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

CENTER FOR MEDICARE

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

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

SUBJECT: Updated CTM Standard Operating Procedures, Exclusions, Reminders, and Other CTM Related Information

DATE: June 28, 2013

CMS is pleased to announce the release of the updated Complaints Tracking Module (CTM) Standard Operating Procedures (SOP). This SOP supersedes all prior versions and replaces the memorandum issued June 8, 2012. CMS is also republishing its CTM Exclusion Criteria (Appendix A) to include a new subcategory. This exclusion list supersedes all prior versions and replaces the one issued in the memorandum dated December 22, 2011.

Beneficiary's complaints are a key element in ensuring that health and drug plans are responsive to beneficiary issues. Proper use of CTM is critical to ensuring the accuracy of complaint information. Sponsors are encouraged to work with CMS staff to not only appropriately resolve individual complaints but also continuously examine the drivers of plan complaints. To assist Sponsors with providing complete resolution notes when responding to and closing CTM complaints, this memorandum includes suggested examples of satisfactory resolution notes in Appendix B.

Medicare-Medicaid Plans (MMPs) should note their CTM operating procedures are the same as for Part C and Part D plans. In addition, MMPs are encouraged to work closely with the CMS/State Contract Management Teams to resolve complaints. State staff will have access to the CTM to review and assist with resolving complaints in coordination with CMS.

In addition, in April 2013, a systems change was made relating to how the CTM handles denied Plan Requests. If the Plan Request is denied, then the Assignment / Reassignment Date is not reset. Consequently, if a plan user downloads complaints from the most recent 10 day period, the complaint may or may not be in the plan download, as it would have retained the original assignment date. For a future release, CMS may increase the number of days that are included in the complaint history when plans download their complaints. Meantime, plan users are encouraged to locate these complaints by running real-time queries directly in the CTM.

For general questions about complaint handling and casework procedures, contact your plan's casework lead or Account Manager. For technical assistance with HPMS or 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, with a copy to your Account Manager.

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.

Scenarios/Issues:

A. Plan receives a complaint that should have gone to a subsidiary or another organization.

B. Plan cannot do further work with the complaint and requires assistance.

C. Plan cannot save or close the complaint after entering Casework Notes and/or a Resolution Date.

D. Plan receives a complaint related to a Retroactive Enrollment.

E. Plan receives a complaint related to a Retroactive Disenrollment.

F. Plan receives a request from a beneficiary seeking an enrollment and/or disenrollment change that is not explicitly outlined in CMS' enrollment guidance.

G. Plan receives an incorrectly categorized complaint or a complaint with no assigned category and subcategory.

H. Plan receives a complaint but disagrees with the issue level.

I. Plan receives a complaint with one or more of the following indicators flagged in CTM: SWIFT, Congressional, and/or, Press or Hill Interest

J. Plan receives a premium withhold complaint.

K. Plan receives a provider/pharmacy complaint in CTM.

L. Plan receives a complaint categorized as "Enrollment Exception – Alleged Marketing Misrepresentation (No RO Action Needed)."

M. Plan receives a second CTM complaint.

N. Plan needs CMS assistance to secure BAE (Best Available Evidence).

O. Plan has supporting documentation that relates to a complaint.

P. Plan receives a Good Cause (GC) complaint.

Q. Plan is approaching a resolution for a complaint.

R. Plan user needs HPMS Access but does not have it.

S. Plan has a general CTM related question or issue.

T. Assignment/Reassignment date is reset.

A. Scenario/Issue: Plan receives a complaint that should have gone to a subsidiary or another organization.

Procedure:

1. From the Plan Request tab, select the option to indicate the complaint belongs to another contract and, if known, enter the name and/or contract number the appropriate plan, along with any pertinent information in Casework Notes.
2. Plans are encouraged to notify the beneficiary that their complaint has been reassigned to the appropriate plan.
3. Plans should seek to resolve a complaint when a plan request is pending if it relates to one of its subsidiaries.
4. If CMS agrees with the request, the plan will no longer be able to see the complaint in the system after it is reassigned to a different contract. If the plan has access to the other contract number, then it will be able to view the complaint under the new contract number.

Please Note:

- Complaints with pending Plan Requests cannot be closed.

B. Scenario/Issue: Plan cannot do further work with the complaint and requires assistance.

Procedure:

1. From the Plan Request tab, select the option to indicate that this complaint is a CMS Issue and explain in Casework Notes:
    a. The reason CMS intervention is needed.
    b. Whether access to services has been provided to the beneficiary.
    c. Any beneficiary contact.
2. CMS will agree or disagree with the Plan Request.
    a. If CMS agrees with the request, the plan will no longer be able to see the complaint.
    b. If CMS disagrees with the request, instructions as to next steps will be provided to the plan in CTM.

Examples of CMS Issues include but are not limited to:

- Instances where a beneficiary seeks a Special Enrollment Period (SEP) that is not explicitly outlined in CMS' enrollment guidance.
- Beneficiary needs a critical retroactive disenrollment action taken in MARx (see Scenario E).
- Beneficiary has lost coverage due to possible erroneous loss of Part A/B entitlement that spans multiple plans. If the a 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 the RPC.

Please Note:

- To reduce the likelihood of repeat complaints, plans are encouraged to make interim contact with their members if a complaint takes more than seven calendar days to resolve, even when a complaint has been referred back to CMS.

