

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



CENTER FOR DRUG and HEALTH PLAN CHOICE

MEMORANDUM

DATE: July 28, 2008

To: All Medicare Part C and D Plan Sponsors

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

Subject: Updated Complaint Tracking Module (CTM) Guidance on Standard Operating Procedures

The Centers for Medicare and Medicaid Services (CMS) is pleased to share the updated Part C and D Plan User Standard Operating Procedures (SOP) and Frequently Asked Questions (FAQ) for the Complaints Tracking Module (CTM) with all Medicare Part C and D Plan Sponsors. The attached documents supersede all prior versions of the SOP and FAQ, and will be reviewed with Plans during the 8/6/2008 Part C and D User Call.

Sponsors should pay particular attention to the revised sections of the SOP noted on the last page, as well as the FAQ recommendation that complaints categorized as urgent should be resolved within ten calendar days and that all other complaints should be resolved within thirty calendar days. It is imperative that all Sponsors understand that correct utilization of the CTM is critical to ensuring accuracy of complaint information. Sponsors are encouraged to continue to communicate regularly and work with the assigned regional office staff to appropriately resolve complaints.

We appreciate your continued dedication to responding to the needs of our beneficiaries. If you have any further questions or comments regarding these procedures or the CTM, please contact CMS via email at ctm@cms.hhs.gov.

Attachment A

**Complaints Tracking Module (CTM)
Standard Operational Procedure
Medicare Advantage (MA) Organization and Prescription Drug Plan (Part D) Sponsor Users
July 2008**

MA Organizations and Part D Sponsors are required to follow the procedures outlined in the CTM Plan SOP at all times, while the CTM User Guide serves as a technical reference only.

Note: Revisions made in this version are summarized on the last page of this document.

#	Scenario/ Issue	Procedure
Complaint-specific Issues		
A	Plan A receives a complaint that should have gone to Plan B	<ol style="list-style-type: none"> Plan A indicates in the Current Entry (Plan Response) field <ol style="list-style-type: none"> if known, the name and/or contract number of the Plan to where the complaint must be reassigned and, any additional pertinent notes related to the complaint. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this complaint belongs to another plan. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the "Notes to Plan" section on the Plan Response page. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system as the complaint is reassigned to a different contract. If Plan A has access to the other contract number, then Plan A will be able to view the complaint under the new contract number. <p>Note: When a complaint is assigned from one contract to another, the "clock" restarts for the new contract. This is captured through the assignment/reassignment date.</p>
B	Plan A receives a complaint that involves one of its subsidiaries	<ol style="list-style-type: none"> Plan A indicates in the Current Entry (Plan Response) field <ol style="list-style-type: none"> if known, the name and/or contract number of the Plan to where the complaint must be reassigned and, any additional pertinent notes related to the complaint.

#	Scenario/ Issue	Procedure
		<ol style="list-style-type: none"> 2. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this complaint belongs to another plan. 3. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. 4. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the "Notes to Plan" section on the Plan Response page. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system under the previous contract number as the complaint is reassigned to a different contract. If Plan A has access to the subsidiary's contract number, then Plan A will be able to view the complaint under the new contract number. <p>Note: When a complaint is assigned from one contract to another, the "clock" restarts for the new contract. This is captured through the assignment/reassignment date.</p>
C	Plan A cannot do further work with the complaint and requires RO assistance to resolve (CMS Issue)	<ol style="list-style-type: none"> 1. Plan A indicates in the Current Entry (Plan Response) field any pertinent notes related to the complaint. 2. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this complaint is a CMS issue. 3. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. 4. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the "Notes to Plan" section on the Plan Response page. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system as the complaint is flagged as "CMS Issue." <p>Note: Examples of CMS Issues include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Beneficiary has an immediate need and a retroactive enrollment or disenrollment action is required, • Complaints related to enrollment exceptions, • Complaints related to CMS enrollment reconciliation processing.
D	Plan A receives an MA	Most likely, the complaint is related to the Part D program

