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CENTER FOR MEDICARE

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

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SUBJECT: Complaint Tracking Module (CTM) and Casework Reminders

DATE: December 29, 2010

With the upcoming new benefit year, now is a good opportunity for your organization to review the following casework reminders and prevention tips to ensure beneficiaries continue to receive high quality customer service and access to services. Good customer service and attentiveness to beneficiary complaints are essential to making the Medicare program a success. The Centers for Medicare & Medicaid Services (CMS) appreciates the efforts of Part C and D organizations (hereinafter referred to as "plans") to address and resolve Medicare enrollees' issues. Even with continued growth in these programs CMS observed further reductions in the volume of CTM complaints as well as improved responsiveness nationally in 2010.

In 2011, the Coverage Gap Discount Program will be introduced, beneficiaries and their advocates will be able to send complaints to CMS via www.medicare.gov, and we anticipate expanding CTM access to all State Health Insurance Programs (SHIPs) that currently do not have it. These three significant changes make it increasingly important that plans have controls in place to not only resolve individual complaints when they are received, but also to use CTM information (in conjunction with grievance and call center data) to identify larger issues that affect many more individuals.

The reminders and prevention tips that follow are intended to supplement the December 9, 2008 and December 28, 2009 HPMS memoranda on these same topics, as well as the CTM Standard Operating Procedures, which was updated in the October 22, 2010 HPMS memorandum.

Casework Reminders:

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

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

3. Many plans have found the newly released "Complaint Attachments" function in CTM useful in providing thorough documentation for complaint resolution. Plans are encouraged to continue uploading documents pertinent to the investigation and resolution of the CTM case, including any relevant beneficiary communications, screen prints from plan systems and notifications received from third parties such as CMS' Retro-Processing Contractor (RPC) or Independent Review Entity.

4. CTM complaints marked as "SWIFT" or Congressional are not to be closed by the plan. Such complaints should be returned as a "CMS Issue" request for final closure by CMS. A prompt return of these complaints to CMS after the plan has completed their investigation will help to reduce the likelihood of follow-up complaints.

5. CMS has observed continued delays in provider or pharmacy complaint resolution, resulting in an increased number of escalations to Congressional offices. Plans are reminded that these types of complaints should be resolved following the timeline requirements outlined in the CTM SOP for claims and payment processing.

6. Plans are reminded not to submit plan requests for reinstatement of beneficiaries that were disenrolled incorrectly due to a plan error that resulted in a subsequent enrollment into LI NET. LI NET enrollments in these instances will not be cancelled or overridden. Plans seeking to retain members should attempt to secure new, prospective enrollments.

7. A high volume of complaints typically are those that are overdue pending RPC action. Plans are encouraged to carefully monitor RPC submissions, ensuring that valid, appropriate, and timely requests are made. Since RPC turnaround times are typically less than 10 days, plans should be able to submit all appropriate RPC requests and still resolve CTM complaints within required timeframes. Plans are reminded to flag these complaints with the RPC indicator in CTM to indicate that no casework action by CMS or the plan is needed and to prevent any duplication of work by CMS and the RPC.

8. Retroactive enrollment complaints that meet CMS' critical criteria should continue to be sent to CMS via plan requests with an indication in the plan notes that the access portion of the complaint has been resolved. Additionally, Category 3 retroactive action requests (see HPMS memo from 2/24/09) should be sent to the CMS caseworker assigned to the complaint to ensure timely CTM processing of the complaint. Plans should not send Category 2 requests (see HPMS memo from 2/24/09) to CMS for action, particularly those that were caused by a plan or agent error.

9. CMS continues to see a significant volume of Late Enrollment Penalty (LEP) complaints. While it is the original plan's responsibility to submit the LEP removal transaction, we encourage the beneficiary's current plan to submit this in order to expedite the process and mitigate any unnecessary inconvenience to the beneficiary..