C. Scenario/Issue: Plan cannot save or close the complaint after entering Casework Notes and/or a Resolution Date.

Procedure:

1. The plan should troubleshoot the issue by:
    a. Confirming that the complaint category is properly assigned. If no category is assigned, refer to Scenario G.
    b. Verifying that the following restricted characters were not entered in the Casework Note and/or the Resolution Date fields: < > & ;
    c. Verifying that there is no pending Plan Request.
    d. Confirming the CMS Retro-Processing Contractor (RPC) Received Date has been entered, if applicable.
    e. When attempting to close the complaint, confirm that a date was entered into the Resolution Date field and that it is not earlier than the Received Date. A CTM cannot be closed unless this entry is made.
2. If no obvious problem is found, the plan should contact the HPMS Help Desk at 1-800-220-2028 or HPMS@cms.hhs.gov.

D. Scenario/Issue: Plan receives a complaint related to a Retroactive Enrollment.

Procedure:

1. The plan investigates the complaint to determine if it is a valid retroactive enrollment request.
    a. If the request is not valid and the complaint is considered resolved, the plan will notify the beneficiary and document the complaint resolution in Casework Notes (see Scenario Q).
    b. If the request is valid, the plan needs to update its system to ensure that the beneficiary has access to drugs and/or health services and update MARx with enrollment/disenrollment change(s).
2. 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. As soon as the plan has submitted the retroactive request to the RPC, the plan must:
    a. Document the development of the complaint in Casework Notes on the Complaint Resolution tab.

b. On the Complaint Resolution tab, select the checkbox and enter the date the complaint was referred to the RPC.

c. The complaint should remain open until the RPC has processed the needed action.

d. After receiving notification from the RPC that the action has been processed as requested, the plan must check MARx to confirm this change, enter the date the RPC notification was received in the RPC Date Received field and close the complaint. The complaint will not close without the RPC notification date. 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.

The RPC cannot process complaints (CTM cases) that fall outside CMS Enrollment or Retroactive Processing Guidance without approval from a CMS caseworker. If the retroactive request falls outside CMS enrollment guidance due to timeliness, plan error or because it lacks required documentation, the plan should refer to Step 3 below to request CMS approval to resolve.

3. 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 the February 24, 2009 HPMS memo), or complaints that fail to satisfy the RPC's requirements on retroactive processing, then the plan should submit a Plan Request to CMS for approval to refer the issue to the RPC.

   a. 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. After submitting the request, the plan should follow steps 2 a-d above.

   b. 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.

Please Note:

- Plans should refer to the Special Note regarding Regional Office Casework Actions in Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Managed Care Manual for instructions on how to submit caseworker actions/approvals to the RPC.
- Organizations must ensure 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, the plan's systems should reflect enrollment as of the effective date, even if the enrollment is pending a transmittal to the RPC and submission to CMS systems.
- For retroactive enrollment complaints received directly by plans (e.g. not via CTM) requiring an effective date of more than 3 months of retroactivity, the plan should update its system to ensure that the beneficiary has access to drugs and/or health services and contact their Account Manager (AM) to request approval.
- Requests for reinstatements for Good Cause are noted in Scenario P. Reinstatements are NOT retroactive enrollments.
- 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.

- Immediate Need cases and cases left open because they are referred to the RPC for retroactive action are excluded from plan turnaround/closure metrics. However, these cases may be included in overall Plan Rating complaint counts.
- Plans are encouraged to inform beneficiaries of any delays associated with having enrollment changes reflected in CMS' systems. The plan should inform the beneficiary that it may take up to one month for the change to be reflected in CMS' systems.
- Congressional cases dealing with enrollment changes should not be sent to the RPC.
- MMPs should investigate retroactive enrollment/disenrollment cases with the respective state enrollment broker. When possible, MMPs should make full use of the RPC to resolve retroactive enrollment/disenrollment issues.
- Individuals who become 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. 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, update internal systems, and close the CTM.

E. Scenario/Issue: Plan receives a complaint related to a Retroactive Disenrollment.

Procedure:

1. The plan investigates the complaint to determine if it is a valid retroactive disenrollment request.
    a. If the request is not valid and/or the complaint is considered resolved, the plan will notify the beneficiary and document the complaint resolution in Casework Notes (see Scenario Q).
2. If the request is valid and the plan can take the appropriate MARx actions themselves to resolve the complaint, they should do so without CMS assistance, updating their systems, closing the complaint and notifying the beneficiary accordingly.
3. 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. Complaints labeled Immediate Need and complaints concerning opt-out due to employer group coverage are considered Critical.
    a. 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 Casework Notes and the plan should indicate any internal systems changes it has made.
        i. If CMS agrees with the request, the plan 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.
        ii. If CMS disagrees with the Plan Request, CMS will describe next steps in CTM.

b. If the complaint is Non-Critical, the plan should submit a request to the RPC with the appropriate documentation asking them to update CMS' systems with their change(s). As soon as the request is made, the plan should follow the steps in D.2.a-d.

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 the February 24, 2009 HPMS memo), or complaints that fail to satisfy the RPC's requirements on retroactive processing, then the plan should submit a Plan Request to CMS for approval to refer the issue to the RPC.

1. 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 its request to the RPC requesting an update to CMS' systems. After submitting the request, the plan should follow steps D.2 a-d.