#	Scenario/ Issue	Procedure
	classified complaint that is not related to the MA program	<p>(prescription drugs). The complaint needs to be recategorized as a Part D complaint and requires a complaint category reassignment. Please do the following:</p> <ol style="list-style-type: none"> 1. Plan A indicates in the Current Entry (Plan Response) field any pertinent notes related to the complaint. 2. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this complaint is related to the Part D program rather than the MA program. 3. Additionally, Plan A selects the appropriate Part D complaint category. Plan A clicks "Select Complaint Category", then selects the most appropriate Part D category, and then clicks the "Select Category" button at the bottom of the pop-up page to save. Plan A's category recommendation should appear in the blue box when saved correctly. Submit the request when complete. 4. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. 5. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the "Notes to Plan" section on the Plan Response page. If the RO agrees with the request, Plan A will also be able to view the request in the "Notes to Plan" section on the Plan Response page. <p>Note: When the RO agrees with the request to designate the complaint as Part D and agrees to the complaint category change, the RO may determine the complaint no longer belongs to Plan A. If that occurs, then Plan A will no longer be able to see the complaint in the system as the complaint was reassigned to another contract or flagged as a "CMS Issue".</p>
E	Plan A receives a Part D classified complaint that is not related to the Part D program	<p>Most likely, the complaint is related to the Medicare Advantage (MA) program. The complaint needs to be recategorized as an MA complaint and requires a complaint category reassignment. Please do the following:</p> <ol style="list-style-type: none"> 1. Plan A indicates in the Current Entry (Plan Response) field any pertinent notes related to the complaint. 2. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this complaint is related to the MA program rather than the Part D program. 3. Additionally, Plan A selects the appropriate MA

#	Scenario/ Issue	Procedure
		<p>complaint category. Plan A clicks “Select Complaint Category”, then selects the most appropriate MA category, and then clicks the “Select Category” button at the bottom of the pop-up page to save. Plan A’s category recommendation should appear in the blue box when saved correctly. Submit the request when complete.</p> <ol style="list-style-type: none"> The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the “Notes to Plan” section on the Plan Response page. If the RO agrees with the request, Plan A will also be able to view the request in the “Notes to Plan” section on the Plan Response page. <p>Note: When the RO agrees with the request to designate the complaint as MA and agrees to the complaint category change, the RO may determine the complaint no longer belongs to Plan A. If that occurs, then Plan A will no longer be able to see the complaint in the system as the complaint was reassigned to another contract or flagged as a “CMS Issue”.</p>
F	Plan A has reached resolution of the complaint but has not yet notified the beneficiary	<ol style="list-style-type: none"> Plan A documents plan resolution notes (see Scenario L), closes the complaint in the CTM and reports the status as resolved. Plan A notifies the beneficiary according to Plan A’s business practices and customer service policies. <p>Note: As a best practice, Plan A attempts to contact the complainant at least 3 times, with the 4th attempt in writing. Plan A should attempt to contact the beneficiary/complainant at different times on different days in order to ensure maintaining best practice. Plan A records detail, including the dates and times of contact attempts, actions taken, etc., of all attempts in CTM and then closes the complaint.</p>
G	Plan A cannot close and/ or save the complaint after entering resolution notes and a resolution date	<ol style="list-style-type: none"> Plan A verifies a resolution date is entered in the resolution date field. Note: Resolution date must be entered in order for the complaint to be recorded as closed/resolved in the CTM. <ol style="list-style-type: none"> If there is no resolution date, enter and save the date the complaint was resolved. The complaint should close. If the complaint still does not save, move to item G.2. If there is a resolution date, move to item G.2.

