DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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**CENTER FOR DRUG and HEALTH PLAN CHOICE**

TO: All Part C Plans and Part D Plan Sponsors

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

SUBJECT: Updated Complaint Tracking Module (CTM) Contract Related Report Exclusion Criteria and Casework Reminders

DATE: December 9, 2008

The Centers for Medicare and Medicaid Services (CMS) appreciates the continued efforts of Part C Plans and D Plan Sponsors to address and resolve Medicare Part D enrollees' issues. This memorandum serves to update the list of contract-related report exclusion criteria for the Health Plan Management System (HPMS) Complaint Tracking Module (CTM). In addition, this reminds plans about policies and procedures regarding Customer Service Call Handling and 2009 Casework Management with Part C Plan Sponsors and Part D Sponsors.

## CMS' Report Exclusions

Since the CTM's inception in 2006, complaints related to certain criteria beyond the control of an organization have been excluded from CMS' contract specific reports. Due to program maturation, the exclusion list has been revised to include only those criteria which are truly beyond the control of the Plans and Plan Sponsors. The attached chart displays the CTM specific report exclusion criteria that become effective on 1/1/2009.

## Referrals to 1-800-MEDICARE

In a November 15, 2007 memorandum, "Reminders for Customer Service Call handling and Casework Management," CMS provided sponsors with guidelines for properly handling beneficiaries' issues over the telephone and for reducing the number of members calls referred to 1-800-MEDICARE. CMS continues to observe that some sponsors refer calls to 1-800-MEDICARE at a high rate. In many instances, those calls could have been resolved by the plan sponsor using existing data sources, such as MARx, and other available resources. CMS encourages Part C plans and Part D sponsors to request that beneficiaries call them directly for prompt assistance, rather than 1-800-MEDICARE. Additionally, plans and sponsors should continue to reinforce this message through various

communication methods such as including relevant language directing beneficiaries to utilize the plan's customer services as part of their Annual Enrollment Period (AEP) communication strategy. CMS has determined that some sponsors are shifting casework that is their responsibility to CMS Regional Offices, rather than managing the cases themselves. Cases forwarded to 1-800-MEDICARE and the CMS Regional Offices are tracked and trended through the CTM and plans will be monitored for cases that are inappropriately shifted to CMS. Compliance actions for inappropriate shifting of casework may be taken, as necessary.

## Social Security Administration (SSA) Premium Withhold

Since early 2007, several memoranda have been released discussing SSA Premium Withhold and systems cleanups. Additionally, specific guidance has been provided via the July 2008 Complaints Tracking Module (CTM) Standard Operating Procedure (SOP) on the proper course for handling SSA premium withhold cases recorded in the CTM. On October 8, 2008 CMS issued the memorandum "REISSUED GUIDANCE- Activation of Premium Withholding for 2009 Plan Enrollments." This memo provides suggested language for plan's customer service call center scripts related to the activation of premium withholding for 2009 plan enrollments. Beneficiaries should be made aware that plan changes and new enrollments may affect their SSA Premium Withholding status and that any requested changes may take up to 90 days before changes will take effect. Complaints regarding SSA premium deductions that exceed 90 days or any complaint that is beyond the plan's control to resolve, should be referred to the appropriate Regional Office. Sponsors should not refer beneficiaries to the Social Security Administration (SSA), 1-800-MEDICARE, or the Regional Offices as an alternative to conducting complaints research utilizing these existing resources and processes.

Sponsors are also encouraged to review information provided in the March 23, 2007 memorandum, "Clarification of Involuntary Disenrollment Policy for Beneficiaries Who Elect Social Security Premium Withholding." This memo clarifies CMS' involuntary disenrollment policy as it relates to members who have selected Social Security withholding or whose premium is paid by another entity.

## Casework Management

Plan Sponsors are asked to refer to the July 2008 version of the Complaints Tracking Module Standard Operating Procedure regarding current timeframes for resolving and closing CTM cases timely. Plans are required to resolve cases designated as Immediate Need within 2 calendar days. Urgent Cases are expected to be resolved within 10 calendar days and all other complaints within 30 calendar days.