2. 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.

Please Note:

- For a Critical retroactive disenrollment issue received directly that is not in the CTM, plans should contact their CMS Lead Caseworker for assistance.
- For a Non-Critical retroactive disenrollment issue received directly that is not in CTM, plans should make a request to the RPC for correction if the plan is unable to make the change themselves.

See the "Please Note" section of the previous scenario for more details relating to retroactive changes.

F. Scenario/Issue: Plan receives a request from a beneficiary seeking an enrollment and/or disenrollment change that is not explicitly outlined in CMS' enrollment guidance (often referred to as an Enrollment Exception).

Procedure:

1. The plan should submit a Plan Request to indicate the complaint is a "CMS Issue" and describe in Casework Notes why the beneficiary is seeking an exception to make an enrollment or disenrollment change outside of a valid enrollment period.

a. If CMS agrees with the request, the plan will no longer be able to see the complaint and CMS will be responsible for resolving the complaint.

b. If CMS disagrees with the request, instructions as to next steps will be provided to the plan in CTM.

Please Note:

- Valid Enrollment Exceptions are excluded from plan performance metrics.
- For prospective MMP enrollment requests, beneficiaries should be referred to the respective state enrollment broker.

G. Scenario/Issue: Plan receives an incorrectly categorized complaint or a complaint with no assigned category and subcategory.

Procedure:

1. The plan needs to explain the reason for their request in the Casework Notes field of the Complaint Resolution tab.
2. From the Plan Request tab:
    a. Select the option to request a change to the complaint's category/subcategory.
    b. Select the appropriate category/subcategory from the drop-down list.
    c. Submit the request when done.

Please Note:

- A plan is not to delay steps to resolve the complaint while the plan's request to change the category/subcategory is pending.
- CMS will only consider a category/subcategory re-assignment request if it is abundantly evident in the Complaint Summary that it was incorrectly categorized at intake. Requests should be infrequent and should not be used for the sole purpose of improving a plan's performance metrics.
- If a beneficiary requests a Good Cause determination while the plan is responding to a CTM related to disenrollment for failure to pay premiums (or Part D-IRMAA), the plan should submit a Plan Request noting that there was no plan error associated with the disenrollment.

H. Scenario/Issue: Plan receives a complaint but disagrees with the issue level.

Procedure:

1. Explain the reason for the request in Casework Notes.
2. From the Plan Request tab, select the option to change the complaint's issue level then submit to CMS for review.
3. Once this option has been selected, the time clock for the plan will stop. If CMS approves of the plan's request, the clock will start over once the issue level has changed. If CMS disapproves the request, an explanation will be provided.
4. If the complaint remains the responsibility of the plan to resolve, casework should continue as CMS evaluates the plan's request to change the issue level.

Please Note:

- For MA/MMP, an Immediate Need complaint is defined as a complaint where a beneficiary has no access to care and an immediate need for care exists. For Part D, an Immediate Need complaint is defined as a complaint that is related to the beneficiary's need for medication where the beneficiary has 2 or less days of medication left.
- For MA/MMP, an Urgent complaint involves a situation where the beneficiary has no access to care, but no immediate need exists. For Part D, an Urgent complaint is defined as a complaint that is

related to the beneficiary's need for medication where the beneficiary has 3 to 14 days of medication left.

- Immediate Need or Urgent issues can only be downgraded if they never were Immediate Need or Urgent. 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 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.
- CMS reserves the right to classify any complaint that does not fit the above definitions for "Immediate Need" or "Urgent."
- 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).

I. Scenario/Issue: Plan receives a complaint with one or more of the following indicators flagged in CTM: SWIFT, Congressional, and/or, Press or Hill Interest

Procedure:

1. Contact the beneficiary/provider to obtain details of their case and begin the investigation, as needed. The plan should inform the complainant of planned actions and anticipated timeframes.
2. Casework should be completed within 2 to 7 calendar days, depending on the issue level. If the complaint cannot be resolved within 7 calendar days, interim casework notes should be entered by the plan, with an explanation of the delay.
3. Record clear and concise Casework Notes of the research and actions taken. Entries should include all actions taken including contact dates and instructions to the beneficiary, complainant and contacts. Include systems updates and the dates the actions were taken.
4. After resolving the complaint, the plan should submit a Plan Request to change the complaint to a CMS Issue. CMS is responsible for final closure of such cases, notifying congressional offices of final resolution, and will make any needed enrollment changes in MARx. As a best practice, plans should request this within 2 to 7 calendar days to allow time for proper closure of the case by the RO.
5. CMS will agree or disagree with the Plan Request. If CMS agrees, the plan will no longer be able to view the complaint. If CMS disagrees, instructions as to next steps will be provided to the plan.

Please Note:

- SWIFT, Congressional, Press, or Hill interest complaints are classified as immediate need or urgent in the CTM.
- For Congressional cases, the plan should NOT notify the congressional office of the resolution as this is CMS' responsibility.
- Plans are unable to close SWIFT cases in CTM. A Plan Request for a change to CMS Issue must be made so CMS can review and close the complaint.
- Plans should not refer any of these cases to the RPC, indicating in the casework notes what enrollment updates are need in MARx.