#	Scenario/ Issue	Procedure
		<ol style="list-style-type: none"> 2. Plan A verifies that the complaint category is assigned properly. <ol style="list-style-type: none"> a. If no category is assigned, refer to Scenario J. b. If a category is assigned, move to item G.3. 3. Plan A verifies that the following restricted characters were not entered in the resolution notes and/or the resolution date field: < > & ; 4. Plan A contacts the HPMS Help Desk at 1-800-220-2028 or HPMS@cms.hhs.gov.
H	Plan A receives complaints related to retroactive disenrollments (RDs) or retroactive enrollments (REs)	<ol style="list-style-type: none"> 1. Plan A develops the complaint to determine if it is a valid RD or RE request. 2. If the RD or RE request is not valid and the complaint is resolved, the plan notifies the beneficiary, documents Plan resolution notes (see Scenario L), closes the complaint in the CTM, and reports the status as resolved. 3. If a complaint is incorrectly coded as an RD or RE and requires referral to another Plan, see Scenario A in this SOP. 4. If the RD or RE request is valid, Plan A determines if the complaint is Critical or Non-Critical. Complaints labeled Immediate Need by 1-800-MEDICARE are ALWAYS considered Critical and are automatically flagged as “CMS Issue”. Other complaints that shall be considered Critical include: <ol style="list-style-type: none"> a. For MA and MAPD: the complaint concerns immediate need to access to care. b. For MA, MAPD, and PDP: the complaint concerns opt-out due to employer group coverage. 5. Critical Retro-Disenrollment or Retro-Enrollment complaints are to be worked by the home regional office. <ol style="list-style-type: none"> a. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this complaint is a CMS issue and indicates in the Current Entry (Plan Response) field “CRITICAL RD” or “CRITICAL RE”. The Plan needs to include reasons why a valid CRITICAL RD/RE request should be granted and the appropriate effective date for the request. b. The lead regional office will approve or deny Plan Resolution Requests and transfer CRITICAL RD and CRITICAL RE complaints to the home region as necessary. The home regional office will approve or deny the Plan Resolution Request and process CRITICAL RDs and CRITICAL REs as appropriate. c. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. Plan A should indicate in the Current Entry (Plan Response) field that the complaint and all development

#	Scenario/ Issue	Procedure
		<p>have been referred to the home RO for processing.</p> <ul style="list-style-type: none"> d. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. e. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the "Notes to Plan" section on the Plan Response page. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system as the complaint is flagged as a "CMS Issue." f. If Plan A needs assistance with critical RD/RE complaints that they receive directly and are NOT in CTM, Plan A will forward information to the Lead Region (using RO e-mail mailboxes, specified at the end of this document). If the email includes protected health information (PHI), the sponsor must use encryption software. <p>6. Non-Critical Retro-Disenrollment or Retro-Enrollment complaints should be referred to the RPC by Plan A.</p> <ul style="list-style-type: none"> a. Plan A leaves the complaint OPEN, documents all complaint development, and indicates in the Current Entry field that the complaint has been referred to the Retro-processing Contractor (RPC). b. Plan A sends all required information to the RPC. c. Plan A documents RPC status in Current Entry (Plan Response) fields. Provide any status you receive from the RPC in the CTM (e.g., receipt confirmation and date, disposition report response and dates received, contact notes and dates with the RPC). d. When a RD or RE complaint is resolved by the RPC, they will notify Plan A of the resolution. Subsequently, Plan A will close the complaint in the CTM. <p>Note: RDs and REs are excluded from Performance Metrics analyses.</p>
I	Plan A receives complaints related to enrollment exceptions (EE)	<ul style="list-style-type: none"> 1. After validating the complaint is truly an enrollment exception request, Plan A indicates in the Current Entry (Plan Response) field <ul style="list-style-type: none"> a. "EE Complaint" and b. any additional pertinent notes related to the complaint. 2. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this is a CMS issue.

#	Scenario/ Issue	Procedure
		<ol style="list-style-type: none"> 3. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. 4. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the "Notes to Plan" section on the Plan Response page. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system as the complaint is flagged as a "CMS Issue."
J	Plan A receives a miscategorized complaint or a complaint with no assigned category and subcategory	<ol style="list-style-type: none"> 1. Plan A indicates in the Current Entry (Plan Response) field any pertinent notes related to the complaint. 2. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this complaint requires reassignment to another complaint category. 3. Additionally, Plan A clicks "Select Complaint Category", then selects the most appropriate category, and then clicks the "Select Category" button at the bottom of the pop-up page to save. Plan A's category recommendation should appear in the blue box if saved correctly. Submit the request when complete. 4. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to recategorize the complaint. The time clock for Plan A will stop once the request is submitted and will commence once the complaint is recategorized by the RO. 5. For updates on the request, Plan A will be able to view the RO action/decision in the "Notes to Plan" section on the Plan Response page.
K	Plan A receives a complaint with an issue level of "Immediate Need" or "Urgent", but Plan A does not agree with the issue level.	<ol style="list-style-type: none"> 1. Plan A indicates in the Current Entry (Plan Response) field any pertinent notes related to the complaint. 2. Plan A selects the check box that the complaint requires reassignment to another issue level and from the drop down box provided selects the appropriate issue level for the complaint from the drop down box. (Please refer to the Issue Level Definitions note below to determine the appropriate issue level for the complaint). Select "Submit" when the request is complete. 3. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to reassign the complaint. The time clock for Plan A will stop once the indicator is checked and will commence once the complaint is reassigned. 4. For updates on the request, Plan A will be able to