10. Requests to downgrade the issue level for complaints after the access portion of the complaint has been addressed will not be approved unless the issue level was originally incorrect. Similarly, requests to re-categorize complaints in the "Enrollment Exception – Alleged Marketing Misrepresentation" categories when a plan believes a complaint is subsequently determined to be unfounded will not be approved.

Casework Prevention Tips:

1. Plan customer service representatives (CSRs) should know what forms of evidence are considered acceptable proof of Low Income Subsidy (LIS) and attempt to obtain "best available evidence" from the beneficiary, rather than refer them to 1-800-MEDICARE. Once eligibility has been verified, the drug plan should provide access to medications at the correct LIS cost-sharing level even when CMS systems do not yet reflect this eligibility. Attachment A of the January 22, 2010 HPMS Memo "Announcement of a New Stage of Monitoring for Best Available Evidence (BAE)" and the May 11, 2009 HPMS Memo "Additional Guidance on Best Available Evidence" are excellent instructions on this process and CMS' expectations.

2. Plans are reminded to submit timely beneficiary reinstatement requests directly to the RPC, rather than directing such requests to 1-800-MEDICARE. In 2011, plans will be able to accept verbal requests for reinstatement as long as the request is documented by the plan.

3. Starting in January 2011, non-LIS Part D beneficiaries will get a 50% discount on brand-name drugs at the point-of-sale and a 7% increase in coverage for all other covered Part D drugs (i.e., generic drugs and diabetic supplies) while they are in the coverage gap. CMS emphasizes that Part D Sponsors are the primary point-of-contact for beneficiaries' specific discount questions; 1-800-MEDICARE will direct callers to their plans. Plans that are able to address questions about the discount at the initial point of contact are less likely to receive related CTM complaints. CMS will implement new subcategories in the Pricing/Co-Insurance category to capture CTM complaints related to this increased coverage, particularly those where beneficiaries indicate they sought answers from their plan first but their issue remains unresolved.

4. Plan CSRs should be knowledgeable of special enrollment periods (SEPs) that may be processed by the plan. They are listed in Chapter 3, Section 30, "Enrollment and Disenrollment Periods and Effective Dates" of the PDP Guidance and Chapter 2, Section 30, "Election Periods and Effective Dates" of the Medicare Managed Care Manual. CMS staff will consider any reasonable request for exceptional circumstance enrollment request not specifically mentioned in these sections. In addition, plan CSRs should be informed of the elimination of the Medicare Advantage Open Enrollment Period, the new Medicare Advantage Annual Disenrollment Period and the timeframe change for the Annual Election Period.

5. CMS has noticed continued beneficiary issues with concurrent enrollments in a Medicare Advantage plan and Medicare supplemental insurance. This is an indication of beneficiary confusion or misrepresentation of coverage. Because this adversely affects beneficiary coverage, plans are asked to use CTM data and outbound call results as a training tool for CSRs to identify ways to prevent CTM complaints relating to this.

6. Enrollment-related complaints continue to represent the majority of CTM issues. Some plans are not properly validating out of area moves or erroneous death indicators identified in the Transaction Reply Reports, causing inappropriate disenrollments for beneficiaries. To avoid a high volume of complaints regarding these issues, plans are urged to follow guidance for these scenarios to prevent unnecessary breaks in beneficiary coverage and access to care issues.

7. In recent years, CMS has seen an increase in "bulk" disenrollments for failure to pay plan premiums. Plans should be regularly identifying delinquent accounts and processing disenrollments on a flow basis, after the appropriate notices have been mailed and grace periods have been applied. Doing so will help reduce the likelihood of abnormal and unexpected trends in CTM data that could result in a plan being identified as a CTM "outlier" for a particular month.

8. CMS continues to observe that some plans repeatedly refer their member calls to 1-800-MEDICARE. Plans are reminded to use all existing data sources to resolve their complaints and once a resolution is achieved, plans should use their beneficiary notification process as an opportunity to inform their members to contact them directly should they have future inquiries or complaints.

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