J. Scenario/Issue: Plan receives a premium withhold complaint.

Procedure:

1. The plan reviews the complaint and checks that their system reflects the same premium amount and payment option specified in the complaint and corrects if necessary.
    a. The plan should inform the beneficiary that it may take up to 90 days to fully correct their premium withhold issue or for SSA/RRB to issue a refund.
    b. The plan should recommend that the complainant call the plan back if there is no resolution after 90 days and close the complaint.
2. If the plan's system and MARx correctly reflects 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.
    a. If this time period has not elapsed, the plan should educate the beneficiary and close the complaint.
3. If the complaint relates to SSA/RRB premium deductions that extend past the expected period, the SSA/RRB withholding issue relates to a non-current year, or actions by the plan will not correct the issue, submit a Plan Request to have the issue treated as a CMS Issue.

Please Note:

- Refer to the March 23, 2007 HPMS memorandum regarding, "Clarification of Involuntary Disenrollment Policy for Beneficiaries who Elect Social Security Premium Withholding."
- CTM complaints that include both a complaint that the beneficiary is getting billed while in premium withhold status and include a plan premium payment problem should remain open until the beneficiary issue is resolved and the beneficiary is made whole.

K. Scenario/Issue: Plan receives a provider/pharmacy complaint in CTM.

Procedure:

1. The plan reviews the complaint, contacting the provider/pharmacy for more information if needed.
2. The plan 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 (Scenario Q) is also recommended for provider/pharmacy complaints.

L. Scenario/Issue: Plan receives a complaint categorized as "Enrollment Exception – Alleged Marketing Misrepresentation (No RO Action Needed)."

Procedure:

1. The plan carefully reviews the allegation of marketing misrepresentation and conducts an investigation, contacting the beneficiary if additional information is needed.

2. After investigating the complaint, the plan 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.
3. The plan 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 Notes should include the name of any agents/brokers involved if it was not provided in the original complaint.
5. If the plan determines the allegation is unfounded, that should be indicated in Casework Notes on the Complaint Resolution tab, along with any documents supporting the plans' findings.

Please Note:

- Plans should carefully review to the October 3, 2008 HPMS memorandum, "Enhancement to Complaints Tracking Module (CTM) to Review and Investigate Marketing Misrepresentation Complaints," prior to handling any marketing misrepresentation complaint.
- Plans are expected to similarly handle complaints categorized as "Enrollment Exception – Alleged Marketing Misrepresentation (RO Action Needed)," which are viewable through the "Marketing Misrepresentation Report" link on the CTM Start Page. For complaints viewable only in this report, plans should follow the steps 1-2 above and are encouraged to upload a response to complaints in this subcategory.
- Plans should not submit Plan Requests seeking re-categorization of marketing complaints when a plan determines a complaint was unfounded.
- CMS shares its alleged marketing misrepresentation complaints regularly with State Departments of Insurance.

M. Scenario/Issue: Plan receives a second CTM complaint.

Procedure:

1. If the prior complaint has already been resolved satisfactorily, the plan should close the complaint and note it was a repeat complaint in the resolution notes. The plan should verify the beneficiary has been informed of the resolution.
2. If the first complaint 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 older complaint, and reference the CTM number of the new complaint in the resolution notes.
3. If the first complaint is sufficiently distinct issue than the second complaint, the plan is to keep both complaints open until they are resolved.

Please Note:

- CTM gives plans the ability to view multiple complaints from the same complainant within their organization. Plans are encouraged to utilize this capability to identify repeat complainants for the purposes of educating them about ways to contact their plan directly for assistance.

N. Scenario/Issue: Plan needs CMS assistance to secure BAE (Best Available Evidence) on behalf of an LIS beneficiary who qualified with Medicaid.

Procedure:

1. The plan completes the plan's portion of the BAE Assistance Worksheet. See Attachment B of the August 4, 2008 HPMS memo.
2. The plan sends the completed worksheet via an encrypted e-mail to the Home Regional Office (RO), noting in the subject line "Immediate BAE Assistance Needed" for an immediate case or "Non-Immediate BAE Assistance Needed" for all others. See Appendix D for a list of Home Regional Offices.
3. CMS RO staff will enter a new complaint in CTM with the information provided by the plan in the worksheet.
    a. The RO contacts the state Medicaid office to verify the beneficiary's Medicaid status.
    b. Enters the beneficiary's Medicaid status in the CMS Only section of the BAE Assistance Worksheet.
    c. Sends the worksheet back to the plan securely or uploads the worksheet to the CTM complaint.
4. Upon receiving the completed BAE Assistance Worksheet back, the plan updates their internal systems. Within one business day of receiving the BAE worksheet from the RO, the plan will attempt to notify the beneficiary of the LIS update to plan systems and inform them that it can take up to 30 days for their LIS to reflect on CMS' systems. After notifying the beneficiary, the plan can close the case in CTM.
5. If in 30-60 days, the beneficiary's CMS record does not automatically update with the LIS, the plan is to submit the change to the RPC along with the worksheet as proof.

O. Scenario/Issue: Plan has supporting documentation that relates to a complaint.

Procedure:

1. From the Complaint Attachment tab, browse to locate the document to upload. The name of the file cannot contain any special characters. Examples of appropriate documents are beneficiary communications (except email), system screen prints, and notifications received from third parties such as the RPC (.pdf, .jpg, .txt, .docx, .xlsx, .zip).
2. Select the type of document being uploaded from the drop-down list that describes the file. If "Other" is selected, the "Other" field text box must also be completed. This becomes a mandatory entry.
3. Click on the Upload File button and the attachment will appear listed. Close the window.
4. Save the CTM record. The attachment will now display on the Complaint Data Entry page.