#	Scenario/ Issue	Procedure
		<p>view the RO action/decision in the "Notes to Plan" section on the Plan Response page.</p> <ol style="list-style-type: none"> 5. IF Plan A has taken action to address the immediate/urgent need (e.g., activated pharmacy system), Plan A can request a change in Issue Level. 6. If Plan A has taken action to address immediate/urgent need complaints, and the Issue Level has been changed per Plan Request to non-critical, and a retroactive MARx enrollment action is needed, Plan A should forward needed MARx enrollment action, as required, to the RPC (see Scenario H6). <p>Note: Issue Level Definitions</p> <ul style="list-style-type: none"> • For MA, an immediate need complaint is defined as a complaint where a beneficiary has no access to care and an immediate need for care exists. Plans are required to resolve these complaints within 2 calendar days. • For Part D, an immediate need complaint is defined as a complaint that is related to the beneficiary's need for medication where the beneficiary has 2 or less days of medication left. Plans are required to resolve these complaints within 2 calendar days. • For MA, an urgent complaint involves a situation where the beneficiary has no access to care, but no immediate need exists. • 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. • CMS reserves the right to classify any complaint that does not fit the above definition to "Immediate Need" or "Urgent" should the complaint be egregious in nature.
L	Plan A is ready to record plan resolution or response notes in the Current Entry (Plan Response) field	<ol style="list-style-type: none"> 1. Plan A records a clear and concise narrative in the Current Entry (Plan Response) field up to 4,000 characters. <ol style="list-style-type: none"> a. All entities reviewing CTM complaint records should be able to understand the Plan Response notation and all action(s) taken and decisions made related to the complaint investigation and resolution. Vague responses such as "Case closed by Plan" should be avoided. b. Identify systems as "pharmacy", "enrollment," etc. c. Minimize the use of word abbreviations. d. Include systems issues, updates and dates actions taken. e. Include system update timeframes and transaction reply code(s) when appropriate. 2. The entry should contain information from Plan A's contact with the beneficiary/complainant and date(s)

#	Scenario/ Issue	Procedure
		<p>of contact.</p> <ol style="list-style-type: none"> In addition, if other person(s) are contacted, record those contact(s) information in the Current Entry (Plan Response) field. Refer to the “Plan Response/ Resolution Examples” document which is available on the CTM Start Page as a link under Documentation. <p>Note: As a best practice, Plan A attempts to contact the complainant at least 3 times, with the 4th attempt in writing. Plan A should attempt to contact the beneficiary/complainant at different times on different days in order to ensure maintaining best practice. Plan A records detail, including the dates and times of contact attempts, actions taken, etc., of all attempts in CTM and then closes the complaint.</p>
M	<p>Plan A receives a complaint with one or more of the following indicators flagged in the CTM:</p> <ul style="list-style-type: none"> Controlled in SWIFT Congressional complainant type Press or Hill Interest 	<ol style="list-style-type: none"> Plan A contacts all parties related to the complaint in accordance with timeliness standards informing on expected plan actions and resolution. Plan A effectuates investigation, resolution and records a clear and concise narrative in the Current Entry (Plan Response) field and includes a “SWIFT or Congressional Resolution” notation. The entry must include all actions taken including contact, dates and instructions provided to the beneficiaries, complainant(s) and contacts. Include systems updates and the dates the actions were taken. In the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this complaint is a CMS Issue. As a best practice, this should be done within 2 to 7 calendar days. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the “Notes to Plan” section on the Plan Response page. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system as the complaint is flagged as a “CMS Issue.” <p>Note: SWIFT, Congressional, Press, or Hill interest complaints are treated as immediate need or urgent in the CTM.</p>
N	<p>Plan A receives a complaint that is related to an SSA Premium Withhold Issue</p>	<ol style="list-style-type: none"> Plan A reviews the complaint for incorrect premium amount and appropriate premium deduction method in accordance with beneficiary preference and makes appropriate corrections, if applicable. If Plan A’s systems and MARx are correct and the beneficiary complains about inappropriate amounts

