaints that require handling by the Retroactive Processing Contractor (RPC) often cannot be fully resolved within these timeframes and are not included in CMS' calculation of plan timeliness provided that the plan has indicated the complaint has been referred to the RPC in the CTM. Complaints referred to the RPC are not to be closed until the RPC has made the necessary update to CMS' systems (see Scenario F.6 of the CTM SOP).

In addition, as described in Scenario V of the CTM SOP, CMS will be the entity responsible for approving "good cause for failure to pay premium" requests in the CTM. If approved by CMS, casework staff will change the issue level to "urgent" so plans can distinguish complaints that require their action from the ones that require CMS action. Since beneficiaries can have up to 3 months to become current with their premiums in these circumstances, plans are not expected to close these complaints within the typical 7-day requirement for resolving urgent complaints. As such, these complaints are not included in our timeliness measures. However, plans are still required to send the required beneficiary notifications within 3 days of receiving the "urgent" notification from CMS in the CTM.

Some complaints recorded in the CTM are excluded from plan performance metrics. With the recent addition of several new CTM subcategories, CMS is updating its exclusion list as indicated in the following table:

Category ID	Category Description	Subcategory ID	Subcategory Description
11	Enrollment/ Disenrollment	16	Facilitated/Auto Enrollment issues
		18	Enrollment Exceptions (EE)*
13	Pricing/Co-Insurance	06	Beneficiary has lost LIS Status/Eligibility or was denied LIS
		16	Part D IRMAA
26	Contractor/Partner Performance	90	Other Contractor/Partner Performance
30	Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information	01	Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information
		90	Other Beneficiary Needs Assistance with Acquiring Medicaid Eligibility Information issue
38	Contractor/Partner Performance	90	Other Contractor/Partner Performance
44	Equitable Relief/Good Cause Requests	01	Good Cause - Disenrollment for Failure to Pay Premiums
		90	Other Equitable Relief/Good Cause Request*
45	Equitable Relief/Good Cause Requests	01	Good Cause - Disenrollment for Failure to Pay Premiums
		02	Refund/Non-Receipt Part D IRMAA*

		03	Good Cause Part D IRMAA*
		04	Equitable Relief Part D IRMAA*
		90	Other Equitable Relief/Good Cause Request*
49	Contractor/Partner Performance	90	Other Contractor/Partner Performance
50	Contractor/Partner Performance	90	Other Contractor/Partner Performance

*Program integrity complaints and subcategories noted above with an asterisk, though housed in the CTM, are not viewable by plans and are excluded from performance metrics.

CMS makes every effort to assign complaints to plans when it is within their control to resolve. Complaints will be re-assigned when appropriate according to the procedure described in the CTM Plan SOP Scenario H.

If you have any questions or comments regarding this memorandum, we encourage you to discuss them further with your Account Manager.