Please Note:

- Plans can also view documents attached by CMS, SHIP, or MMP State Reviewers.
- If a document was uploaded by a plan and subsequently reassigned to another plan, the second plan will not be able to view uploaded documentation. If that documentation is believed to be necessary to resolve the complaint, the plan should submit a Plan Request seeking CMS assistance.

P. Scenario/Issue: Plan receives a Good Cause (GC) complaint.

Procedure:

1. Good Cause (GC) complaint is actionable for the plan after CMS has made a favorable determination and marked the CTM complaint as "urgent."
2. Upon receipt of a GC CTM, the plan will send the required notification to the beneficiary within 3 business days of receiving the "urgent" plan action in CTM. The notice will indicate that the individual has 3 months from the effective date of disenrollment to pay all owed amounts required for the reinstatement to occur.
3. An individual previously enrolled in an employer/union sponsored plan who paid premiums directly to the plan and not to the employer/union, may request reinstatement for GC if s/he was disenrolled for failure to pay plan premiums and/or failure to pay Part D-IRMAA. An individual who paid premiums directly to the employer/union and not the plan may request reinstatement for GC only if s/he was disenrolled for failure to pay Part D-IRMAA. Upon request by CMS or receipt of the GC CTM for "plan action," the plan must contact the employer/union to determine whether the employer/union will permit reinstatement. The plan must respond to CMS within 3 business days of receipt of the request or CTM for plan action. If the employer/union agrees to permit reinstatement, CMS will review the reinstatement request. If CMS approves the GC request (favorable determination), the plan needs to collect all delinquent premium amounts, if any, the individual was responsible for paying directly to the plan.
4. After all beneficiary owed amounts have been paid in full, within 5 calendar days the plan will submit a Plan Request indicating this is a "CMS Issue."* Once paid, the plan will immediately grant access to drugs/services for the beneficiary.
5. CMS will accept the CTM as a "CMS Issue" and upon payment of Part D-IRMAA owed amounts, if any, reinstate the beneficiary in MARx by cancelling the disenrollment, and close the case. The plan will send the beneficiary a notice of reinstatement once it receives the TRR from CMS.
6. If the required payment is not received within the required timeframe, the plan will send a Plan Request indicating this is a "CMS Issue." The CMS caseworker will accept the case as a "CMS Issue," contact the beneficiary to inform him/her that the disenrollment stands, that reinstatement will not occur, and close the case.

Please Note:

- Plans are encouraged to supplement the letter sent to beneficiaries indicating favorable determinations, with telephone calls promoting payment options other than checks.

- Without CMS special approval, reinstatement may NOT occur prior to the full payment of the required owed amounts.
- For purposes of this SOP, requests for GC reinstatement are called "complaints" because CMS is using the CTM system to communicate with plans for these requests for reinstatement. "Complaints" entered into CTM for GC reinstatement requests are not included in plan performance metrics.
- Plans still need to collect premiums owed to themselves for the 3 months following disenrollment when the individual has requested GC reinstatement after having been disenrolled for failure to pay Part D IRMAA.
- CTM will not allow a plan to close a complaint in a GC subcategory.
- Plans should not grant access to care in cases where an individual still owes Part D–IRMAA. These cases will be notated in CTM by special casework notes by CMS.
- Beneficiaries contacting plans directly seeking reinstatement for good cause should be referred to 1-800 Medicare after first verifying the disenrollment was not caused by plan error.
- See Chapter 3 of the Medicare Prescription Drug Benefit Manual and Chapter 2 of the Medicare Manage Care Manual for more information, including model notices.

** Upon receipt of full payment by check, plans may wait 5 calendar days before granting access to services and submitting a Plan request for "CMS Issue" to assure the payment clears the bank. If the plan doesn't receive confirmation within 5 calendar days, it must grant access to services and submit the Plan Request to CMS. If the plan later finds that the payment did not clear the bank, it may contact CMS to cancel the reinstatement.*

Q. Scenario/Issue: Plan is approaching a resolution for a complaint.

Procedure:

1. The plan will notify the beneficiary or complainant according to the plan's business practice and customer service policy.
    a. If the plan is having difficulty contacting the beneficiary, CMS strongly recommends that the plan attempt to contact the complainant at least three times at different times on different days. Details, including the dates and times of contact attempts, actions taken, etc. should be documented in CTM.
    b. 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.
2. The plan records a clear and concise narrative (up to 4,000 characters) in the Casework Note field of the Complaint Resolution tab. All entities that review CTM complaint records should be able to easily understand the notes clarifying the issue, action(s) taken and decisions made to investigate and resolve the complaint.
    a. See Appendix B for guidance on documenting resolution notes.

3. To close a resolved complaint in the CTM:
    a. Make a selection from the "Contact Made" dropdown list and select "System Update Action Taken" if appropriate. At least one of these must be selected to close the complaint.
    b. Select "Yes" to indicate that the complaint has been resolved and enter a Resolution Date. The final Casework Note entered will automatically populate into the Resolution Summary. Other notes may be added to the Summary by simply checking the box under the Casework Note.