#	Scenario/ Issue	Procedure
		<p>being deducted, then Plan A should review the transaction dates. Keep in mind that transactions take 60 to 90 days to post to all CMS and SSA systems. If the transactions are within this period, educate the beneficiary and close the complaint.</p> <ol style="list-style-type: none"> 3. If the complaint is regarding SSA premium deductions that extend past the expected period or an action by Plan A will not correct the issue, report the complaint to the Regional Office where the beneficiary resides (i.e., the Home Region) using current methods (i.e., via the Plan Request function) and leave the complaint OPEN. If the complaint is NOT in the CTM, send the complaint to the RO mailbox (specified at the end of this document). The subject line should state "SSA Premium Issue – Not in CTM" and the message should indicate the research already conducted. 4. Plan A should note if the complaint category needs to be changed in the Current Entry (Plan Response) field when returning the complaint to CMS as a "CMS Issue". Refer to Scenario J. <p>Note: Refer to the March 23, 2007 HPMS memorandum regarding, "Clarification of Involuntary Disenrollment Policy for Beneficiaries who Elect Social Security Premium Withholding".</p> <p>Note: Plan A should report plan premium payment problems to Plan A's CMS DPO representative.</p> <ul style="list-style-type: none"> • CTM complaints that include both a complaint that the beneficiary is getting billed while in SSA premium withhold status AND include a Plan A premium payment problem should remain OPEN until the beneficiary issue is resolved and the beneficiary is made whole. When Plan A has exhausted all avenues to resolve the beneficiary issue, the complaint should be considered a "CMS Issue" and the Home Region assigned should contact the appropriate CMS DPO representative on plan premium payment issues. • CTM complaints that include ONLY Plan A payment issues may be closed. Plan A should contact their CMS DPO representative on these issues, if necessary.
O	Plan A receives a complaint related to Premium Reconciliation – Refund or Billing Issue	<ol style="list-style-type: none"> 1. Plan A reviews the complaint, following the instructions detailed in the July 23, 2007 HPMS Memorandum regarding "Update on the 2006 Premium Withholding Reconciliation (PWR) including file layouts for new ad-hoc member level report". 2. The Beneficiary Detail File should be utilized to determine amounts refunded and amounts owed by the beneficiary, according to CMS records. This file was made available to plans in September 2007. Special TRRs will also be available to assist in analyzing complaints arising from the Premium