Additionally, sponsors are reminded to refer cases outside of their control using the "Plan Request" function in the Complaints Tracking Module, as described in the CTM Standard Operating Procedure. Examples of these types of cases, include, but are not limited to, the following: complaints related to enrollment exceptions; reassignment requests; and complaints related to CMS enrollment reconciliation processing.

Finally, in an effort to reduce the number of open complaints in the CTM, CMS recommends the following protocol for resolving duplicate cases from the same beneficiary. If a sponsor has multiple open complaints in the CTM from the same beneficiary, relating to the same issue, the Plan should close the oldest case(s). The sponsor should also annotate in the Casework Summary a reference to other applicable complaints. Detailed plan closure notes should be used when closing any complaints in CTM. Sponsors are encouraged to take all necessary steps to improve performance in this area, including conducting additional training of the staff responsible for closing cases in the CTM.

## 2009 4Rx Data

It is vitally important that plans have a system in place to handle incoming calls from members who have access to care issues, particularly at the beginning of the year. Many of these beneficiaries may be new members in 2009 who have not yet received their member identification cards, enrollment letters, or 4Rx information, and need medications at the pharmacy. Some may be existing members whose benefits have changed with the new plan year. Part D Sponsors should be prepared for these calls with call center personnel educated to provide their members with the necessary information to ensure the access to care inquiries are handled appropriately and expeditiously. These calls should be handled directly by Part D sponsors and should not be referred to 1-800-MEDICARE or a CMS Regional Office.

## Low Income Subsidy (LIS)

Similarly, Part D Sponsors' Customer Service Representatives should be well prepared to handle calls from beneficiaries whose Low Income Subsidy (LIS) status is changing in 2009. Part D Sponsors should refer to the August 29, 2008 "Reassignment of Low Income Subsidy Beneficiaries for 2009" HPMS Memorandum for more detail. Plan representatives also should be familiar with whether or not their plan is participating in the Optional Grace Period as mentioned in the September 26, 2008, "2009 LIS Grace Period Policies" HPMS Memorandum. If your plan is participating, the plan Customer Service Representatives should be well-versed in guiding plan members through this process.

## Online Enrollment Center (OEC) and Plan Enrollment Submissions

Part C plans and Part D sponsors are reminded that it is mandatory to download online enrollments via the Online Enrollment Center (OEC) on a daily basis. Adherence to this guidance will reduce the number of complaints submitted to 1-800-MEDICARE and to the CTM. Sponsors and plans are asked to ensure that they are adhering to this requirement and to improve performance in this area. Similarly, to ensure synchronization with plan enrollment systems and MARx, plan sponsors should be regularly submitting enrollments to CMS as further detailed in the November 13, 2008 HPMS Memorandum, "Ongoing Enrollment and Report Reconciliation, Corrections and Retroactivity."

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

## ATTACHMENT

### CTM Contract Reporting Exclusions List

Effective 1/1/2009

| Part D: Exclusion Description |
|---|
| "Beneficiary has lost LIS Status/Eligibility" |
| "EE (Enrollment Exceptions)" |
| "Facilitated enrollment issues" |
| "Individual is using someone else's prescription drug coverage to pay for prescriptions" |
| "Missing Medicaid Eligibility in MBD" |
| "Overcharged premium fees" |
| "Website/CMS Website (Plan Finder)" |
| "Website/Plan Website" |
| “Program Integrity/Fraud, Waste, and Abuse” category***** |
| CMS Issue |
| Complaints flagged as “Hide Complaint from Plan” ***** |
| Enrollment Exception (word search) |
| Facilitated enrollment (word search) |
| Pending reassignment requests - Plan Requests (word search) |

* These are not excluded from complaint rate calculations.

| Part C: Exclusion Description |
|---|
| “Enrollment Reconciliation—dissatisfied with decision” |
| “Individual is using another beneficiary’s MA card” |
| CMS Issue |
| Pending reassignment requests - Plan Requests (word search) |