Please Note:

- To reduce the likelihood of CMS contacting the plan for a status update on a particular complaint, plans are encouraged to provide ongoing, interim documentation and notes as they work toward the ultimate resolution of the complaint
- Plans are encouraged to send a letter when they are unable to contact a beneficiary to inform them of a resolution. The "Template Resolution Letter" is available in the Documentation section of CTM. The date the letter was sent should be documented in Casework Notes.
- Plans can work directly with SHIP CTM users as needed for SHIP entered complaints without requiring additional beneficiary disclosure agreements from the SHIP. MMPs can work similarly with MMP State Users.
- If the resolution involves a refund from the plan to the beneficiary (any overpayment of co-payments, premiums, late enrollment penalties, 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).

R. Scenario/Issue: Plan user needs HPMS Access but does not have it.

Procedure:

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:

    Centers for Medicare & Medicaid Services
    ATTENTION: Lori Robinson
    7500 Security Boulevard
    Mail Stop: C4-18-13
    Baltimore, MD 21244

    The use of a traceable mail carrier is encouraged to ensure a timely delivery. HPMS user access may take 2 weeks or longer.
3. Once the plan user is notified of their HPMS access, the 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.

Please Note:

- A Plan user with HPMS access that needs CTM access should send an e-mail that includes their four character HPMS ID to HPMS_Access@cms.hhs.gov. The e-mail's subject should read "CTM Access Request." and the message should contain the user's HPMS ID.

S. Scenario/Issue: Plan has a general CTM related question or issue.

Procedure:

1. The plan should seek resolution with their Lead Caseworker or Account Manager for casework/CTM process questions.
2. The plan can seek answers to technical questions by emailing: CTM@cms.hhs.gov, with a copy to their Account Manager. Be sure to include the plan's contract number and complaint ID (s).

T. Scenario/Issue: Assignment/Reassignment date is reset.

Procedure:

1. The following are general timelines for the automatic resetting of Assignment/Reassignment dates, other than those noted in specific scenarios above:
    a. Complaint is re-opened.
    b. Issue Level is changed from non-Issue/Urgent to Urgent/Immediate Need (Issue Level is upgraded).
    c. CMS Issue flag is set or removed. Plan Request must be accepted for the clock to be reset.
    d. Contract is changed.

Please Note:

- The Assignment/Reassignment date is not changed when a Plan Request to have a complaint designated as a CMS Issue is denied.

Appendix A: CTM Exclusion Criteria and Performance Standards

Excluded Subcategories:

Some complaints recorded in selected subcategories are excluded from Part C and Part D plan performance metrics. A list of excluded subcategories is below. Exclusionary criteria does not apply to MMPs.

Category ID	Category Description	Subcategory ID	Subcategory Description
11	Enrollment/ Disenrollment	16	Facilitated/Auto Enrollment issues
		18	Enrollment Exceptions (EE)*
		24	Disenrollment Due to Loss of Entitlement
03	Enrollment/ Disenrollment	11	Disenrollment Due to Loss of Entitlement
13	Pricing/Premium/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 are only re-assigned under very limited circumstances described in the CTM Plan SOP Scenario G.

Timeliness:

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 calendar days, and at least 95% of CTM complaints designated without an issue level within 30 calendar days. Sometimes, complaints that require handling by the Retroactive Processing Contractor (RPC) 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 D & E of the CTM SOP).

As beneficiaries have up to three months to become current with their premiums when they have a CMS approved, favorable good cause determination, plans are not expected to close these complaints within the typical timeframes for resolving complaints. These complaints are not included in our timeliness measures. However, plans are still required to send the required beneficiary notifications within 3 business days of receiving the notification from CMS that the beneficiary has an approved good cause request.

Appendix B: Suggested Examples of Plan CTM Resolution Notes

Complete and accurate plan resolution notes assist CMS staff and our 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 CTM.

CTM casework notes by the plan 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 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, etc.).
- Include dates of system updates and enrollment/disenrollment effective dates.

Below are examples of CTM Plan Casework 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 not constitute new plan requirements.

A. SWIFT / Congressional
B. Immediate Need
C. CMS Issue
D. Access to Benefits
E. Enrollment Exception
F. Retroactive Enrollment (any issue level)
G. Retroactive Disenrollment (critical)
H. Marketing Misrepresentation
I. Best Available Evidence (BAE)
J. Good Cause / Part D IRMAA
K. Employer Coverage
L. Provider / Pharmacy
M. Premium Deduction
N. Claims
O. Out of Service Area
P. Belongs to Another Plan Contract
Q. Unable to Contact