#	Scenario/ Issue	Procedure
		<p>Reconciliation.</p> <ol style="list-style-type: none"> 3. If an action by Plan A will not correct the issue, then in the Plan Resolution Request for CMS section, Plan A checks the option to indicate that this is a CMS issue. 4. The CTM will not allow Plan A to close the complaint while a Plan Resolution Request is pending CMS resolution. The complaint is flagged in the CTM for the RO to agree or disagree with the plan request. A time stamp is recorded when Plan A makes the request and another time stamp is recorded once the RO makes a decision. 5. For updates on the request, Plan A will be able to view if the RO disagrees with the request in the "Notes to Plan" section on the Plan Response page. If the RO agrees with the request, Plan A will no longer be able to see the complaint in the system as the complaint is flagged as a "CMS Issue". <p>Note: Refer to the March 23, 2007 HPMS memorandum regarding, "Clarification of Involuntary Disenrollment Policy for Beneficiaries who Elect Social Security Premium Withholding".</p>
P	Plan A receives a provider complaint in the CTM	<ol style="list-style-type: none"> 1. Plan A reviews the complaint and contacts the provider for additional information if needed. 2. Plan A takes any necessary steps to address the complaint, acknowledges the complaint in the complaint summary (noting any steps toward resolution), and closes the complaint in the CTM.
Q	Plan receives a complaint categorized as "Enrollment Exception – Marketing Misrepresentation (No RO Action Needed)"	<ol style="list-style-type: none"> 1. Plan A carefully reviews the allegation of marketing misrepresentation. 2. After investigating the complaint, Plan A corrects any underlying issues that may have led to the beneficiary complaint. 3. The Plan enters any action taken to correct the situation in the Complaint Summary field and closes the complaint in the CTM. Documentation in the Complaint Summary field should include the name of the agent/broker involved in the complaint.
R	Plan A identifies an MA or Part D complaint where the Plan needs the complaint to be entered into the CTM as a CMS Issue or where RO assistance is required to resolve the complaint.	<ol style="list-style-type: none"> 1. Plan A identifies a complaint that should be addressed by CMS as a CMS Issue. 2. Plan A identifies the appropriate RO where the complaint should be addressed following direction by CMS and in this SOP. 3. Plan A sends an e-mail to the appropriate Lead or Home RO mailbox (specified at the end of this document). 4. The e-mail subject line should include "Complaint NOT in CTM" and the message should indicate the research already conducted. <p>NOTE: Plan A should evaluate the complaint, exhausting all established CMS requirements prior to forwarding to ROs. If e-mail includes protected health information (PHI), the sponsor must use encryption software when sending</p>

#	Scenario/ Issue	Procedure
		the e-mail.
S	Plan A receives a repeat complaint from the same caller	<p>Plan A identifies the new complaint is the same issue of a previous complaint entered into the CTM.</p> <ol style="list-style-type: none"> 1. Plan A searches for all complaints by the same member and researches the issue. 2. If the issue was resolved in a different complaint after the member called in the repeat complaint, the plan will close the case and annotate that it is a repeat complaint. 3. If the issue is still open, but the plan is working to resolve the issue or the plan has not yet begun to investigate the issue, the plan should close the newer issues stating that the issue is being worked and referencing the CTM complaint that is being addressed. 4. If the issue is a different issue than the previous issue, the plan should not close the newer issue as a repeat caller case, but should treat the complaint as a separate issue.
Access		
T	Plan user needs HPMS Access but does not have it	<ol style="list-style-type: none"> 1. Plan user completes the standard "Application for Access to CMS Computer Systems" form found at http://www.cms.hhs.gov/AccessstoDataApplication. 2. Plan user sends the completed, signed, original form (with wet signature/date) to the following address: ATTENTION: Lori Robinson Centers for Medicare & Medicaid Services 7500 Security Boulevard Mail Stop: C4-14-21 Baltimore, MD 21244 <p>Note: We strongly recommend the use of a traceable mail carrier to ensure a timely delivery. HPMS user set up may take 2 weeks or longer.</p> <ol style="list-style-type: none"> 3. Once the Plan user is notified of their HPMS access, Plan user sends an e-mail to HPMS_Access@cms.hhs.gov to request CTM access. The e-mail's subject should read "CTM Access Request" and the message should contain the user's HPMS ID.
U	Plan user has HPMS access but needs CTM access	<ol style="list-style-type: none"> 1. Plan user sends an e-mail to HPMS_Access@cms.hhs.gov to request CTM access. The e-mail's subject should read "CTM Access Request" and the message should contain the user's HPMS ID.
General		
V	Plan A has a general CTM related question or issue	<ol style="list-style-type: none"> 1. Plan A sends the inquiry to CMS at CTM@cms.hhs.gov. 2. The subject line should state if the question or issue is

#	Scenario/ Issue	Procedure
		<p>related to Medicare Advantage or Part D.</p> <p>3. The e-mail includes:</p> <ul style="list-style-type: none"> a. the name and contract number of Plan A, b. the question or issue, c. pertinent information related to the concern at hand, and d. complaint ID(s), if the matter is complaint-specific.

Key & Definitions

1. BAE = Best Available Evidence
2. CIS = Customer Inquiry System; CMS' tracking and triage system for CMS received correspondences from external entities, such as Congressmen, Senators, etc. (now defunct and being replaced by SWIFT)
3. "CMS Issue" contract assignment = a complaint is flagged as a "CMS Issue" when the complaint is a CMS issue and is not attributed to the MA Organization or Part D Sponsor
4. Congressional Complainant = CMS complaint submitted by congressperson on behalf of his/her constituents
5. CTM = Complaints Tracking Module, a module within HPMS
6. DPO = Division of Payment Operations (CO)
7. EE = Enrollment Exception
8. HICN = Health Insurance Claim Number; beneficiary's unique identifier
9. Home Region = Regional Office that services the state or territory where the beneficiary or provider resides
10. HPMS = Health Plan Management System
11. Immediate Need complaint = a.k.a. "immediate action"; type of issue level. For MA, a complaint that is related to a situation where the beneficiary has no access to care and an immediate need for care. For Part D, a complaint related to the beneficiary's need for medication where the beneficiary has 2 or less days of medication left. MA Organizations and Part D Sponsors are required to resolve these complaints within 2 calendar days from the time it is assigned. CMS reserves the right to classify any complaint that does not fit the above definition to "Immediate Need" should the complaint be egregious in nature
12. Lead Region = Regional Office that has primary responsibility for the management of complaints for a particular plan
13. "Other" contract assignment = a complaint is identified as "other" in the contract number field when the beneficiary complains about a MA Organization or Part D Sponsor but the contract number was not identified or found at the time of intake
14. PHI = Protected Health Information
15. Plan A, B, etc. = Any MA Organization/Part D Sponsor
16. RD = Retroactive Disenrollments
17. RE = Retroactive Enrollments
18. RO = Regional Office
19. RPC = Retro-processing Contractor (i.e., Integriguard)
20. SWIFT = CMS' tracking and triage system for CMS received correspondences from external entities, such as Congressmen, Senators, beneficiaries, etc. (replaces CIS)
21. "Unknown" contract assignment – a complaint is identified as "unknown" in the contract number field when the beneficiary complains about a MA Organization or Part D Sponsor that is not known or when beneficiary complaint is not directed toward a MA Organization or Part D Sponsor
22. Urgent complaint = type of issue level. For MA, an urgent complaint involves a situation where the beneficiary has no access to care, but no immediate need exists. For Part D, a complaint that is related to the beneficiary's need for medication where the beneficiary has 3 to 14 days of medication left.

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_RO10@cms.hhs.gov
American Samoa, Arizona, California, Commonwealth of the Northern Mariana Islands, Guam, Hawaii, Nevada
10 – Seattle - PartDComplaints_RO9@cms.hhs.gov
Alaska, Idaho, Oregon, Washington

July 2008 Revisions

Scenario / Issue	Change Made
Throughout	Replaced references to “CIS” with “SWIFT”
A	Added note reminding that the “clock” restarts when a complaint is assigned from one contract to another.
B	Added note reminding that the “clock” restarts when a complaint is assigned from one contract to another.
F	Clarified best practice on beneficiary/complainant contact.
H5a	Added instructions to include reasons why a valid CRITICAL RD/RE request should be granted.
H5f	New procedures for CRITICAL RD/RE complaints that are not in CTM
H6	Changed references to Integriguard to the RPC (Retro-processing Contractor)
	Enhanced procedures for documenting status received from the RPC
K	Clarified resolution timeframes for immediate need cases
L	Clarified best practice on beneficiary/complainant contact.
N	Modified procedures to use the Plan Request function rather than e-mail to report Premium Withhold complaints that cannot be corrected to the ROs. Changed procedures to indicate that, once a Plan has exhausted all avenues to resolve the Premium Withhold issue, the complaint should be considered a “CMS Issue” and assigned to the Home Region.
P	New provider complaint procedures.
Q	New “Enrollment Exception – Marketing Misrepresentation (No RO Action Needed)” procedures.
R	New procedures for times when a complaint is needed to be entered into the CTM or when RO assistance is required.
S	New procedures about repeat complaints.
Keys & Defs	Added BAE, Home Region, Lead Region, RPC and SWIFT definitions.
RO Mailboxes	Listed appropriate RO Mailboxes at the end of the document.