Typical Scenario	Plan Response / Request
A. <u>SWIFT / Congressional</u> The plan received a SWIFT or Congressional complaint in CTM.	*Once the complaint is resolved by the plan, the plan should submit a request to change the complaint to a CMS Issue for final closure by CMS. Plan notes should provide the following:* The plan spoke to 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 was satisfied with the resolution to their complaint. The case is now being submitted to CMS for final closure.
B. <u>Immediate Need</u> (enrollment) Member was disenrolled from their plan and is in immediate need of medical service or medication.	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*>. ***** *If the plan chooses to submit a reinstatement request to the RPC, be sure to select the RPC flag in CTM after the request has been made. The complaint can be closed when the plan receives confirmation from the RPC that the action has been taken.*
<u>Immediate Need</u> (disenrollment) Member was enrolled into a new plan that needs to be cancelled. Member is in need of services approved by their prior plan and needs immediate reinstatement with that plan.	*For immediate disenrollment requests, the plan needs to submit a request to change the complaint to a CMS Issue and provide the following in their notes:* The plan is requesting CMS to cancel the member from <*contract-PBP*> and reinstate them with their prior plan because <*source of issue and reason for the plan's request*>. We have called the member on <*date*> to advise them that their case has been sent to Medicare for review.
C. <u>CMS Issue</u> The plan cannot do further work with the complaint and needs CMS assistance to resolve.	The plan is requesting a change to CMS Issue for assistance in resolving this complaint. A <*correction or exception*> is being requested because <*reason*>. *If the case is immediate, the plan should also notate when applicable …* Plan systems have been opened to allow the member access to plan benefits. We have called to notify the member on <*date*> of their access to the plan and to advise them that their case has been sent to Medicare for review.
D. <u>Access to Benefits</u> The member's provider/pharmacy informed him/her that their plan did not cover a medical service or medication.	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.

E. Enrollment Exception The plan is requesting an exception for a beneficiary/member to enroll or disenroll from their plan.	*The plan is to submit a request to change the complaint to a CMS Issue and provide the following information in their notes:* The beneficiary does not qualify for an SEP that the plan is able to process. As such, the beneficiary request CMS approval for an exception to <*enroll into or disenroll from*> <*contract-PBP*> for <*effective date*> due to <*reason*>. We informed the beneficiary that the matter will be referred back to Medicare for review.
F. Retroactive Enrollment (any issue level) Member was inappropriately disenrolled from their plan.	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 of a reinstatement, they should 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. ****** If the plan chooses to submit a reinstatement request to the RPC, be sure to select the RPC flag in CTM after the request has been made. The complaint can be closed once the plan receives confirmation from the RPC that the action has been taken.*
G. Retroactive Disenrollment (critical) Member enrolled into a PDP but did not realize that this action would disenroll him from his retiree plan. He is now in immediate need of medical services from his retiree plan.	*For critical disenrollment requests only, the plan should submit a request to change the complaint to a CMS Issue and notate the following in their notes. (Non-critical disenrollment requests should be handled by the plan, similar to above.) Refer to the CTM Plan SOP for more guidance.* 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*>.
H. Alleged Marketing Misrepresentation (No RO Action Needed) Member is only reporting that they were misled into enrolling into their plan. 1-800-Medicare has enrolled them into a new plan but they do not need any change to the new plan's effective date.	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.

I. <u>Best Available Evidence</u> (BAE) Member states he/she has Low Income Subsidy (LIS) but MARx does not reflect this.	The plan's system does not show that the member has LIS but he/she has provided valid Best Available Evidence (BAE). We have updated our system and notified the member that he/she can now access their medication at the correct LIS copay.
A completed BAE Assistance Worksheet was received from CMS for a member who says he/she has Medicaid but cannot provide Best Available Evidence.	*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*>.
J. <u>Good Cause / Part D IRMAA</u> CMS has approved a Good Cause reinstatement for a member and has changed the CTM issue level to Urgent, indicating to the plan that they are responsible for the next step.	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 (Exhibit 21b from Chapter 3 of Medicare Prescription Drug Benefit Manual) on <*date*>.
Member made full plan premium payment by the due date.	*If member was disenrolled for non-payment of plan premiums, the plan should submit a request to CMS to change the complaint to a CMS Issue and notate the following in their notes:* The member has made full payment by the required date. Since the member has met the requirements for a Good Cause reinstatement, we have granted them access to the plan. We are requesting that CMS take the MARx action to reinstate the member in <*contract-PBP*>. The plan <*has sent/will send*> the member a Notice of Favorable Decision letter (Exhibit 22a from Chapter 3 of Medicare Prescription Drug Benefit Manual) on <*date*>. *If member was disenrolled for non-payment of Part D IRMAA, the plan should submit a request to CMS to change the complaint to a CMS Issue and notate the following in their notes:* The member has made full payment of premiums by the required date. We are requesting CMS to confirm that the member has also paid any applicable Part D IRMAA amounts and take the MARx action to reinstate the member in <*contract-PBP*>.
Member <u>did not</u> make full plan premium payment by the due date.	The member is no longer eligible for a Good Cause reinstatement since the member failed to make full payment by the required date. The member will remain terminated as of <*date*>. The complaint is being sent back to CMS for closure of the complaint.