Attachment B

Complaints Tracking Module (CTM) Frequently Asked Questions (FAQs)

July 2008

1) What is the CTM?

The Complaints Tracking Module (CTM) is a module within the Health Plan Management System (HPMS) which assists CMS and our contracted plans in tracking and resolving beneficiary complaints. It is the Centers for Medicare and Medicaid Services' (CMS) central repository for complaints received from various CMS sources, including, but not limited to, 1-800-Medicare call centers and regional offices. Plans are required to resolve complaints in the CTM based on specific timeframes as indicated by CMS. Complaints in the CTM are used for various performance measures to ensure plan compliance and CMS oversight.

2) What is the difference between CTM complaints and grievances?

The difference is in how they are received. Grievances are received directly by the plan from the beneficiaries. Plans are required to report grievances to CMS per the Part D Reporting Requirements. Conversely, CTM complaints are received by CMS (through 1-800-Medicare call centers, phone calls to the CMS regional offices, etc.) and then entered in the CTM for resolution by either the plan or by CMS. CMS recommends that plans track grievances separately from CTM complaints.

3) How do I get access to the CTM?

Prospective Plan users must complete the "Application for Access to CMS Computer Systems" form at <http://www.cms.hhs.gov/AccessToDataApplication> and then send the completed, signed, original form (with wet signature/date) to the following address:

ATTENTION: Lori Robinson
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: C4-14-21
Baltimore, MD 21244

We strongly recommend the use of a traceable mail carrier to ensure a timely delivery.

Once the new Plan user is notified of their HPMS access, the Plan user should send an email 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.

4) What is the turn around time for complaints resolution?

For complaints flagged with an issue level of immediate action/need, plans are required to resolve them within two calendar days. It is recommended that complaints categorized as urgent should be resolved within ten calendar days and that all other complaints be resolved within thirty calendar days.

- 5) **Which date does CMS use to measure performance and turn around time frames?**
CMS uses the contract assignment/reassignment date. This date reflects when the complaint is assigned to the contract.

- 6) **Do you have guidance for the plans on how to use the CTM?**
Yes, CMS posts the updated versions of the CTM Plan Standard Operating Procedures (SOP) on the CTM Start Page as a link under Documentation. CMS recommends that all Plans review this document thoroughly and follow the procedures provided. Further technical guidance is provided in the User's Guide, which is available on the CTM Start Page as a link under Documentation.

Note: Plans are required to follow the procedures outlined in the CTM Plan SOP at all times, while the User Guide serves as a technical reference only.

- 7) **Who may I contact for specific issues and/ or questions?**
Submit your question(s) to the CTM mailbox at ctm@cms.hhs.gov. If your issue is regarding a specific CTM complaint, please include the complaint ID. If you have a technical problem using HPMS or the CTM, please contact the HPMS Help Desk at 800-220-2028 or hpms@cms.hhs.gov.

- 8) **How do I run CTM reports for my organization?**
Plans have the ability to generate Aging Reports in the CTM, which will include all cases after May 1, 2006. The Aging Report will use the Assignment/Reassignment Date for reporting. Plan users can access this report via the "Plan Aging Report" selection on the CTM start page. In addition, the plan download file may be used to generate ad hoc or custom reports at the discretion of each organization.

- 9) **Are cases referred to Integriguard included in my organization's Part D Performance Metrics?**
No, CMS excludes cases referred to Integriguard in the Performance Metrics analyses. However, Plans should still address these types of cases in a timely manner to prevent the likelihood of a duplicate case being entered in the CTM and to provide good beneficiary customer service. Plans should follow the CTM Plan SOP for additional guidance.

- 10) **What is the difference between a Home Region and a Lead Region?**
Home Region is determined by the state or territory where the beneficiary resides. Lead Region is determined by the Regional Office that is responsible for the casework management of that Plan. In some instances, the Home and Lead Region are the same, but in other instances they differ.