Member will be disenrolled from their Employer Group Plan (800 series PBP). CMS has asked the plan to re-enroll this member so they will not lose coverage.	The plan has re-enrolled the member into <contract-PBP> for <*date*> using the EGHP SEP. Our systems have been updated so that member will have no break in group coverage. The plan has <*called or sent a letter*> notifying the member of their reinstatement and access to services.
Good Cause / Part D IRMAA (continued) Member was disenrolled from their Employer Group Plan (800 series PBP) and the plan has asked the employer if the member can be enrolled back into their plan.	The plan has confirmed with the member's Employer Group Plan on <*date*> that they will allow a retroactive reinstatement for the member. Plan has submitted a prospective enrollment using the EGHP SEP for <*date*>. *If the member wants a retroactive effective date for this enrollment to prevent a break in coverage with their plan, submit a request to CMS for approval of a retroactive enrollment and the MARx action:* We are requesting CMS approval for a retroactive effective date of <*date*> into <*contract-PBP*> so there is no lapse in group coverage for this member.
K. Employer Coverage The member's enrollment into a Medicare plan rejected because the enrollee is currently enrolled in an employer plan.	The plan contacted the enrollee and he/she understood that enrollment in <*contract-PBP*> will disenroll them from their employer plan and confirmed that member wants to be enrolled in our plan. We resubmitted the enrollment with the Employer Subsidy Override Flag and the enrollment has been accepted. The member was notified <*by phone or letter*> that they are enrolled in <*contract-PBP*> as of <*date*> and currently has access to the plan.
Member was disenrolled from their employer plan and the plan has asked the employer if the member can be re-enrolled back into their plan.	The member was disenrolled from their employer plan on <*date*> due to <*cause*>. Plan has confirmed with the member's employer on <*date*> that they are willing to enroll the member prospectively. The plan has submitted a new enrollment using the EGHP SEP for <*date*>. We have <*called and/or sent a letter*> notifying the member of their enrollment and access to the plan. *If the member wants a retroactive effective date for the new enrollment to eliminate any break in coverage, ask the employer plan if they are willing to reinstate the member retroactively. If they will allow this, send a request to CMS for a change to CMS Issue and notate the following request in the plan's notes:* The employer plan has stated that they will allow this member to be reinstated retroactively with their plan. We are requesting CMS' approval of a retroactive effective date for <*contract-PBP*> to <*date*> and the MARx action. *If CMS approves, the plan should update their system and notify the member of their reinstatement.*
L. Provider/Pharmacy Provider states that plan has been too slow in processing their claims.	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*>. or 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.

M. <u>Premium Deduction</u> Member recently cancelled their plan but plan premiums continue to be deducted from their Social Security or Railroad Retirement Board benefit.	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 1-800-Medicare if the deductions have not stopped at that time.
Premiums are being deducted from the member's Social Security benefits and the member is receiving a premium bill.	The member's record shows that he/she selected to have premiums deducted from their Social Security benefits but the plan has not received these payments. As a result, the member was switched by the plan to a coupon book. We have requested billing to stop sending bills to the member and we have reported the plan payment issue to the DPO. We have notified the member that the billing will stop and they will receive a refund of premiums they paid directly to the plan.
N. <u>Claims</u> A medical service was not covered or not fully covered by the member's plan.	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.
O. <u>Out of Service Area</u> The member was disenrolled for moving out of the plan's service area but the member states that they did not move.	*If the plan disenrolled the member in error:* 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*>. *If the member asks for CMS approval of an enrollment exception to be reinstated with their plan because they did not leave the service area, the plan should submit a request to change the complaint to a CMS Issue and additionally notate:* The member is requesting CMS approval of an enrollment exception to reinstate the member into <*contract-PBP*> for <*effective date*> due to <*reason*>. We informed the member that the matter will be referred back to Medicare for review.

P. <u>Belongs to Another Plan Contract</u> After speaking to the member, the plan learns that the member's issue is with another plan.	*The plan should submit a request to CMS to change the contract assignment to a different contract, notating the reason for their request in plan notes:* 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 beneficiary that the matter will be referred back to Medicare and/or the other plan for review.
Q. <u>Unable to Contact</u> The plan has made unsuccessful calls (different days and times) to the member for additional information or to notify them of the resolution to their complaint.	The plan has made unsuccessful calls to the member on <*dates and times*>. We have left messages with 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: Key Definitions and Acronyms:

BAE - Best Available Evidence

CMS Issue - A complaint is outside a plan's control to resolve and is not attributed to the MA Organization or Part D Sponsor.

Congressional - Complaint submitted by congressperson on behalf of his/her constituents

CTM - Complaints Tracking Module, a module within HPMS

DPO - Center for Medicare's Division of Payment Operations

EE - Enrollment Exception

GC - Good Cause

HICN - Health Insurance Claim Number; beneficiary's unique identifier

Home Region - Regional Office that services the state or territory where the beneficiary or provider resides.

HPMS - Health Plan Management System

IRMAA - Income Related Monthly Adjustment Amount

LEP - Late Enrollment Penalty

Lead Region - Regional Office that has primary responsibility for the management of complaints for a particular plan. For smaller plans, the Home Region and Lead Region are often the same.

MMP - Medicare-Medicaid Plan.

Non-Immediate Need/Non-Urgent/Routine Complaints - Indicates no Issue Level designated. It is expected that plans resolve these complaints within 30 calendar days.

PHI and PII - Protected Health Information and Personally Identifiable Information

RO - CMS Regional Office

RPC - CMS' Retro-Processing Contractor (currently Reed and Associates)

RRB - Railroad Retirement Board

SEP - Special Enrollment Period

SWIFT - Strategic Work Information Folder Transfer. It is CMS' tracking system for some CMS received correspondence from external entities, such as elected officials.

TRR - Transaction Reply Report

Appendix D: 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, Northern Mariana Islands, Guam, Hawaii, Nevada

10 – Seattle – PartDComplaints_RO10@cms.hhs.gov
Alaska, Idaho, Oregon, Washington